WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 8.084
Volume 10, Issue 5, 136-140. Case Study ISSN 2277– 7105

CHORIOANGIOMA COMPLICATED BY AN ABRUPTIO PLACENTA, CASE REPORT

Zakaria Idri[1]*, Chrif Boukhriss[1], Mohammed Oukabli[2], Jaouad Kouach[1] and Driss Moussaoui[1]

[1]Department of Gynecology and Obstetrics of the Military Hospital of Instruction Mohammed V in Rabat.

[2]Pathology Department of the Military Hospital of Instruction Mohammed V In Rabat.

Article Received on
10 March 2021,

Revised on 31 March 2021,
Accepted on 21 April 2021

DOI: 10.20959/wjpr20215-20411

***Corresponding Author**
Zakaria Idri
Department of Gynecology and Obstetrics of the Military Hospital of Instruction Mohammed V in Rabat.

ABSTRACT

Chorioangioma is the most common placental neoplasm, it's a rare condition that can induce several fetal complications. We report a case of a G31p2 37 year-old patient with a chorioangioma diagnosed tardily during etiological investigation of a late intrauterine growth restriction complicated by an abruptio placenta.

KEYWORDS: Chorioangioma, Intrauterine growth restriction, Abruptio placenta

INTRODUCTION

Chorioangioma is the most common placental neoplasm, with an incdence of 1% of all pregnancies. Chorioangioma is often asymptomatic but it can be revelated by a complication like intrauterine restriction, fetal demise, or neonatal angioma. Here we report a case of a chorioangioma complicated by an intrauterine growth restriction.

CASE REPORT

A G3P2 37-year-old patient, with no particular history, admitted at 35 weeks of gestation. The obstetric history finds two vaginal deliveries at term, the current pregnancy is a pregnancy followed with a correct prenatal assessment. Ultrasound follow-up was unremarkable until the 33-week growth ultrasound which revealed stagnation of growth. The ultrasoud control of the growth carried out at 35 weeks noted a restriction of the growth at the expense of all the parameters of the biometry with an estimate of the fetal weight at 2100g, the amniotic fluid was in normal quantity. The obstetric Doppler study (umbilical artery, cerebral artery,

uterine artery, and ductus venosus) showed no abnormalities. The patient was hospitalized to take charge of her delivery, the etiological assessment of her intrauterine growth retardation showed a 7 cm thick placenta, with multiple rounded images of varying sizes, hypoechoic. The doppler was positive for some and negative for others (figure 1). During her hospitalization, the patient presented with metrorrhagia of blackish clotting blood associated with uterine contracture suggesting an abruptio placentae, auscultation of fetal heart sounds found fetal bradycardia. An emergency cesarean section was performed allowing the extraction of a newborn male, an apgar score of 10/10, a birth weight of 2000g. Neonatal examination did not reveal a cutaneous hemangioma. Examination of the deliveries revealed a fresh hematoma involving a third of the maternal side of the placenta, and fleshy, renitent, congested masses on the fetal side of the placenta (figure 2). Pathologic study of the placenta confirmed the diagnosis of placental chorioangioma (figure 3).

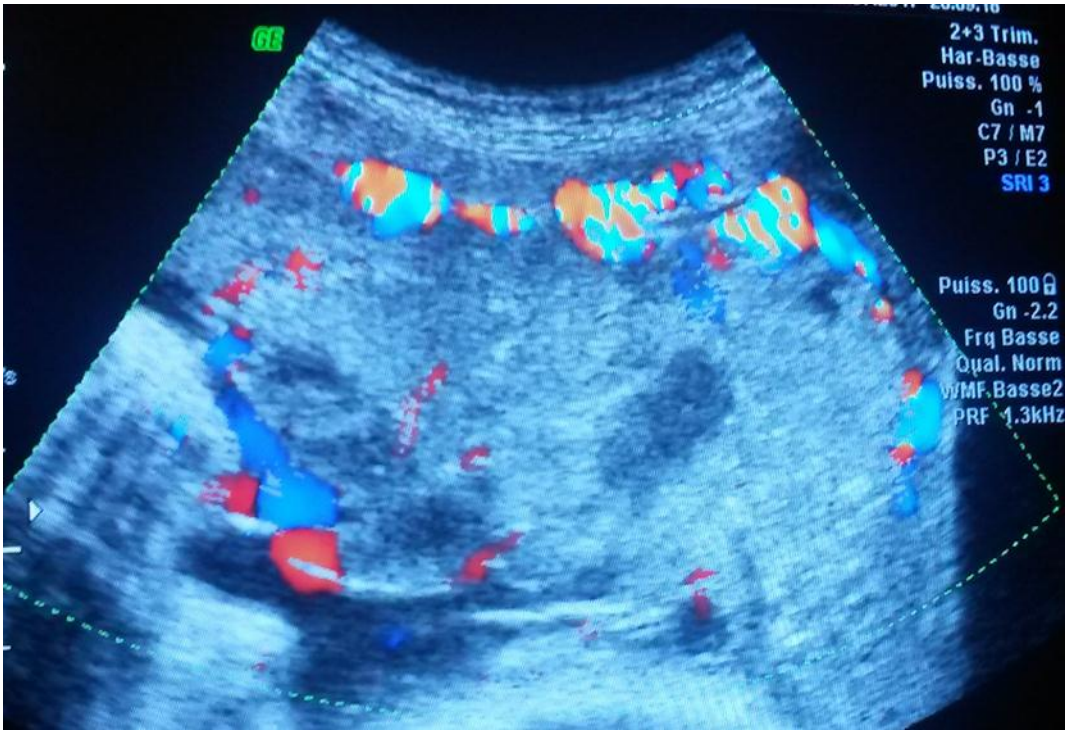

Figure 1: Ultrasound image of the placenta showing a thick placenta containing hypoechoic formations with doppler positive for some and negative for others.

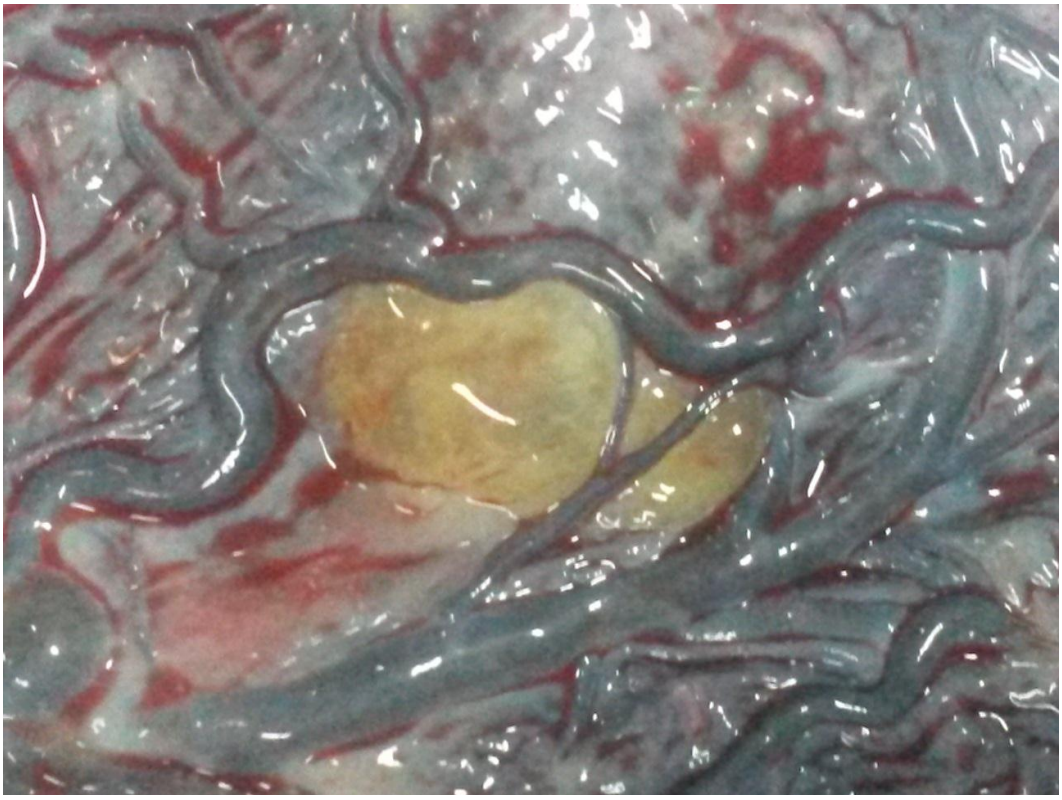

Figure 2: Picture of fetal side of placenta showing fleshy, renitent, congested masses

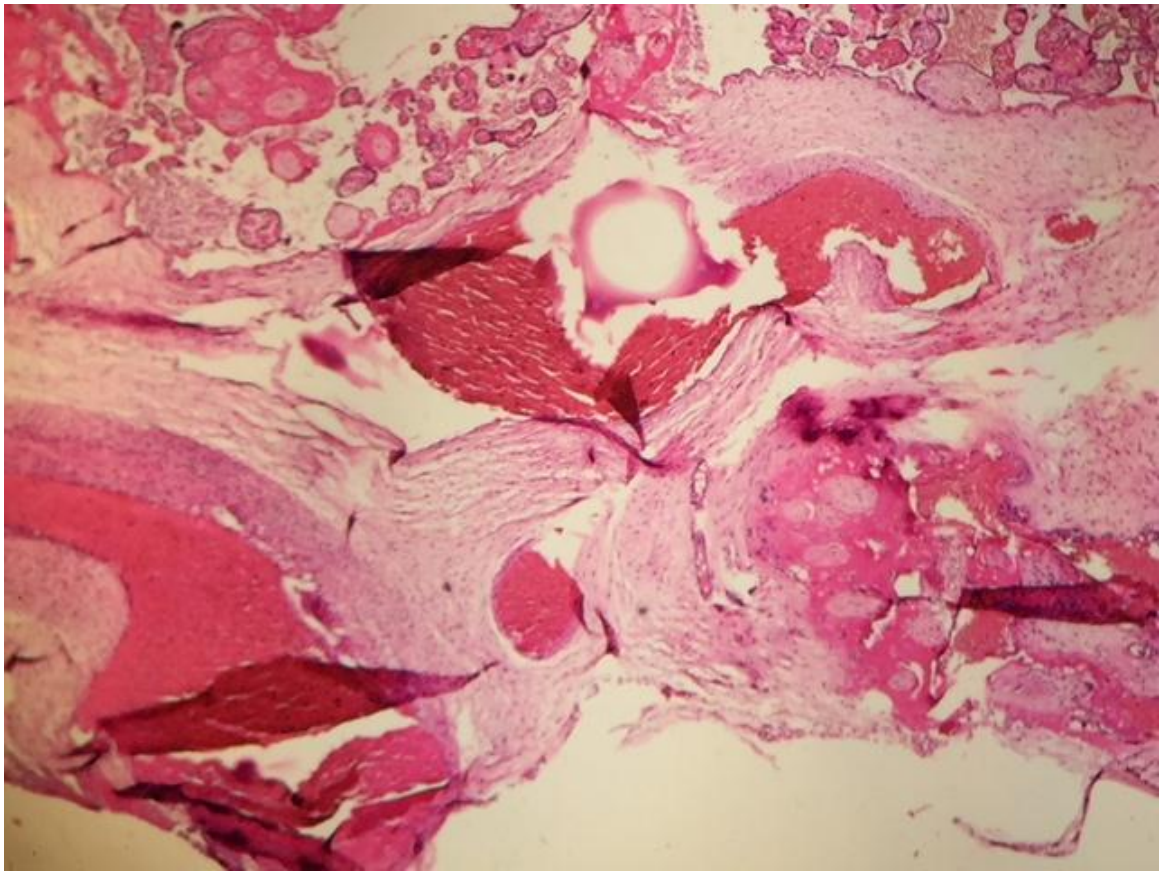

Figure 3: Picture of the microscopic study of the placenta showing a placental

proliferation made up of congestive vessels of variable size and with a turgid wall (HEx10).

DISCUSSION

Placental chorioangioma is the most frequent placental tumor, it is a benign placental tumor found in 1% of the placentas in the event of systematic anatomopathological examination of the placenta[1], yet only 10% to 20% of these tumors are diagnosed. that they remain asymptomatic in the rest of the cases.[2] Chorioangiomas are often asymptomatic and are discovered incidentally during routine obstetric ultrasounds. Ultrasound diagnosis is possible for chorioangiomas larger than 2cm.[3] It is a homogeneous mass, similar in tone to that of the placenta, sometimes with hypoechoic areas (corresponding to areas of necrosis); its border is distinctly rounded, its location subchorionic, often adjacent to the insertion of the cord.[4,5] The differential ultrasound diagnosis arises mainly with placental infarction, subchorionic thrombosis, placental cyst, or decidual hematoma. The use of color Doppler eliminates differential diagnoses and confirms the vascular nature of the mass except in cases of necrosis or calcifications. Placental chorioangioma can cause fetal complications, namely prematurity, intrauterine fetal demise, intrauterine growth restriction, abruptio placentae, heart failure, hydramnios, fetal anemia and thrombocytopenia.[2.5]

CONCLUSION

Chorangioma is a rare case and its detection is often related to complications. A thorough examination of the placenta is crucial in complicated pregnancies for identifying this tumor. Early antenatal diagnosis of chorangioma can reduce maternal morbidity as well as fetal morbidity and mortality.

REFERENCES

1. Mubiayi N, Cordonnier C, Le Goueff F, Subtil D, Devisme L, Decocq J, et al. Les chorio-angiomes placentaires diagnostiqués au second trimestre de la grossesse : à propos de quatre observations. J Gynecol Obstet Biol Reprod, 2002; 31: 187-92.
2. Gallot D, Sapin V, Beaufrère AM, Boda C, Laurichesse-Delmas H, Déchelotte P, et al. Récurrence de chorio-angiomes multiples: à propos d'un cas. Gynecol Obstet Fertil, 2003; 31: 943-7.
3. L.Durin, P.Bajrot et M.Herlicovlez. Chorioangiome placentaire, Apport de l'échographie : A propos de 2 cas. J Radiol, 2002; 83: 739-41.
4. Fournet P, Eloit S, Allessandri JL, Amat MC, Hivert A. Le chorioangiome placentaire,

corrélations échographiques, radiologiques et anatomopathologiques. J. Gynecol Obstet Biol Reprod, 1989; 18: 913-8.

5. Rousseau O, Giacalone PL, Boulot P et al. Chorioangiome placentaire. A propos de 2 cas et revue de la littérature. J Gynecol Biol Reprod, 1195; 24: 529-33.