

HYSTEROSCOPIC TREATMENT OF RETAINED PLACENTA: A CASE REPORTKhalid Lghamour*¹ and Pr. Anas Chenguiti Ansari²¹Gynecology-Obstetrics Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.²Department Head of the Consultation, Diagnosis and Screening Center, Maternity Souissi, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.

*Corresponding Author: Khalid Lghamour

Gynecology-Obstetrics Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.

Article Received on 02/06/2022

Article Revised on 22/06/2022

Article Accepted on 12/07/2022

ABSTRACT

Retained products of conception (RPOC) can occur after early or mid-trimester pregnancy termination and also following vaginal or cesarean delivery. It is frequently associated with continuous vaginal bleeding, pelvic pain, and infection. Late complications include intrauterine adhesions formation and infertility. Conventionally, surgical management of retained placental tissue is largely performed using blind dilatation and curettage. Hysteroscopic removal using diathermy loop has been shown to be successful while increasing complete removal rates and reducing risk of uterine perforation.

KEYWORDS: Hysteroscopy, hysteroscopic tissue removal, retained placenta.**INTRODUCTION**

Retained products of conception (RPOC) is defined by retention of trophoblastic tissue inside the uterine cavity.

It is a complication that involves about 1% of full-term pregnancies,^[1] whether delivered by vaginal or cesarean section, and it is more common after miscarriage or voluntary termination of pregnancy, in the first or second trimester, with a reported prevalence of up to 6%.^[2]

Operative hysteroscopy is the gold standard surgical treatment for retained placenta or trophoblast. This treatment will remove the abnormal tissue that remains inside the uterine cavity following a miscarriage.

CASE REPORT

Patient 33 years old, gravida 5 para 4, 4 vaginal deliveries, 4 living children, the fifth pregnancy ended with a spontaneous abortion at 9 weeks of amenorrhea; the patient presented pelvic pain with reddish genital bleeding, she expelled at home. Four weeks later, she came in consultation. The vaginal touch found a long cervix closed posteriorly with blackish lochia, the endovaginal ultrasound showed a Gutenberg's type 3 placental retention.

A diagnostic hysteroscopy was performed one week later, which showed a retained placenta 4 cm from the orifice on the posterior surface of the uterus. Hysteroscopic treatment with scissors and forceps, extraction of placental debris, which was sent for anatomopathological study.

Histopathology showed a morphological aspect compatible with placental retention, a proliferative endometrium with no histological sign of malignancy.



Figure 1: Ultrasound image of retained placental tissue.

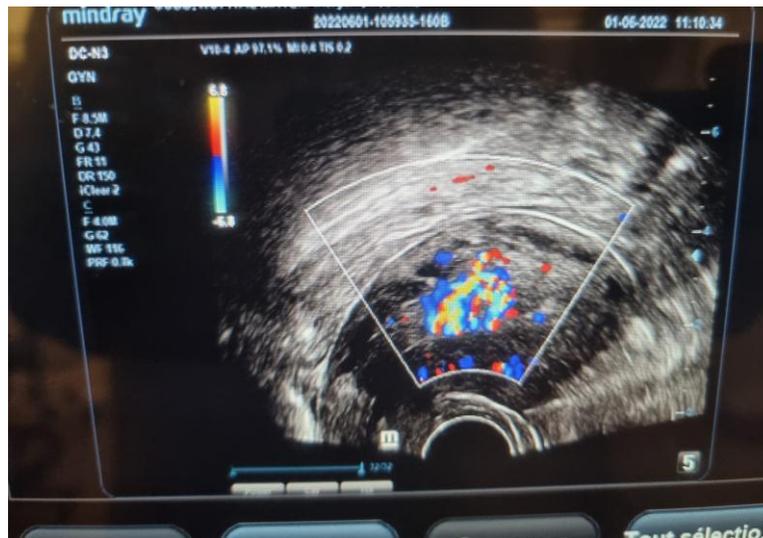


Figure 2: retained placental tissue Type 3 of Gutenberg classification.

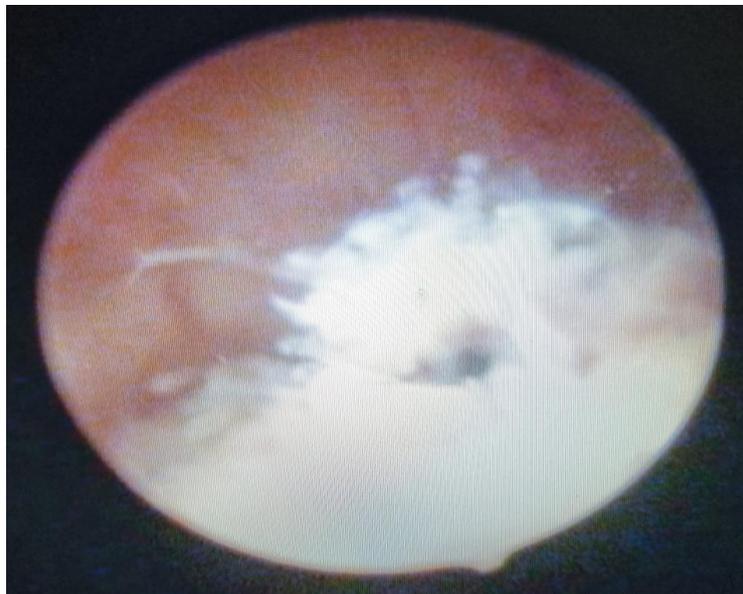
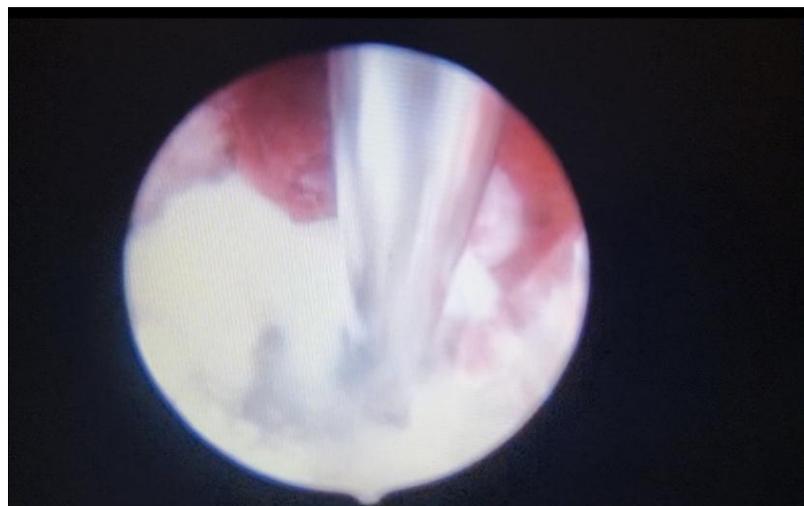


Figure 3: Hysteroscopic view of retained placental tissue.



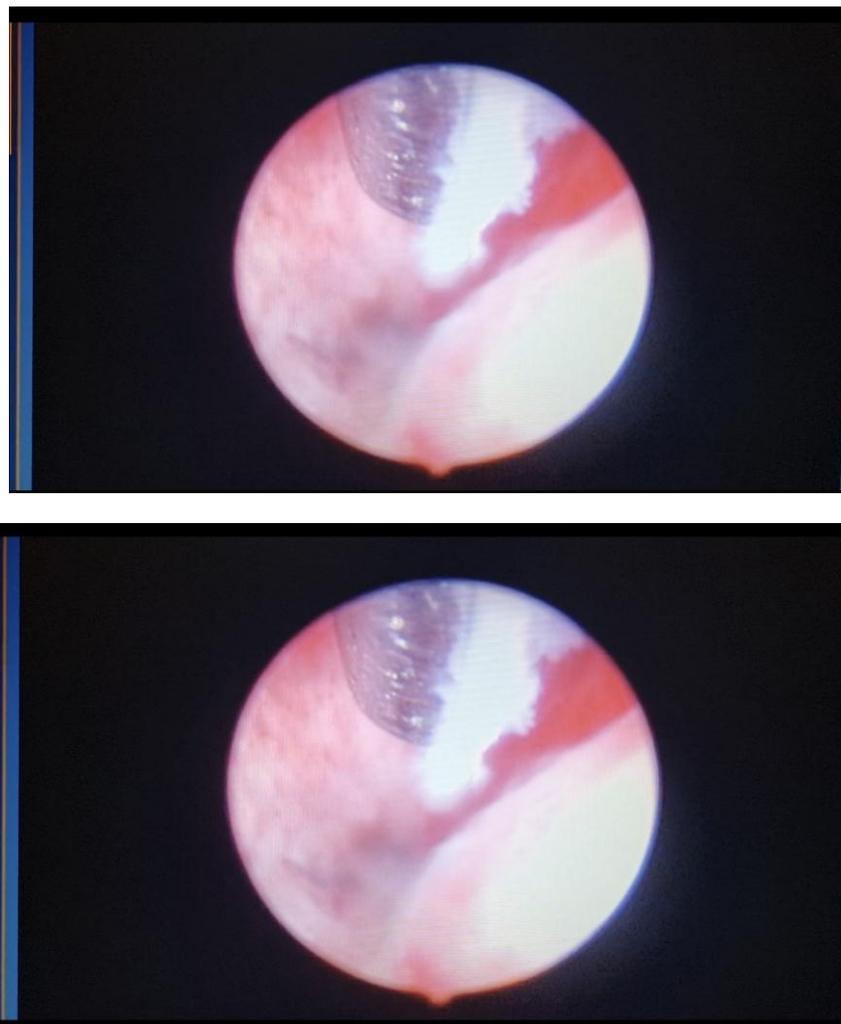


Figure 4: Hysteroscopic morcellation of retained placental tissue.

DISCUSSION

In everyday clinical practice, it is not uncommon for patients to suffer from major vaginal bleeding, abdominal pain, or fever a few days after vaginal delivery, caesarean section, or curettage following abortion. In such cases, the existence of residual trophoblastic tissue may be suspected.^[3]

The diagnosis is usually made in the presence of ultrasound findings of a heterogeneous intracavitary hyperechoic focal mass, with poorly defined endometrium-myometrium interface, a fluid layer, and/or increased and irregular endometrial thickness. A color Doppler examination should also be used to improve the diagnostic accuracy: Demonstrating blood flow in the mass can help distinguish between RPOC and a hematoma, as well as to classify RPOC on the basis of its vascularity.^[4]

Kamaya *et al.* first tried to categorize them on the basis of Doppler vascularity, from Type 0 (avascular) to type 3 (marked vascularity),^[4] whereas the Gutenberg Classification represents the evolution of this characterization; it incorporates both vascularity and

echogenicity of ultrasound findings.^[5] Used as preoperative evaluation, the Gutenberg classification is very useful in surgical planning as it allows to predict the risk of bleeding during hysteroscopic removal of RPOC and so to determine the safest environment in which to safely perform the procedure (in office vs. operating room setting).^[6] In the study conducted by Alonso Pacheco *et al.*,^[6] a comparison between the hysteroscopic management of RPOC in Gutenberg type 0–1 versus type 2–3 RPOC was made, demonstrating that patients classified as Gutenberg type 2 or 3 RPOC required the use of monopolar energy during the procedure, compared to none of the patients classified as Type 0–1, in order to reduce the risk uncontrollable massive bleeding.

Ultrasonographic Patterns of RPOC. Gutenberg Classification

- a-type 0: hyperechogenic avascular mass.
- b-type 1: different echoes with minimal or no vascularization.
- c-type 2: highly vascularized mass confined to the cavity.
- d-type 3: highly vascularized mass with highly vascularized endometrium.

Management has traditionally been dilatation and curettage, often guided by sonography. However, sometimes bleeding or symptoms are persistent, and tissue evacuation is incomplete.^[7,8]

Hysteroscopic visualization and removal of products under vision not only ensures more likely to achieve complete removal but also it is less likely to cause uterine perforation and intrauterine adhesions in particular when hysteroscopic morcellation is used. One of the main concerns regarding this technique is the visibility, while the patient is still bleeding vaginally.

Extraction of retained trophoblastic tissue by hysteroscopy is easy to learn and a safe and effective alternative to blind curettage. Retained tissue can be removed by direct visualization of the uterine cavity. As a small-diameter hysteroscope is used, this technique can be performed in the office without anaesthesia or cervical dilatation and is well tolerated by the patient.

We prefer not to use current, in order to avoid surgical trauma and reduce inflammation and the possibility of adhesions.^[9,10]

Because hysteroscopic examination can be performed as an ambulatory procedure in the office and does not require use of an operating room, hospitalization, or anaesthesia, it is more profitable. In our experience, the management of retained trophoblastic tissue using diagnostic-operative ambulatory hysteroscopy is a suitable option after abortion.

CONCLUSION

Diagnostic-operative ambulatory hysteroscopy is a suitable alternative to blind curettage in the management of retained trophoblastic tissue. This technique can be performed in the office without anaesthesia and with a low rate of complications.

Operative hysteroscopy should be considered the treatment of choice in women with RPOC, as it is described as a safe and feasible procedure, with low rates of postoperative intrauterine adhesions formation, and possible advantages in terms of future conception rates.

REFERENCES

1. Capmas P, Lobersztajn A, Duminil L, Barral T, Pourcelot AG, Fernandez H. Operative hysteroscopy for retained products of conception: Efficacy and subsequent fertility. *J Gynecol Obstet Hum Reprod*, 2019; 48: 151-4.
2. Smorgick N, Barel O, Fuchs N, Ben-Ami I, Pansky M, Vaknin Z. Hysteroscopic management of retained products of conception: Meta-analysis and literature review. *Eur J Obstet Gynecol Reprod Biol*, 2014; 173: 19-22.
3. Achiron R, Goldenberg M, Lipitz S, Mashiach S. Transvaginal duplex Doppler ultrasonography in bleeding patients suspected of having residual trophoblastic tissue. *Obstet Gynecol*, 1993; 81: 507-11.
4. Kamaya A, Petrovitch I, Chen B, Frederick CE, Jeffrey RB. Retained products of conception: Spectrum of color Doppler findings. *J Ultrasound Med*, 2009; 28: 1031-41.
5. Tinelli AP, Haimovich S. *Hysteroscopy*. New York, NY: Springer Berlin Heidelberg, 2017.
6. Alonso Pacheco L, Timmons D, Saad Naguib M, Carugno J. Hysteroscopic management of retained products of conception: A single center observational study. *Facts Views Vis Obgyn*, 2019; 11: 217-22.
7. Ben-Ami I, Schneider D, Maymon R, Vaknin Z, Herman A, Halperin R. Sonographic versus clinical evaluation as predictors of residual trophoblastic tissue. *Hum Reprod*, 2005; 20(4): 1107-11.
8. Van den Bosch T, Daemen A, Van Schoubroeck D, Pochet N, De Moor B, Timmerman D. Occurrence and outcome of residual trophoblastic tissue: a prospective study. *J Ultrasound Med*, 2008; 27(3): 357-61.
9. Hatfield J, Brumsted J, Cooper B. Conservative treatment of placenta accreta. *J Minim Invasive Gynecol*, 2006; 13: 510-3.
10. Obispo C, Muñoz JL. Histeroscopia diagnóstica ambulatoria, Técnicas indicaciones. *Prog Obstet Ginecol*, 2006; 49: 215-8.