



CASE REPORT: PLACENTAL POLYP PRESENTING AS A CASE OF SECONDARY POSTPARTUM HAEMORRHAGE

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ABSTRACT Placental polyp is one of the rare diseases that can affect women after delivery or abortion for indefinite period which forms a polypoidal mass in the uterus.¹ The incidence of placental polyp is less than 0.25% of all pregnancies.² The case report is of a 41 year old woman, G8 P6L6 A1 who presented on postpartum day 19 and 30 with secondary postpartum haemorrhage. She underwent check curettage on postpartum day 19 and was discharged. And had to undergo emergency hysterectomy on postpartum day 32 as she presented in shock due to secondary postpartum haemorrhage and the histopathologic findings were compatible with a placental polyp. Placental polyp can be missed on ultrasound and blind procedure like curettage and histopathology gives a confirmatory diagnosis. In our study, the diagnosis was confirmed by histopathology.

KEYWORDS : Placental Polyp, Secondary postpartum haemorrhage, Histopathology

INTRODUCTION

Placental polyp is an intra uterine polypoidal or pedunculated mass of placental tissue retained in the uterus that has undergone neovascularisation after resolution of gestation, commonly occurring after therapeutic abortion and spontaneous delivery.³ The predominant content is necrotic and hyalinized chorionic villi.² Placental polyps mostly occur after therapeutic abortion and spontaneous delivery but extremely rare after spontaneous abortion.^{3,4}

Case History

A 41 year old woman, G₈P₆L₆A₁ presented in active labour at 39⁵ weeks gestation. Patient had retained placenta after normal vaginal delivery. Manual removal of placenta was done following which she had torrential postpartum haemorrhage which was controlled with oxytocics and prostaglandins. Her haemoglobin level post delivery came down to 6.3 gm% which on admission was 12.3 gm%.

USG done the following day showed normal uterus without any evidence of retained products of conception. Two units of blood transfusion given and discharged on postpartum day six.

On 19th postpartum day, patient presented again with secondary postpartum haemorrhage. Patient was readmitted and haemoglobin level dropped to 8.4 gm%. She had another episode of heavy bleeding after admission. Ultrasonography done, which showed evidence of retained products of conception for which check curettage was done and minimal products were removed. Her haemoglobin level dropped to 5.1 gm%. Further two units of blood transfusion were given. Patient had repeated episodes of bleeding per vagina on and off the next week and she received another two more units of blood transfusion and her haemoglobin level came up to 6.3 gm%. Her serum Beta HCG was positive.

On 30th postpartum day, patient had another bout of secondary postpartum haemorrhage and went into shock with haemoglobin level dropping down to 5.5 gm%. She was transfused another three units of blood and underwent emergency laparotomy on 32nd postpartum day and hysterectomy was done. Post operative period was uneventful and patient was discharged on 7th post operative day. Patient received a total of nine units of blood after delivery. Clinical diagnosis of placental polyp/ placental site trophoblastic tumour was done. Cut specimen showed pedunculated pedicle originating from fundus. On histopathology diagnosis showed placental polyp.

DISCUSSION

Placental polyp is generally regarded as a rare condition. Its incidence is estimated to be 1 in 40,000-60,000 deliveries.⁵ There are two types of placental polyps: 1) Acute, occurring within first four weeks of delivery and 2) Chronic, discovered months or years later, as long as 20 years postpartum.⁶ Placental polyp can be a life-threatening condition and sometimes may even require an emergency hysterectomy. Most feared complications are profuse haemorrhage and hypovolemic

shock. Ultrasound with color Doppler imaging can diagnose placental polyp with abundant blood flow.⁶

Because the fundal or cornual myometrium is thin and relatively atonic, attachment of placental tissue in these areas are difficult to remove. Furthermore, placental polyps originate in partial or focal areas of placenta accreta where the villi get attached to the underlying myometrium as a result of defective decidua mostly in the cornual area. Therefore, these polyps are usually attached to the cornu or fundus.^{5,5} The term placental polyp is considered obsolete now, having been replaced by the terminology "hypervascular placental polyploid mass".^{5,7,8} Haemorrhage from hypervascular placental polyploid mass may require prompt diagnosis and treatment as it leads to haemodynamic instability.

Clinical management of hypervascular placental polyploid mass has dramatically improved with advances in imaging technology and hysteroscopic equipment. Imaging techniques i.e. pelvic USG with Doppler imaging is useful, as it differentiates the tissue from increased vascularity to that of reduced vascularity.^{9,10,11} MRI is useful to identify myometrial involvement.¹² Once hypervascular placental polyploid mass is diagnosed, hysteroscopic resection is currently the treatment of choice.

Uterine artery embolization is a modern non operative alternative to hysterectomy reserved for massive haemorrhage.^{13,14} In patients who are desirous of fertility, temporary iliac artery occlusion is preferred over uterine artery embolization as there is less chance of myometrial damage. Moreover, temporary iliac artery occlusion provides excellent control of haemorrhage for superior visualization during hysteroscopic resection of hypervascular placental polyploid mass and should be considered strongly in women who desire fertility.¹⁵

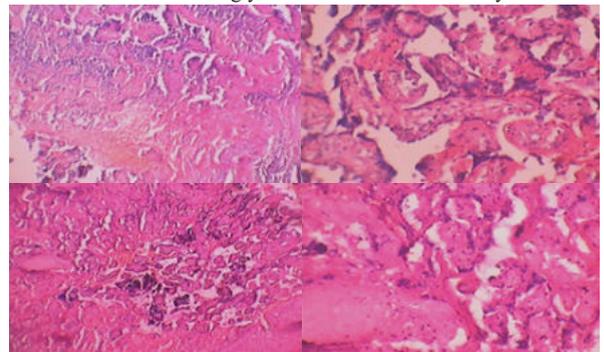


Figure 1: Histopathologic Picture Of Placental Polyp Of The Case

CONCLUSION

Placental polyp should be considered in any case of parous woman with unexplained abnormal uterine bleeding and slightly elevated serum hCG level. Histopathological examination of tissue is required

for definitive diagnosis. To preserve fertility and lessen morbidity in the cases of placental polyp, an optimal investigation and management with efficient planning is required.²

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