


Original article

# Feto-Maternal Outcome in Patients with Placenta Previa at Aljala Maternity Hospital, Tripoli, Libya

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## ABSTRACT

To assess maternal and fetal morbidity associated with placenta previa. All patients with placenta previa who delivered in services hospital, Aljala Maternity hospital during the years 2020 to 2022 were involved. This study designed as descriptive retrospective cross-sectional study. Total number of 55 patients having placenta previa during the study period, 52.07% of patients were in age group 31-40 years while 15.5% of patients with placenta previa were less than 30 years ( $p < 0.05$ ). Regarding the gestational age, the current study showed that the mean gestational age for the patients who had PP was 37.19 weeks. The result was statistically insignificant with  $p$  value of 0.618. Most of the patients had H/O previous cesarean section (15 previous I C/S, 26 previous II C/S, 3 previous III C/S, 2 previous IV C/S, and 1 previous V C/S) which accounts 86.1% of the participated patients. Increased number of caesarean sections significantly associated with PP ( $p = 0.0001$ ). Around two third of women underwent urgent C/S (66%), and the rest of them (34%) had elective type. One third of the patients came with H/O vaginal bleeding. 21% of the patients had a complain of pain (most of them lower abdominal pain). 12.7% of the patients came shocked. Four percent of the participated women underwent hysterectomy, one of them had elective cesarean section. 15% of the patients had intrapartum bleeding, and 24% of the participated women had blood transfusion which reach 6 units in one case. With regard the birth weight, most of the neonates had average birth weight (80.4%). The percentage of low birth weight (LBW) was 9.4%. On the other hand, the percentage of macrosomia (birth weight is above 4.5kg) was 10.2% for the  $P$  value 0.737. 41.5% of the neonates had H/O admission to the neonatal intensive care unit. The most of the neonates were with mother (58.5%). There was one neonatal death during the admission in NICU. Placenta previa is danger to both the mother and the baby with high maternal morbidity and adverse perinatal outcome. Regular antenatal care with adequate arrangement of blood transfusion and multidisciplinary approach can reduce maternal morbidity and mortality.

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## INTRODUCTION

Placenta previa is a serious health issue and is associated with high fetal-maternal morbidity and mortality. Placenta previa (PP) is characterized by the abnormal placenta overlying the endocervical os, and it is known as one of the most feared adverse maternal and fetal-neonatal complications in obstetrics [1]. All placentas overlying the os (to any degree)

are termed previas and those near to but not overlying the os are termed low-lying [1,2]. It appears to be an association between endometrial damage and uterine scarring and subsequent placenta previa [1,3]. Risk factors for placenta praevia include those that increase the likelihood of uterine scar tissue (including higher parity, prior caesarean delivery or prior abortion) or multiple gestations [2,3]. It occurs in 2.8/1000 singleton pregnancies and 3.9/1000 twin pregnancies [1,4]. For pregnant women with placenta previa, the odds of placenta accrete are 11% for one prior cesarean section (CS) and 67% for a fifth or more repeated CS [5,6]. Other risk factor associated with placenta previa is smoking during pregnancy [6].

Placenta praevia can result in life-threatening maternal complications such as haemorrhage and shock and in adverse infant outcomes such as prematurity, stillbirth and because the patient may need to be admitted to hospital for observation, she may need blood transfusion, and she is at risk for premature delivery. The incidence of hysterectomy after Caesarean section (CS) for placenta previa is 5.3% (relative risk compared with those undergoing CS without). The use of routine obstetric ultrasound during antenatal follow-up helps in the early diagnosis of placental abnormalities and hence, possible prevention of morbidity and mortality. Moreover, cases diagnosed at mid pregnancy should be repeated at approximately 32 weeks gestation, because the placenta undergoes a process termed trophotropism. Trophotropism occurs when the placenta grows into an area with increased blood supply, typically the fundus, and the part that is closest to the cervix eventually regresses and atrophies. The complexity of placenta previa can be determined by tissue destruction, newly formed vessels, and vascular invasion of surrounding tissues. Prenatal diagnosis of abnormal placentation allows the development of a multidisciplinary approach to achieve the best outcomes for mother and baby. However, performing a transvaginal ultrasound routinely on all women is not recommended [5,6].

Placenta accreta is graded according to the depth of invasiveness: accreta, when the villi adhere to the myometrium without invading it; increta, when the villi invade the myometrium; and percreta, when the invasion reaches the uterine serosa that 90% of women diagnosed with placenta previa or accreta are at an increased risk of antepartum hemorrhage prior to a gestational age of 37 weeks. The majority of them require an emergency preterm delivery. Hence, a scheduled delivery is preferably planned at 36-37 gestation [6].

Obstetric hemorrhage is major contributor to maternal deaths with placenta previa morbidity with placenta previa can significantly be reduced if diagnosed antenatally. This will ensure arrangement in properly equipped hospital with multidisciplinary approach and availability of blood transfusion, anesthesia, ICU and neonatal facilities [6,7]. This is extremely challenging in low resource countries where blood transfusion and operative services are not available at periphery where most of the population is residing. Repeated multiple studies which emphasize the underlying cause of ante and postpartum hemorrhage will go a long way in sensitizing people at government level to improve facility at primary, secondary and tertiary level. In cases where placenta accreta is diagnosed, placental magnetic resonance imaging is an accurate method of topographic stratification that makes it possible to define anatomy, plan the surgical approach, and consider other therapeutic possibilities. In terms of management of placenta accreta, there are two treatment options: cesarean hysterectomy or a conservative approach. With the latter, there is a choice between leaving the placenta in situ and waiting for its later resolution, or a one-step surgery that addresses the abnormally invasive placenta, vascular control, and myometrial damage in a single surgical procedure [8].

Previous studies have reported the associated risk factors of PP, and only a few reports have focused on the clinical outcomes of PP. Information about these conditions is important so that women with a specific type of PP can be appropriately counseled regarding their outcomes and clinical care providers can be appropriately prepared for their deliveries. Thus, the objective of this study was to investigate the maternal and neonatal outcomes of women with PP in Aljala- Maternity Hospital, Tripoli, Libya.

## METHODS

### *Study design*

The study designed as descriptive cross sectional retrospective study conducted at Aljala maternity teaching hospital, Tripoli, Libya from the period from January 2022 to December 2022. All mothers diagnosed with placenta previa during the study period were involved.

### *Data collection*

The data was collected using a questionnaire filled from the files of patients attending the hospital with placenta previa. All confirmed diagnosis of placenta previa were evaluated in detailed and their data was collected from their medical records.

### *Statistical analysis*

Statistical analysis was computerized using the Statistical Program for Social Sciences (SPSS version 21) that used for data entry and analysis. Data were presented as frequencies, means  $\pm$  standard deviation and percentages.

### Ethical consideration

An ethical approval was obtained from the medical staff of obstetrics and gynecology department and Aljala hospital committee. The confidentiality of the names and information of the patients were respected.

## RESULTS

### Demographics

A total number of 55 patients having placenta previa during the study period, 52.07% of patients were in age group 31-40 years while 15.5% of patients with placenta previa were less than 30 years ( $p < 0.05$ ). Regarding the gestational age, the current study showed that the mean gestational age for the patients who had PP was 37.19 weeks. The result was statistically insignificant with  $p$  value of 0.618. Most of the patients had H/O previous cesarean section (15 previous I C/S, 26 previous II C/S, 3 previous III C/S, 2 previous IV C/S, and 1 previous V C/S) which accounts 86.1% of the participated patients. Increased number of caesarean sections significantly associated with PP ( $p = 0.0001$ ).

Around two third of women underwent urgent C/S (66%), and the rest of them (34%) had elective type. One third of the patients came with H/O vaginal bleeding, 21% of the patients had a complain of pain (most of them lower abdominal pain). 12.7% of the patients came shocked. Four percent of the participated women underwent hysterectomy, one of them had elective cesarean section. 15% of the patients had intrapartum bleeding, and 24% of the participated women had blood transfusion which reach 6 units in one case. No maternal death.

With regard the birth weight, most of the neonates had average birth weight (80.4%). The percentage of low birth weight (LBW) was 9.4%. On the other hand, the percentage of macrosomia (birth weight is above 4.5kg) was 10.2% for the  $P$  value 0.737. 41.5% of the neonates had H/O admission to the neonatal intensive care unit. The most of the neonates were with mother (58.5%). There was one neonatal death during the admission in NICU.

### Age distribution of the patients with pp

The mean age for the patients was  $(35.1 \pm 7.3)$  years. The maximum age of the patients was 47 years and the minimum age was 21 years. Most of the age distribution of the patients in this study was between 31-40 years, which account for 52.7%. The least percentage was patients between 21-30 years (15.5%).

Table 1. Age distribution of the patients, Aljala hospital, 2022.

Age distribution of patients	Frequency	Percent
21-30 years	9	15.5%
31-40 years	23	52.7%
41-50 years	18	31.8%
Total	55	100%

### The distribution of the gravidity

In respect to gravidity, about 57.3% of the patients who had placenta previa were between gravida above 7. The result also showed that 25.3% of the patients had gravidity between 5 and 7. Only 10 patients had H/O G2-G4 which accounts 17.4%. The result was statistically significant with  $p$  value of 0.0001.

Table 2. The distribution of the gravidity among the patients, Aljala Maternity Hospital, 2022.

Gravidity of the patients	Number (%)
G2 - G4	10 (17.4%)
G5 - G7	13 (25.3%)
>G7	32 (57.3%)
Total	55 (100%)

### Distribution of the patients by the parity

Regarding the parity, the result showed the following; 76.1% of the successful VBAC group and 90.2% of the failed VBAC group were between para 1 and para 3, 21.7% of the successful VBAC group and 7.6% of the failed VBAC group were between para 4 and para 6, 2.2% of both groups were more than para 6. The result was statistically significant with  $p$  value of 0.01.

**Table 3. The distribution of the parity among the patients.**

Parity of the patients	Frequency (%)
P1 – P3	6 (10%)
P4 – P6	8 (16.4%)
>P6	41 (73.6%)
<b>Total</b>	<b>55 (100%)</b>

**Distribution of the H/O abortion among the patients with PP**

With regard the abortion, the majority of the patients in both groups had previous history of abortion (59.1%). The result was statistically insignificant with p value of 0.481.

**Table 4. Distribution of the abortion (Ajala hospital, 2022).**

H/O abortion	Frequency (%)
No	22 (40.9%)
Yes	33 (59.1%)
<b>Total</b>	<b>55 (100%)</b>

**Distribution of the patients by the gestational age**

Regarding the gestational age, the current study showed that the mean gestational age for the patients who had PP was 37.19 weeks. The result was statistically insignificant with p value of 0.618.

**Table 5. Distribution of the PP by the gestational age (Ajala hospital, 2022).**

Gestational age (%)	Frequency
Preterm	10 (19.6%)
Term	43 (78.4%)
Post-term	2 (4%)
<b>Total</b>	<b>55 (100%)</b>

**Distribution of the H/O the past obstetrics history and risk Factors**

Most of the patients had H/O previous cesarean section (15 previous I C/S, 26 previous II C/S, 3 previous III C/S, 2 previous IV C/S, and 1 previous V C/S) which accounts 86.1% of the participated patients.

**Table 6. Distribution of risk factors among the patients, Ajala Teaching Hospital 2022.**

Risk factors	Frequency (%)
Previous C/S	47 (86.1%)
H/O Uterine surgery	2 (4%)
H/O Previous DIC or EIC	8 (14.4%)

**Distribution of the clinical presentation**

One third of the patients came with H/O vaginal bleeding. 21% of the patients had a complain of pain (most of them lower abdominal pain). 12.7% of the patients came shocked.

**Table 7. Distribution of clinical presentation among the patients.**

Complain	Frequency (%)
Vaginal bleeding	19 (35.7%)
Pain (LAP, Back P.)	12 (21%)
Shocked	7 (12.7%)

**Maternal outcome**

Four percent of the participated women underwent hysterectomy, one of them had elective cesarean section. 15% of the patients had intrapartum bleeding, and 24% of the participated women had blood transfusion which reach 6 units in one case. No maternal death was observed.

**Table 8. Distribution of maternal outcome among the patients.**

Maternal outcome	Frequency (%)
Intrapartum Bleeding	8 (15%)
PPH	6 (10%)
Hysterectomy	2 (4%)
Blood Transfusion	12 (24%)
Bladder Injury	0 (0%)
ICU admission	2 (4%)
Maternal death	0(0%)

**Type of cesarean section**

Around two third of women underwent urgent C/S (66%), and the rest of them (34%) had elective type.

**Table 9. Distribution of type of C/S among the patients.**

C/S type	Frequency (%)
Emergency C/S	36 (66%)
Elective C/S	19 (34%)
<b>Total</b>	<b>55 (100%)</b>

**Gender of the neonate**

Regarding the gender of the neonate, the percentage of females was higher (59%) than the males (41%).

**Table 10. Distribution gender of the baby, (Al-jala Maternity Hospital, 2022).**

Gender of the baby	Frequency (%)
Male	21 (41%)
Female	34 (59%)
<b>Total</b>	<b>55 (100%)</b>

**Birth weight of the neonates**

With regard the birth weight, most of the neonates had average birth weight (80.4%). The percentage of low birth weight (LBW) was 9.4%. On the other hand, the percentage of macrosomia (birth weight is above 4.5kg) was 10.2% for the P value 0.737.

**Table 11. Birth weight of the neonates (Aljala hospital, 2022).**

Birth weight	Frequency (%)
<2.5kg	5 (9.4%)
2.5kg-4.5kg	44 (80.4%)
>4.5kg	6 (10.2%)
<b>Total</b>	<b>55 (100%)</b>

**NICU Admission**

41.5% of the neonates had H/O admission to the neonatal intensive care unit. The most of the neonates were with mother (58.5%). There was one died of the neonates during their admission in NICU.

**Table 12. Distribution of the admission to NICU among the neonates.**

NICU admission	Frequency (%)
No	32 (58.5%)
Yes	23 (41.5%)
<b>Total</b>	<b>55 (100%)</b>



## DISCUSSION

The high cesarean delivery rate is associated with an increased risk of placenta previa in subsequent pregnancies since the risk of PP rises as the number of prior cesarean sections increases. Placental previa is a serious obstetrical complication and its management is challenging, with more difficult surgical operations and higher hysterectomy rate. With the rapid growth of the aging population, there will be more multipara with a scarred uterus and PP in the future, which will pose a huge challenge to health care providers [20].

PP diagnosed in early pregnancy may not persist in late pregnancy and near term. PP is suspected and diagnosed in approximately 5% of pregnancies between 15 and 16 weeks and almost 90% of PP resolves to a normal position by term, which may be explained by the elongating of the uterus and the gradually rising position of the placenta away from the cervix with increasing gestational age. However, such a mechanism will be interfered with if the placenta is covered in uterine scarring from a prior CS such that the placenta cannot move normally [21,23].

This study found that although a significant number of women had previous history of abortion, the known risk factor for placenta praevia was not significantly associated after being adjusted for confounders in multivariate regression. It might be due to the study design and sample size. This was in contrast with the finding of Tuzovic and Ilijic that the percentage of previous abortions was significantly higher among women with placenta praevia, which yielded a risk of 2.75. The mechanism of how previous abortions predispose to placenta praevia development could be explained with possible endometrial damage during repeated abortions, which impedes successful fundal implantation of the placenta [22].

The effects of a previous cesarean section were obvious, and the placenta was unlikely to “migration” in the presence of a hysterectomy scar. According to this study, patients who had previous delivery by caesarean section have an increased risk of placenta praevia. Most studies have reported an association between previous caesarean section and placenta praevia. Similarly, in a meta-analysis of 170640 pregnant women, a pattern of risk factors for placenta praevia was found with the increasing number of caesarean section deliveries (24, 25).

The correlation between gestational age and different types of placenta previa remains controversial. Some studies reported no differences in gestational age at delivery of infants born to mothers with different types of placenta previa. However, more studies agreed that premature delivery was more frequent in women with complete placenta previa [21,25].

Some studies have addressed whether types of placenta previa are associated with the severity of symptoms in mothers and neonates. Our results show that women with PP had a higher rate of intraoperative blood loss, postpartum hemorrhage, transfusion, and hysterectomy and that the infants born to women with PP had lower Apgar scores at 1 min [26]. Nevertheless, our results showed that the proportion of women with hysterectomy was lower than that reported in most other studies. One possible and important reason for the low hysterectomy rate in our study is that obstetricians in our hospital believe that retaining the uterus is of great significance to young women who desire to preserve fertility, so it is acceptable to have an increased risk of postpartum hemorrhage and transfusion in women with PP if we can preserve the uterus [27-29]. Due to the small number of participants in our study, it is difficult to make generalizations to other populations.

## CONCLUSION

Placenta previa danger to both the mother and the baby with high maternal morbidity and adverse perinatal outcome. Regular antenatal care with adequate arrangement of blood transfusion and multidisciplinary approach can reduce maternal morbidity and mortality.

*Conflict of interest.* Nil

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## نتائج الأمهات لدى المرضى الذين يعانون من المشيمة المنزاحة في مستشفى الجلاء للولادة، طرابلس، ليبيا

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### المستخلص

لتقييم مرآة الأم والجنين المرتبطة بالمشيمة المنزاحة. تمت مشاركة جميع مريضات المشيمة المنزاحة اللاتي ولدن في مستشفى الخدمات، مستشفى الجلاء للولادة خلال الأعوام من 2020 إلى 2022. صممت هذه الدراسة كدراسة وصفية استرجاعية مقطعية. إجمالي عدد 55 مريضة مصابة بالمشيمة المنزاحة خلال فترة الدراسة، 52.07% من المرضى كانوا في الفئة العمرية 31-40 سنة بينما 15.5% من المرضى الذين يعانون من المشيمة المنزاحة كانوا أقل من 30 سنة ( $P < 0.05$ ). وفيما يتعلق بعمر الحمل، أظهرت الدراسة الحالية أن متوسط عمر الحمل للمرضى الذين لديهم PP كان 37.19 أسبوعاً. وكانت النتيجة ذات دلالة إحصائية بقيمة  $p = 0.618$  معظم المرضى خضعوا لعملية قيصرية سابقة (15 C/S سابقة، 26 C/S II سابقة، 3 C/S III سابقة، 2 C/S IV سابقة، و 1 C/S V سابقة) وهو ما يمثل 86.1% من المرضى المشاركين. زيادة عدد العمليات القيصرية المرتبطة بشكل كبير بـ PP ( $P = 0.0001$ ). حوالي ثلثي النساء خضعن لعملية C/S عاجلة (66%)، والباقي منهن (34%) من النوع الاختياري. ثلث المرضى جاءوا مع نزيف مهبلية 21% H/O. من المرضى اشتكوا من الألم (معظمهم آلام في أسفل البطن). 12.7% من المرضى أصيبوا بالصدمة. خضعت أربعة بالمائة من النساء المشاركات لعملية استئصال الرحم، وخضعت إحداهن لعملية قيصرية اختيارية. 15% من المرضى أصيبوا بنزيف أثناء الولادة، و 24% من النساء المشاركات خضعن لعمليات نقل دم تصل إلى 6 وحدات في الحالة الواحدة. وفيما يتعلق بالوزن عند الولادة، فإن معظم الولدان كان متوسط وزنهم عند الولادة (80.4%). وبلغت نسبة انخفاض الوزن عند الولادة 9.4%. في المقابل بلغت نسبة العملاقة (الوزن عند الولادة أكثر من 4.5 كجم) 10.2% للقيمة  $P = 0.737$ . تم إدخال 41.5% من الأطفال حديثي الولادة إلى وحدة العناية المركزة لحديثي الولادة. معظم المواليد كانوا مع أمهاتهم (58.5%). كانت هناك حالة وفاة واحدة لحديثي الولادة أثناء القبول في وحدة العناية المركزة لحديثي الولادة. تشكل المشيمة المنزاحة خطراً على كل من الأم والطفل مع ارتفاع معدلات الإصابة بالأمراض لدى الأمهات ونتائج سلبية في الفترة المحيطة بالولادة. الرعاية السابقة للولادة المنتظمة مع الترتيب المناسب لنقل الدم واتباع نهج متعدد التخصصات يمكن أن تقلل من معدلات المراضة والوفيات النفاسية.

**الكلمات الدالة:** نتائج الأمومة والجنين، المشيمة المنزاحة، مستشفى الجلاء للولادة، ليبيا.