Manual Removal of Placenta

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There is no creature more treacherous than a woman who retains her placenta after delivery of her child. Not only she may start severe haemorrhage at any unpredictable moment but as the time goes on her general condition is very liable to deteriorate. So third stage of labour must be managed with great care and skill.

In the third stage of labour undue interference do more harm than good and normal cases in a minute becomes abnormal. The obstetrician's judgement must be sure and swift and error of commission carry with them penalties as great or greater than those of omission.

Thus the aim of our study is to do manual removal of placenta carefully whenever it is retained.

Material & Method

The present study deals with 92 cases of manual removal of placenta in Obst. department of B. M. C. H. On admission, age, parity, past obstetric history and clinical findings were recorded.

Majority of the patients fall in the age group of 18 to 35 years. Twelve cases were primipara, 24 cases of 2nd to 4th para. 56 cases were of parity of 5 and above. This condition is commoner in grand multipara as they are predisposed to neglected obstetrics, maternal exhaustion, uterine inertia and operative interference.

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Many of these cases were brought directly from the villages after home delivery with retained placenta with or without bleeding. 16 cases came in a state of shock with profuse bleeding. Another 30 cases of home delivery came with retained placenta but bleeding was not so marked. Remaining cases were of operative interference leading to prophylactic removal of placenta as the patients were already under general anaesthesia, 16 cases were delivered in our hospital and placenta was retained for half an hour. Table I shows the different indication for manual removal of placenta.

Table I
Indication for Manual Removal of Placenta

Indication.	No. of Cases.	Percentage.
Retained placenta	30	32.6%
Post Partum haemorrhage.	32	34.8%
Prophylactic removal	30	32.6%

Patients were examined thoroughly after that every measures were taken to resuscitate the patient. Blood transfusion started and under general anaesthesia placenta was removed manually; in most of the cases attempt to remove the placenta was undertaken after lapse of one hour.

Table - II illustrates the different causative factors behind retention of placenta. Malpresentation were present in 13%, twin pregnancy in 10.8% of cases, grand multiparity were associated with 26% of cases. Uterine malformation present with 4.3%. 13% of cases were associated with Hydramnia. 13% of cases were of mismanaged labour, where as 19.5% were associated with antepartum haemorrhage.

Table II
Showing different associated pathology.

Associated Pathology.	No. of cases.	Percentage
Malpresentation.	12	13%
Multiple pregnancy.	10	10.8%
Multiparity.	24	26%
Malformation of uterus	4	4.3%
Hydramnios.	12	13%
Antepartum haemorrhage	18	19%
Mismanaged labour.	12	13%

Table - III demonstrates the time interval between retained placenta and its manual removal.

Table III

Time	No. of cases	Percentage
Within one hour	36	39.1%
Within one to 6 hours	15	16.3%
Within 6 to 12 hours	15	16.3%
More than 12 hours	26	28%

TABLE IV Illustrates the different complication encountered.

Table IV

Complication	No. of cases.	Percentage.
Shock	16	17%
Haemorrhage	14	15.2%
Pyrexia.	20	21.7%
Sepsis.	16	17%

Discussion

There is lot of controversy over normal duration of 3rd stage of labour as to when it should be considered as pathological. According to Eastman (1966) placenta should be expelled within an hour after delivery of the child. Since the third stage is always a time of anxiety, there is natural tendency to wish to get it over and in case in which oitocic drugs have not been given at the end of second stage, it is valuable to regard a minimum period of twenty minutes as essential for the safe delivery of placenta (Donald page 687). Complete delivery depends upon gentleness, patience and care. In almost all cases the patience will be rewarded by the uterus completing its physiological function fully.

In our series placenta were removed within an hour in 39% of the cases only as most of them reported to us after home delivery in a precarious condition of infection, exhaustion and shock, when more than 12 hour had already been passed. These cases were resuscitated from shock after removal of placenta their overwhelming amount of infection were controlled by higher antibiotics and corticoids.

There was one case of placenta accreta in the present series, According to Phancuf (1933)

the incidence of placenta accreta is 1 in 6,000 to 40,000 Though Eastman (1966) in his survey of 70,000 deliveries did not come across a single case.

Prophylactic removal of placenta was done in 32.6% of cases as the patient were under general anaesthesia for some operative interference.

In the present series not a single death was due to manual removal of placenta, 2.1.% of patient died due to some associated condition and it is similar to the incidence reported by Seth et al 1966 i.e. 2.5 percent.

As a future precaution the availability of suitable cross matched blood for transfusion is clearly essential in the patients with bad third stage history and hospital confinement indicated absolutely.

Summary

Obstetrician should be very much careful in managing the third stage of labour than in landing in the problem of retention of placenta.

If retention of placenta has at all occurred one should be very much sure and swift in his judgement to remove the placenta manually.

It is suggested that if manual removal of placenta is properly performed in time it is fairly safe and useful obstetric operation.

Reference

1. Donald, I : Practical obstetric problem 4th Ed. Newman street, London 1969.682.
2. Eastman (1966) cited by Hellman, L.M. and Jack, A Pritchard : Williams, Obstetric 13th Ed. Appleton century craft, Educational Division/Meredith Corporation, New York, 1966. P. 947 & 949.
3. Phaneuf L. A. (1933) cited by reference 4.
4. Seth, S.S. Purandare, B.N. & Manni, K.M.J. Obs. & Gynae. of India 16: 602.1966