

Retro Placental Hematoma: Maternal and Fetal Prognosis at the Maternity of the University Hospital of Bouake

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Abstract

Introduction: Retroplacental haematoma (RPH) is a very serious complication of pregnancy, with life-threatening consequences for both the mother and foetus. The aim of this study is to determine the incidence and epidemiological characteristics of patients with retroplacental haematoma (RPH) and describe the maternal-foetal complications at Bouaké University Hospital. **Methods:** This was a cross-sectional prospective, descriptive and analytical study carried out at Bouaké University Hospital over a period of 3 years, from January 1, 2019 to December 31, 2021. All parturients with RPH whose delivery took place at the hospital were included in the study. Data were entered and analysed using EPI INFO software version 7.2.2.6. **Results:** We recorded 2,0959 deliveries, including 202 cases of RPH, representing an incidence of 0.96%. The 21 to 35 age group accounted for 64.4%, multigestas and large multigestas accounted for 58.5% and multiparas accounted for 41.6%. The main signs on clinical examination were metrorrhagia (100%), arterial hypertension (84.6%) and cervical cerclage (79.7%). Preeclampsia accounted for 50% of per-gestational pathologies. Maternal mortality was 12.9%. Morbidity was dominated by anaemia in 64.1%, followed by disseminated intravascular coagulation (DIC) in 21.8%, and the factors associated with this maternal prognosis were multiple gestations, multiparity, Sher grade IIIb and the occurrence of complications such as DIC, shock, renal complications and HELLP syndrome. Neonatal mortality was

79.2%, and the factors associated with these fetal prognoses were cup size ≥ 5 cm and hematoma weight ≥ 500 g. **Conclusion:** Better screening of at-risk populations, early diagnosis and treatment in an organised and equipped medical and surgical facility would improve prognosis.

Keywords

Retroplacental Haematoma, Lethality, Bouaké and Prognosis

1. Introduction

Retroplacental haematoma (RPH) is a very serious complication of pregnancy, with life-threatening consequences for both the mother and foetus. Retroplacental haematoma (RPH) is a paroxysmal syndrome in the last months of pregnancy or labour, characterised anatomically by a haematoma located between the placenta and the uterine wall; this haemorrhagic state can range from the simple bursting of an infarct on the surface of the placenta to haemorrhagic raptus affecting the entire genital area and even extending beyond it [1]. It is one of the major causes of haemorrhage in the third trimester of pregnancy. Haemorrhage is the leading cause of maternal death, accounting for 500,000 deaths worldwide according to the WHO [2]. Placental abruption is responsible for 20% - 25% of antepartum haemorrhages [3] [4]. It is also associated with an increased risk of disseminated intravascular coagulopathy, maternal shock, and renal failure and is one of the main causes of postpartum hemorrhage [3] [5] [6]. It remains an unpredictable pathology despite the recognised risk factors: extreme maternal age, multiparity, black race, a history of PRH, thrombophilia, drug use, high blood pressure (hypertension) and the occurrence of direct shock to the abdomen [3] [7] [8]. RPH sometimes occurs in the absence of these risk factors. In developing countries, abruptio placenta is related to about 1% of maternal mortality with significant prenatal mortality and morbidity about 7% to 20% [3]. Despite the seriousness of this condition, we have no up-to-date data for Bouaké. With this in mind, we are conducting this study to determine the prevalence and epidemiological characteristics of patients with RPH and to describe the maternal-fetal complications at Bouaké University Hospital.

2. Methods

2.1. Study Design and Setting

This was a cross-sectional prospective, descriptive and analytical study conducted over a period of 3 years, from the 1st of January 2019 to the 31st of December 2021. It took place in the obstetrics and gynaecology department of Bouaké University Hospital. The city of Bouaké is located in the centre of Ivory Coast and is the second most populous city after Abidjan, with a general population estimated at 1,542,000 according to the MICS 2021 [9]. The city has a university hospital, which

is a tertiary-level hospital according to the country's health pyramid. The centre has a gynaecology department, which provides medical and surgical care for Gynaecological and Obstetric pathologies. It is a referral service, receiving patients referred from general and peripheral hospitals in the town of Bouaké, as well as from surrounding towns in the centre, north and west of the country. The maternity ward in the Gynaecology and Obstetrics department has 4 delivery cubicles, 6 post-natal beds and an operating theatre with two operating theatres. The daily team consists of a Gynaecologist Obstetrician, three medical doctors with a diploma in Gynaecology and Obstetrics, four midwives and two nurses.

2.2. Study Population

The study population consisted of all parturients with 28 or more weeks of gestation, admitted to the delivery room in the department. Sampling was exhaustive. All parturients with RPH whose delivery took place at the university hospital were included in the study, regardless of their origin, and all cases of RPH were confirmed after delivery by the presence of haematomas or cupules. We did not include in the study patients admitted on suspicion of RPH but in whom the examination did not reveal any placental cup and patients who did not give their consent.

2.3. Data Collection and Analysis

The variables studied were sociodemographic characteristics, course of pregnancy, delivery and neonatal parameters. The questionnaire was developed after reviewing different literatures. The data were entered into a computer and analysed using EPI INFO software version 7.2.2.6 with the use of Chi-squared statistical tests for numbers ≥ 5 and Fisher for numbers < 5 with $\alpha = 5\%$. A P-value of less than 0.05 was considered to be statistically significant. Descriptive statistics were used to describe the characteristics of the study respondents by using means and standard deviations for numerical variables, frequencies along with percentages for categorical variables and table.

3. Results

3.1. Incidence

During the study period, we recorded 20,959 deliveries at the Bouaké University Hospital maternity unit, including 202 cases of RPH, representing an incidence of 0.96%.

3.2. Epidemiological Characteristics

The mean age was 29.8 ± 7.2 years, with extremes of 15 and 45 years. The 21 - 35 age group accounted for 64.4% of cases. The patients were in a couple in 90.1% of cases and had domestic activity in 63.9% of cases. Large multigestations and multigestations accounted for 58.5% of cases. The average parity was 4, with extremes of 0 and 12. Multiparous and large multiparous males accounted for

41.6% of cases. Nulliparous women accounted for 21.8%. Of the 202 patients, 10 (5%) had not had a pregnancy follow-up. Of those with a pregnancy follow-up, 62.9% had undergone less than the mandatory 4 parental consultations (ANCs). Only one of the 202 patients had a history of RPH. Patients were referred from a public health facility in 87.6% of cases. The reasons for evacuation were dominated by 3rd trimester metrorrhagia, RPH and uterine contractures in 51.5%, 18.2% and 10.4% of patients, respectively.

3.3. Clinical Aspects

Gestational age was between 37 and 41 SA + 6 days in 48.1% of cases. Mono-foetal pregnancies accounted for 98.5%. Clinical signs on admission were dominated by metrorrhagia (100%), uterine contracture (98.5%), cervical cerclage (79.7%) and absent foetal heart sounds (83.1%) at the obstetrical level. General symptoms included hypertension in 84.6% of cases, proteinuria (45.5%) and shock (11.4%). RPH was classified as Sher grade III in 80% of cases, including 72.8% as grade IIIa. Grades 1 and 2 accounted for 3.5% and 17.3%, respectively. Caesarean section was the mode of delivery in 82.2% of patients. The mean time from admission to delivery was 51.3 ± 42.3 minutes, with extremes of [15 minutes - 4 hours]. On examination of the placenta, the mean cup size was 6.8 ± 2.2 cm with a range of [3 - 16 cm], and the cup size was greater than or equal to 5 in 88.1% of cases. The mean weight of the haematoma was 504.8 ± 245 g [100 - 1500 g].

3.4. Variables Related to Maternal Prognosis

During the study period, there were 26 maternal deaths, representing a case-fatality rate of 12.9%. Factors statistically associated with maternal death were multigestity ($p = 0.04$), multiparity ($p = 0.01$), Sher grade IIIb ($p = 0.0001$) and the occurrence of complications such as DIC ($p = 0.0001$), shock ($p = 0.0001$), renal complications ($p = 0.002$) and HELLP syndrome ($p = 0.0001$) (**Table 1**). Maternal morbidity related to RPH was dominated by anemia in 64.1% of cases, followed by DIC in 21.8% and postpartum infection in 5.1%.

3.5. Variables Related to Neonatal Prognosis

During the study period, neonatal case fatality was 79.2%. Factors statistically associated with foetal mortality were cup size ≥ 5 cm ($p = 0.0001$) and haematoma weight ≥ 500 g ($p = 0.0001$) (**Table 2**). Foetal weight was between 1501 and 2500 g in 45.5% of cases. The Apgar score at the 5th minute of life was less than 3 in 81.2% of cases. Of the live neonates, 71.4% were transferred to the neonatology unit.

4. Discussion

In order to study retroplacental hematoma at Bouaké University Hospital, we carried out this prospective study in the gynecology-obstetrics department. It

Table 1. Distribution of patients according to factors associated with maternal prognosis.

	Maternal prognosis		p value
	Dead	Alive	
Age			
≤35 ans	17	139	0.122
>35 ans	9	37	
Gestivity			
≤3	6	78	0.04
>3	20	98	
Parity			
≤3	9	109	0.01
>3	17	67	
Antenatal care			
≤3	15	112	0.558
>3	11	64	
Mode of admission			
Not referred	2	23	0.646
Referred	24	153	
Cup size			
<5 cm	4	20	0.554
≥5 cm	22	156	
Weight of hematoma			
<500	10	83	0.406
500 - 1000	16	91	0.348
>1000	0	2	1
Classification of Sher			
I	1	4	0.502
II	2	32	0.183
IIIa	15	132	0.06
IIIb	8	8	<0.0001
Complications			
Persistent anaemia	10	86	0.321
DIC	16	18	<0.0001
Shock	4	0	<0.0001
Renal complication	3	0	0.002
HELLP Syndrome	5	2	<0.0001

Table 2. Distribution of patients according to factors associated with foetal prognosis.

	Fetal prognosis		p value
	Stillborn	Alive	
Gestational age			
<37 SA (week of amenorrhoea)	89	24	0.860
≥37 SA	71	18	
Mother admission mode			
Not referred	17	8	0.140
Referred	143	34	
Newborn weight			
<1500 g	28	6	0.620
≥1500 g	132	36	
Cup size			
<5 cm	6	18	<0.0001
≥5 cm	154	24	
Hematoma weight			
<500 g	63	30	<0.0001
≥500 g	97	12	
admission-delivery delay			
≤60 minutes	92	21	0.427
≥60 minutes	68	21	

enabled us to describe the sociodemographic and clinical characteristics of pregnant women, to determine the prevalence of retroplacental hematoma and to describe maternal-fetal complications. The limitations of this study could be information bias, due to the fact that the data were collected from respondents using a self-administered questionnaire, and that it was impossible to verify the information provided.

4.1. Incidence

During the study, we recorded 20,959 deliveries at the Bouaké University Hospital maternity ward, including 202 cases of RPH, giving an incidence of 0.96%. Our incidence is comparable to those of Budak and Igwebe, who found 0.66% and 0.8%, respectively [10] [11]. However, it is lower than those reported in Nigeria, India and Côte d'Ivoire [12] [13] [14], which were 1.46%, 3.9% and 4.4%, respectively. This difference could be explained by the type of study, the diagnostic criteria and the study populations.

4.2. Epidemiological Characteristics

The 21 - 35 age group was the most represented (64.4%), with an average age of

29.8 years. The same trends have been reported by other authors for the mean age: 29 years for O Thiam in Senegal [3] and 29.14 for N Adewole in Nigeria [15]. Different authors [16] [17] have assessed the role of maternal age in the occurrence of PRH differently. According to the literature, the risk between maternal age and RPH was linked only by parity [17]. Patients' professional occupations may constitute an obstacle to access to care. In our study, 63.9% of patients had no fixed income. This is twice as high as in the N adewole study in Nigeria [15]. According to Nayama [18], low socioeconomic status is a risk factor for RPH. RPH appears to be a pregnancy pathology that spares no parity. However, multiparous women were the most common in our series (41.6%). Multiparity is a known risk factor for RPH [18] [19]. The risk of occurrence increases with the number of pregnancies and becomes considerable from the fifth parity onwards [18] [19]. Thieba [20] in Burkina Faso asserted that the increase in the prevalence of RPH in pregnant women, and in particular in primiparous and young pregnant women, was linked to insufficient or inadequate monitoring of pregnancy, rather than to the existence of hypertension or previous renal damage. In our study, nulliparous women accounted for 21.8%. This may be explained by the fact that multiparity favours the occurrence of RPH because of alterations in the uterine mucosa, and primiparity favours the occurrence of toxæmia gravidarum. In our series, more than half of the patients (62.9%) had not undergone the required number of antenatal consultations. According to the literature, the frequency of RPH tends to decrease as the number of ANC's increases, and poor antenatal surveillance is a factor predisposing patients to RPH [18]. Pregnant women were referred from a public health facility in 87.6% of cases, and the same finding was made by Ousmane thiam in Senegal [21], which was 66%, and Godwin s in Tanzania [8] (46%). This high frequency of patients being evacuated could be explained on the one hand by the fact that our facility is the only public facility in Bouaké performing complete emergency obstetric and neonatal care.

4.3. Clinical Aspects

RPH was classified as Sher III in 80.7% of cases, including 72.8% as grade IIIa. Our results are similar to those of F Abedlkader in Mauritania [17], who found 86.5%, but higher than those of O thiam in Senegal [21], who found 63%, and J Coleman in Ghana [22] who found 53%, which could be explained by the delay in consultation, thus worsening the maternal-fetal prognosis. Gestational age was full term in 48.1% of cases. The labor of O thiam in Senegal [21] was approximately 36 SA and F adelkader [17] at a gestational age of 34.7. However, Nayama in Niger [18] found cases of RPH between 20 and 27 weeks of gestation (2.5%). It should therefore be considered in pregnant women with risk factors when the pregnancy is at least 20 days gestation.

4.4. Variables Related to Maternal Prognosis

Maternal mortality was 12.9% in our study, which is much higher than the re-

sults of Godwin in Tanzania [8] at 3.6%, J Coleman in Ghana [22] at 2% and Doumbia in Côte d'Ivoire [14] at 2.9%. Morbidity was represented by anaemia in 64.1% of cases, which is higher than the study by O Thiam in Senegal [21], who found 17.8%. This could be explained by the lack of blood products in our health facilities. The factors statistically associated with maternal death were multiple gestations, multiple pregnancies, Sher grade IIIb and the occurrence of complications such as DIC, shock, renal complications and HELLP syndrome.

4.5. Variables Related to Neonatal Prognosis

Fetal weight was between 1501 and 2500 g in 45.5% of cases, whereas F Abdelkader in Mauritania [17] found a fetal weight of less than 1500 g in 46.39% of cases. Neonatal mortality was 79.2%, similar to the study by Doumbia [14] at 78.6% but higher than O Thiam in Senegal [21] at 60.5%, which could be explained by the severity of the clinical picture but also by the low weight of the foetuses, reflecting their fragility. Newborns presented a malformation in 1.5% of cases. Of the live newborns, 71.4% were transferred to the neonatology unit. The factors statistically associated with foetal mortality were cup size ≥ 5 cm and haematoma weight ≥ 500 g.

5. Conclusion

Because of its brutality and the severity of its maternal and foetal consequences, RPH is a medical and obstetric emergency par excellence. Better screening of at-risk populations, early diagnosis and treatment in an organised and equipped medical and surgical facility would improve the prognosis.

Authors' Contributions

All authors have read and approved the final version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Survey Sheet

RETRO PLACENTAL HEMATOMA: Maternal-fetal prognosis at the maternity ward of the Centre Hospitalier Universitaire de Bouaké

File no.:

I. General Information

Age:

Geographical origin: Urban Rural

Profession: Civil servant Housewife Student

Tradeswoman Other

Marital status: Married Single

II. Background

Medical:

Surgical:

Toxic: Alcohol tobacco other drugs

Gyneco-obstetrical:

- Gestité:

- Parity:.....

- Gynecological history:

Spontaneous abortion Fetal Death In Utero

- Obstetrical history:

Caesarean section Threatened premature delivery

Premature rupture of membranes Retroplacental hematoma

Delivery hemorrhage

III. Current Pregnancy

Prenatal follow-up:

Urban Health Center/Rural Health Center Private clinic

Not followed Regional Hospital University Hospital

General Hospital

Number of prenatal consultations:

Number of fetuses:

Complications:

1st and 2nd trimester hemorrhage Anemia Gestational diabetes

Threat of premature delivery Premature rupture of membranes

Hypertension-preclampsia eclampsia

IV. Admission

Mode of admission:

Referred from another center Not referred

Reason for admission:

Hemorrhagic shock Delivery Uterine contractures

Metrorrhagia Absence of BDCF Preeclampsia
 Eclampsia Trauma Gestational arterial hypertension Threat of pre-
 term delivery Retroplacental hematoma

V. Clinical Examination

General examination:

General condition: good Shock

- Blood pressure: systole:diastole:.....

- Edema: Yes No

- Urinary dipstick:

Obstetrical examination:

- Uterine height:

- Fetal heart sounds: absent present

- Uterine contraction: Yes No

- Uterine hypertonia: Yes No

- Metrorrhagia: Yes No

Appearance: Quantity:

- Cervical condition: Dilatation

- Water status: Intact Broken

Fetal presentation: Seated Cephalic Transverse

SHER classification: I: II: IIIa: IIIb:

VI. Additional Tests

Biology:

hemoglobin: Platelets: Prothrombin rate:

activated partial thromboplastin rate:

Fibrin degradation products: Fibrinogen:

Blood urea: Creatinine:

GOT/GPT: 24-hour proteinuria:

VII. Maternal Prognosis

Mortality: Yes No

Morbidity:

Persistent anemia Disseminated intravascular coagulation

Hemorrhagic shock state

Renal complication HELLP syndrome Delivery hemorrhage

Uterine atony Chorioamnionitis

Post-partum infection Thrombophlebitis

Cardiac damage Neurological damage

Length of hospital stay (days):.....

IX. Fetal Prognosis

Fetal characteristics:

- Term of delivery:
- Birth weight:
- Sex: Male Female
- Mortality: Stillborn Alive
- Morbidity:
- APGAR score:
- Respiratory distress: Yes No
- Congenital malformation: Yes No
- Transfer to intensive care: Yes No
- Transfer to pediatrics: Yes No