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# Perinatal prognosis in the case of abruption placentae at Souissi Maternity: Retrospective study about 39 cases during one year

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**Abstract**
Over a period of 1 year (from May 2015 to May 2016) we have collected 39 deliveries in case of HRP performed at the Souissi Maternity, University Teaching Hospital Rabat-MOROCCO.
The frequency of abruption placentae was 9.6 per 1000 deliveries. The mean age of our patients was 24 years, 51.2% of our patients were primiparas. The average parity was 3. According to gestational age, 82.04% of cases were at term, 15.4% of premature deliveries, and 2.56% of post term. In 30.77% of our patients, they were admitted for Placenta abruption, 25.64% were admitted for late-pregnancy bleeding, 17.94% were admitted for eclampsia, preeclampsia or gravid hypertension tended that 7.69% were admitted for threat of premature delivery with premature rupture of the membranes. We had 94.87% deliveries by caesarean section and 5.12% normal vaginal deliveries. 61.53% of births were alive, and 38.46% were born dead. Maternal morbidity and mortality was marked by 1 case of postpartum hemorrhage during vaginal delivery, with no mortality. Fetal complications were characterized by 15 deaths, acute fetal distress and low birth weight, which necessitated the hospitalization of newborns in pediatrics.

**Keywords:** placenta abruption, preeclampsia, caesarean section, morbidity-mortality

## 1. Introduction
Placental abruption corresponds to the premature detachment of a normally inserted placenta. The anatomical lesion consists of a hematoma located beneath the basal plaque of the placenta (decidual basal hematoma) interrupting feto-maternal circulation and rapidly leading to hemodynamic disorders, coagulation abnormalities and acute fetal distress [1, 2].
The placenta abruption is an acute hemorrhagic event occurring in the last weeks of pregnancy or during labor and characterized by the formation of a hematoma prematurely detaching the normally inserted placenta. This hemorrhagic condition can range from the simple bursting of an infarct on the surface of the placenta to hemorrhagic inburst reaching the entire genital area and even exceeding it (utero-placental apoplexy) [3, 4]. The hematoma thus formed between the uterine wall and the placenta interrupts the feto-maternal circulation, leading to hemodynamic disorders, acute or chronic fetal distress, haemostatic disorders.
It is a serious complication involving the fetal prognosis by interruption of feto-maternal exchanges and sometimes by hemorrhagic shock and coagulopathy [5]. Our study aims to analyze the perinatal prognosis in the case of a placental abruption, describing the epidemiological, clinical and prognostic aspects.

## 2. Objectives
Placenta abruptio results from the premature detachment of a normally inserted placenta. It is a serious complication involving fetal prognosis by interruption of fetal-maternal exchanges and sometimes by hemorrhagic shock and coagulopathy. Our study aims to analyze the perinatal prognosis in the case of a placental abruption, describing the epidemiological, clinical and prognostic aspects

## 3. Material and Methods
We report a retrospective series concerning deliveries in case of placental abruption during a period from 1 May to 31 May 2016, carried out in our department at the Souissi Maternity Hospital in Rabat-MOROCCO. We found 39 cases out of a total number of deliveries.

## 4. Results
The frequency of HRP was 0.2%. During this 12-month period, we corrected 39 cases of placenta abruption (18,472 numbers of deliveries during this study period). The average age of our patients was 24 years (18 years to 42 years), primiparas 51.2% of patients were primiparas. The parity average is 3.

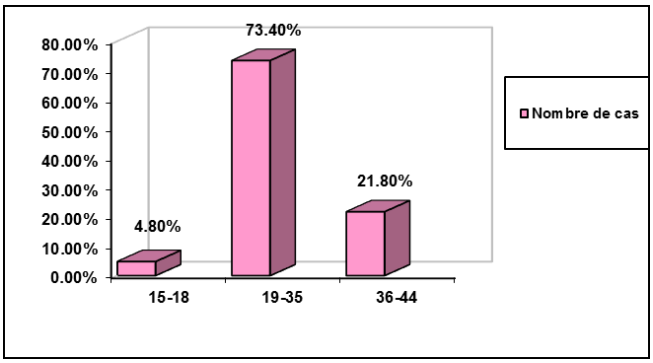


**Fig 1:** Distribution of patients by age

Gestational age was ultimately in 82.04% of cases at term, 15.4% of premature deliveries, and post term in 2.56%.

**Table 1:** Distribution of patients by gestational age

| Gestational age | Number of patients | % |
|---|---|---|
| 27Weeks - 37 Weeks | 6 | 15,4 |
| 38 Weeks - 41 Weeks | 32 | 82,04 |
| > 41 | 1 | 2,56 |
| Total | 39 | 100 |

In 30.77% of our patients, they were admitted for placenta abruption, 25.64% were admitted for late-pregnancy bleeding, and 17.94% were admitted for eclampsia, pre-eclampsia or gestational hypertension while 7.69%. Were admitted for threat of premature delivery with premature rupture of the membranes.

**Table 2:** Distribution according to the admission pattern

| admission pattern | Number | % |
|---|---|---|
| Placenta abruptio | 12 | 30,77 |
| Late-pregnancy bleeding | 10 | 25,64 |
| Eclampsia, Preeclampsia, gestational hypertension | 7 | 17,94 |
| Premature labor, premature rupture of membranes | 3 | 7,69 |
| Others | 7 | 17,96 |
| **Total** | **39** | **100%** |

We had 94.87% deliveries by caesarean section and 5.12% deliveries by normal vaginal delivery. The main indications of the low track were fetal intrauterine demise with good cervical bishop score. 61.53% of births were alive, and 38.46% were born dead. The birth weight ranged from 1150 grams to 4280 grams, 48.71% had a weight of less than 2500 grams.

**Table 3:** Modes of delivery and fetal prognosis

| Prognosis | Vaginal delivery | caesarean section | Total | % |
|---|---|---|---|---|
| Alive Babies | 0 | 24 | 24 | 61,53 |
| Intra uterine fetal demise | 2 | 13 | 15 | 38,47 |
| Total | 2 | 37 | 39 | 100 |

Maternal morbidity and mortality was marked by 1 case of delivery hemorrhage encountered during low birth, with no mortality. Fetal complications were characterized by 15 cases of death, acute fetal distress and low birth weight, which necessitated the hospitalization of newborns in pediatrics.

## 5. Discussion

In our study, the frequency of placenta abruption was 0.2%; while the study conducted by Sarr FR at all frequency was 2.9%; our results are similar to those found by Thieba the frequency was 0.96% [4, 5]. Our results are also comparable to those found by NYAMA 0, 4-1%.

[2] The caesarean section was 94.87%, a rate significantly higher than that recorded at the Dakar University Hospital by Sarr FR; Diouf at all [4] was 2.25% while Gaye and Thieba [5, 6] reported 15% and 35.6%, respectively. In our study the maternal lethality of the placental abruption is around 6.6%. This rate remains comparable to that of developing countries [7, 8] but remains higher than those reported in the Western literature [8, 9]. Placenta abruption remains the leading cause of per natal mortality in most western countries [10]. It accounts for 12.4% of per natal deaths in Norway. In France, in 1996, the placental abruption was the leading cause of stillbirth (19.1%) in the per natal survey of Seine-Saint-Denis [11]. In the USA, ANANTH notes that 11.9% of per natal mortality is caused by the placental abruption. This mortality is 19 times higher in the complicated pregnancies of the placental abruption compared with uncomplicated the placental abruption pregnancies [12]. All recent studies in the literature give fetal results similar to those of our study. If the child is alive, caesarean section is urgently required (unless the presentation is initiated). If the child is dead, the evacuation will be done by natural means always helped by an early rupture of the membranes, the work having to be fast. If the dynamics is insufficient, the prescription of oxytocic is justified.

## 6. Conclusion

Despite the progress made in understanding the pathophysiology of the placental abruption, it remains a severe complication of pregnancy that can lead to maternal and fetal prognosis.

Reduction of maternal fetal and maternal mortality and morbidity requires improved prenatal monitoring, early diagnosis, and rapid and timely removal of the uterus.

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