Chorioangioma of Placenta: A Case of Incidental Finding in Cesarean Section

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Abstract
Background: Chorioangioma is a benign angioma of placenta arising from chorionic tissue. Large chorioangioma are known to have adverse effects on both mother and fetus [1]. The incidence is 1% of all pregnancies. Large chorioangioma can result in polyhydramnios, hydrops fetalis, intrauterine growth retardation, sudden intrauterine fetal death, preterm labor, and neonatal death associated with congestive cardiac failure [2-5].

Case: We report a case of incidental finding of chorioangioma of placenta in a 42-year-old female with intrauterine growth restriction, and fetal distress at 39 weeks gestation that necessitated on emergency lower segment cesarean section at 39 weeks gestation. Postpartum period was uneventful.

Conclusion: The high risk of morbidity and mortality associated with large chorioangiomas warrants institutional antenatal care and timely delivery.

Keywords: Placenta, Intrauterine growth restriction, Fetal distress, Emergency lower segment cesarean section

Introduction
Chorioangioma placenta is considered a rare tumour of placenta. Chorangiommas are benign vascular tumors of the placenta arising from chorionic tissue. The rate of their occurrence rises almost linearly with maternal age over 30 years old. Primipara, twin pregnancies, hypertension, diabetes are found more often in combination with chorangiomas [2]. Large placental chorioangioma has adverse effects on both mother and fetus.

Case Presentation
A 42-year-old female, gravida 3 with two living children that were delivered vaginally presented to us at 39 weeks gestation with labor pains. Her first antenatal visit to the hospital was at 36 weeks of gestation. On examination, blood pressure was 111/61 mmHg, pulse 84 b/m, afebrile, abdominal examination: uterus 38 weeks size, cephalic presentation, fetal parts were palpable, and fetal heart sounds audible 130 - 140 b/m.

Vaginal examination: Cervical os 3 - 4 cm dilated, effacement 60%, high presenting part, and the membranes were intact. She was neither hypertensive nor diabetic nor anemic. No history of reduced fetal movements. Ultrasound at 22 weeks of gestation showed a subchorionic hematoma (Figure 1), measuring 64 x 12.7 mm in the anterior wall. No obvious gross congenital abnormalities were detected.

Normal amniotic fluid index. There were no gross structural abnormalities. Placenta was located on the posterior wall upper segment.

During the course of labor, Patient went into fetal distress was delivered through emergency cesarean section, A male baby weighing 2.065 Kg with Apgar scores 9 and 10 at 1 and 5 minutes, respectively was delivered. Placenta weighed 500 g. On gross examination of the placenta, a piece of macerated placenta was seen (Figure 2), placental tissue measures 15.5 x 15 x 3.5 cm, umbilical cord measures 15 cm in length, located eccentrically 1.5 cm away from the placental margin.

Histopathology of placenta revealed edematous membranes and parenchymal chorangiosis infarction. Umbilical cord was trivascular (Figure 3). The gross examination of the placenta revealed placental tissue measuring 15 cm x 20 cm, eccentrically located umbilical cord and a piece of macerated placenta (Figure 2).

Figure 1: Ultrasound image in 22 weeks of pregnancy. No signs of abnormality.
Maternal complications commonly associated with chorioangioma are polyhydramnios, preterm labor, preeclampsia, and placental abruption. Of the above associated clinical complications, the correlation of chorioangioma with polyhydramnios and preterm delivery is significant, latter being caused due to hydramnios [6, 7]. The increased blood flow through the low resistance vascular channels in the chorioangioma acting as an arteriovenous shunt can cause fetal congestive heart failure. Other complications associated with large chorioangiomas are hydrops fetalis, hemolytic anemia, congenital anomalies, fetal thrombocytopenia, cardiomegaly, and intrauterine growth retardation [8, 9].

Large chorioangioma associated with polyhydramnios can lead to high perinatal morbidity and mortality. Postpartum hemorrhage is a well-known complication in mother.

In our case the chorioangioma was associated with intrauterine growth restriction and intrapartum fetal distress. No episode of postpartum hemorrhage was noted.

Conclusion
The high risk for morbidity and mortality that is associated with large chorioangiomas warrants institutional and timely delivery. Diagnosis is by antenatal ultrasound. Doppler is necessary to assess the feto-maternal circulation and to rule out arteriovenous shunts. Regular follow up examinations are of paramount importance for patients with choriangiomas.

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Conflict of Interest
None.

References