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## Unusual presentation in a case of placenta succenturiata: A case report

Deepa Chauhan<sup>1</sup>, Moulika Shah<sup>2</sup>, Abhijit S Ambike<sup>3</sup>

<sup>1</sup> Junior Resident, Department Of Obstetrics and Gynaecology, BKL Walawalkar Rural medical College and Hospital Dervan, Post Sawarda, Taluka Chiplun, Dist Ratnagiri, Maharashtra, India

<sup>2</sup> Senior Resident, Department Of Obstetrics and Gynaecology, BKL Walawalkar Rural medical College and Hospital Dervan, Post Sawarda, Taluka Chiplun, Dist Ratnagiri, Maharashtra, India

<sup>3</sup> Associate Professor, Department Of Obstetrics and Gynaecology, BKL Walawalkar Rural medical College and Hospital Dervan, Post Sawarda, Taluka Chiplun, Dist Ratnagiri, Maharashtra, India

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### Abstract

Placenta succenturiata is a morphological abnormality of the placenta where one or more lobes are present outside the placental body [1]. The lobe has communications that course through the membranes. This lobe may get retained in the uterus after delivery causing postpartum haemorrhage. The retained lobe may be identified by sonography during the antenatal period and usually after delivery on examination of the placenta. We report an unusual case of placenta succenturiata in our Rural Hospital.

**Keywords:** placenta, Succenturiata, morphological, sonography

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### Introduction

The term succenturiate derives from the Latin word "succenturio" meaning "to substitute". Succenturiate lobe is one or, more small accessory placental lobe, size of a cotyledon which develops in the membranes at a distant from the periphery of the main placental disc usually having vascular connections of fetal origin which runs through the membranes connecting main placenta to the succenturiate lobe [2]. Division of placenta into multiple lobes is a common abnormality in the placental configuration. It is called as bipartite when there are two lobes and tripartite when there are three. Attachment of the lobes is in the cord origin. Connections are by vessels, membranes and by thinned out portion of the placenta. Succenturiate lobe is formed by the persistence of one or more group of villi away from the main portion of the placenta. It is connected to the main placenta by membranes and vessels. It can rarely lead to Postpartum Haemorrhage [3]. The incidence of succenturiate placenta among women with singleton pregnancies was 1.04% [4].

### Case Report

23 Years old primipara with postnatal day 10 was referred to our hospital in view of high grade fever (104 F) and severe anaemia. She complained of giddiness and generalized weakness since 2 days. She had a full term vaginal delivery with left mediolateral episiotomy 10 days back. She developed post-partum haemorrhage after delivery for which she received 1 unit of Packed cell volume and discharged after 2 days. She was asymptomatic for the next 5 days following which she developed high grade fever and profuse bleeding per vaginum. She was treated by her gynaecologist by injectable antibiotics and anti-pyretic for the same. Her outside haemoglobin was 2.6gm%,

hence she was referred to our hospital in view of severe anaemia and high grade fever.

### On Examination

She was conscious oriented, pulse was 130/min, BP 100/60mmHg, temperature 104 F, severe pallor with generalised oedema was present. Per abdomen examination revealed uterus was 18-20 weeks and flabby, non-tender. Local examination showed altered foul smelling discharge was present and on per vaginum the os was open, soft mass was felt in the cervical canal. Patient was admitted in ICU, routine investigation and ultrasonography abdomen was done which was s/o Retained placenta. Case was managed with IV fluids, antibiotics and blood transfusion. Manual removal of placenta was done under GA. 6X9cm placental lobe was removed. Examination of the lobe revealed no vascular attachments or membranes of Postoperative recovery was uneventful. Her antenatal scans did not show any evidence of succenturiate lobe.

### Case discussion

Placenta succenturiate is a morphological abnormality of the placenta where one or more lobes are present outside the main body of placenta. It can have various sizes, and is connected by blood vessels to main placenta. It develop froms the chorionic villi that did not involute from the chorion. The world wide incidence is 1% approximately. The two main risk factors are advance maternal age and women who have undergone invitro fertilization. If missed after delivery of the baby, the succenturiate lobe may be retained, leading to atonic postpartum haemorrhage [5].

We present a case of patient who delivered ten days back, and referred to us as a case of puerperal sepsis with severe anaemia. Patient had a full term vaginal delivery at a private hospital and treated with I unit of Packed cell volume for PPH, she was discharged three days later, and she was asymptomatic for 1 week followed which she developed high grade fever for which she visited her gynaecologist, who gave her I.V antibiotics, IV fluids, analgesic, and diuretics. Patient was referred to us for further management. Her treating gynaecologist transfused PCV for PPH, and on her second visit he did not do a scan and a per vaginal examination to rule out any missing lobe of the placenta or membranes in the uterine cavity. High index of suspicion is necessary in cases of PPH.

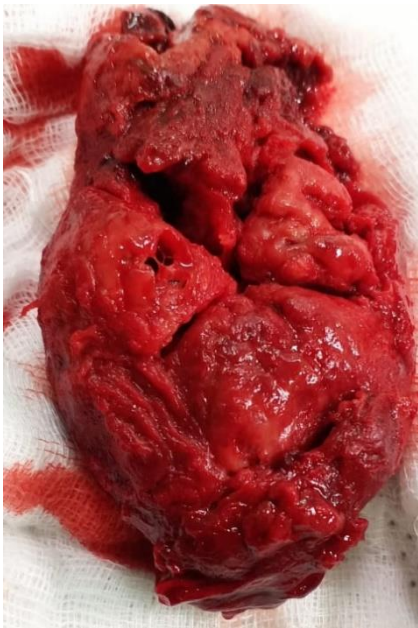


Fig 1

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