

# A Case of Abruptio of the Succenturiate Lobe of Placenta

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## ABSTRACT

Succenturiate lobe of placenta is a morphological abnormality, in which there are one or multiple accessory lobes connected to the main part of the placenta by blood vessels. It has been known to be located on the lower segment and then present either as placenta previa or as a case of vasa previa, if vessels connecting the main placenta with the succenturiate placenta lie below the presenting part. Here, we present a rare case of antepartum hemorrhage resulting from the abruptio of the succenturiate lobe of placenta.

**Keywords:** Abruptio placenta, succenturiate lobe, accidental hemorrhage

Antepartum hemorrhage, i.e., bleeding after the 20th week of pregnancy, occurs in 25% of all pregnancies and placental abruption accounts for approximately one-quarter of such cases.<sup>1</sup> Placental abruption and placenta previa are the two common causes of antepartum hemorrhage. The diagnosis of placental abruption is always clinical,<sup>2,3</sup> and the condition should be suspected in women who present with vaginal bleeding or abdominal pain or both. The succenturiate placenta is a morphological abnormality, in which there are one or multiple accessory lobes connected to the main part of the placenta by blood vessels.<sup>4</sup> The incidence is 16-28 cases per 10,000 pregnancies. Here, we report a case in which placental abruption occurred in the succenturiate lobe of the placenta.

## CASE REPORT

Mrs SDC, 33-year-old, G<sub>2</sub>P<sub>1</sub> with previous preterm delivery was on regular antenatal follow-up. She was admitted at 32 weeks of gestation with complaints of spotting for 3 days followed by fresh bleeding on

the day of admission with a diagnosis of ? accidental hemorrhage. Ultrasound examination done at admission showed a single live intrauterine gestation at 31-32 weeks in cephalic presentation with adequate liquor. Placenta was anterior with no previa and with evidence of a small retroplacental clot. Her condition was stable and bleeding was minimal.

On general physical examination: Patient was conscious and of good built; weight 66 kg; no pallor/icterus/pedal edema; pulse rate - 98/min; blood pressure - 124/80 mmHg.

Examination of respiratory and cardiovascular systems revealed no abnormality.

Per abdominal examination: Uterus 30-week size, relaxed, fetus in cephalic presentation; fetal heart sound (FHS) - present and regular (150 beats/min).

Routine tests: Hemoglobin - 11 g/dL; human immunodeficiency virus/Venereal Disease Research Laboratory/hepatitis B virus surface antigen (HIV/VDRL/HbsAg) - NR; urine and stool - NAD.

Ultrasonography (USG): Single live intrauterine gestation at 31-32 weeks, liquor adequate, anterior placenta, evidence of a small retroplacental clot, cervix long with internal os closed. Diagnosis: G<sub>2</sub>P<sub>1</sub> at 32 weeks of gestation with ? abruptio placenta.

As the patient's condition was stable, bleeding was minimal and in view of the preterm gestation, she was put on conservative management, with close watch on both fetal and maternal conditions. She received steroid prophylaxis for fetal lung maturity. There were

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small intermittent bouts of bleeding but the maternal and fetal condition remained stable.

Repeat ultrasound 2 weeks after admission showed a live fetus in cephalic presentation 34-35 weeks, with anterior placenta and a small retroplacental clot. The estimated fetal weight was 2.5 kg. A decision for induction of labor was taken since the estimated fetal weight was 2.5 kg and because of the facts that the patient was covered with steroids for fetal lung maturity and had intermittent bleeding. Labor was induced with prostaglandin tablets and followed by artificial rupture of membranes (ARM), which revealed blood-stained liquor. Further augmentation with slow oxytocin drip resulted in a vaginal delivery of a live baby girl of 2.6 kg. Placenta was delivered and revealed a succenturiate lobe (Figs. 1 and 2). There was a huge retroplacental clot occupying the whole of succenturiate lobe, while the rest of the placenta was normal.

## DISCUSSION

Placental abruption is defined as the complete or partial separation of the placenta before delivery and is one of the leading causes of vaginal bleeding in the second-half of pregnancy.<sup>1,2</sup> Approximately 0.51% of the pregnancies are complicated by placental abruption.<sup>2,5</sup> It is one of the most important causes of maternal morbidity and perinatal mortality. Approximately 10% of all preterm births and up to one-third of all perinatal deaths are caused by placental abruption.<sup>2,6</sup> Placental abruption is suspected in all patients presenting with bleeding, uterine contractions and fetal distress.

Hemorrhage into the decidua basalis occurs as the placenta separates from the uterus, which usually manifests as vaginal bleeding. However, at times the hemorrhage may be concealed with no signs of vaginal bleeding. Bleeding, if it continues, may result in fetal and maternal distress and if not attended to appropriately can result in maternal and fetal death. Management depends on severity of abruption, period of gestation, fetal and maternal condition. In case of deteriorating maternal condition and fetal demise, pregnancy is terminated by attempting a vaginal delivery if no contraindications exist. Labor induced with amniotomy, usually progresses rapidly and may be further augmented with oxytocin drip.

Cesarean section is needed when labor does not progress well or the maternal condition becomes unstable. In case of a live fetus and a stable maternal condition, management is decided by the period of gestation. In term gestation, induction of labor is the

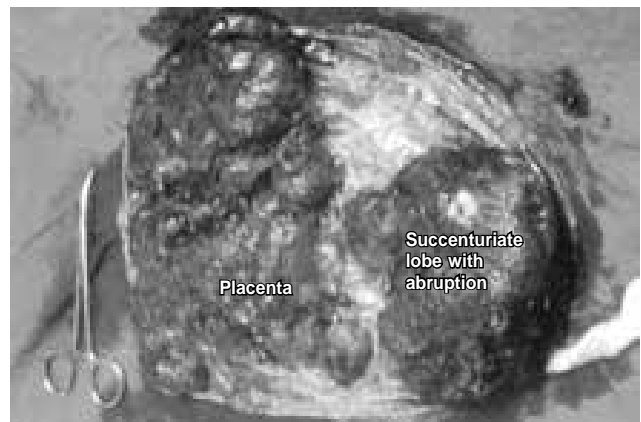


Figure 1. Postnatal picture showing fetal surface of the placenta and succenturiate lobe.

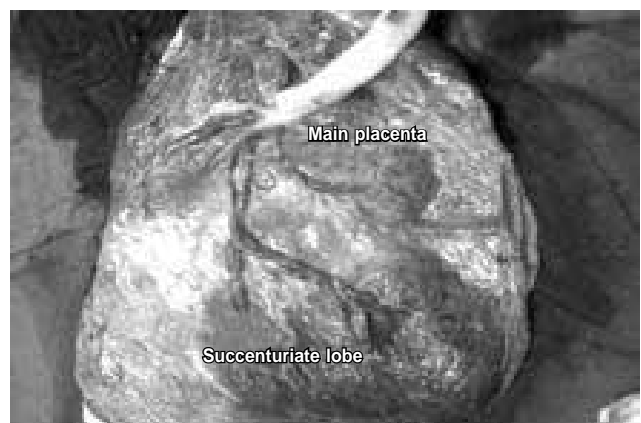


Figure 2. Postnatal picture showing maternal surface of the placenta and abruption of the succenturiate lobe.

best option. In preterm gestation, a policy of wait and watch, along with steroid injections for fetal lung maturity usually pays good returns. Close monitoring of both maternal and fetal condition is carried out to watch for fetal and maternal distress. Labor is induced at term or at the first signs of fetal or maternal distress.

Succenturiate placenta is usually a postnatal diagnosis but can also be suspected on an antenatal ultrasound.<sup>4,7,8</sup> Its antenatal recognition is important as vessels connecting the main placenta with the succenturiate placenta, if lying below the presenting part: Vasa previa may rupture during labor causing massive hemorrhage and fetal death. In addition, there is an increased risk of postpartum hemorrhage from retention of placental material.<sup>4,7,8</sup> A bilobate placenta is a similar anomaly and it is not clear from literature as to what is the exact difference, if any exists.<sup>9</sup> It appears that some authors use the term 'bilobate' when both segments of the placentas are almost equal in size and 'succenturiate' when there is a greater difference between the two segments. When

an outlying portion of the placenta has not maintained its vascular connections with decidua vera, the placenta is called placenta spuria. Succenturiate placentas are known to be located on the lower segment and the management then would be that as of placenta previa.

## CONCLUSION

Our case was treated as a case of placental abruption and was managed conservatively till fetal maturity and then delivered by induction of labor at term. Succenturiate lobe with complete abruption of the lobe was noted on delivery of the placenta. This case is presented for the rare occurrence of placental abruption in the succenturiate lobe.

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