

Incidental Finding of a Large Concealed Placental Abruption on Ultrasound at Term

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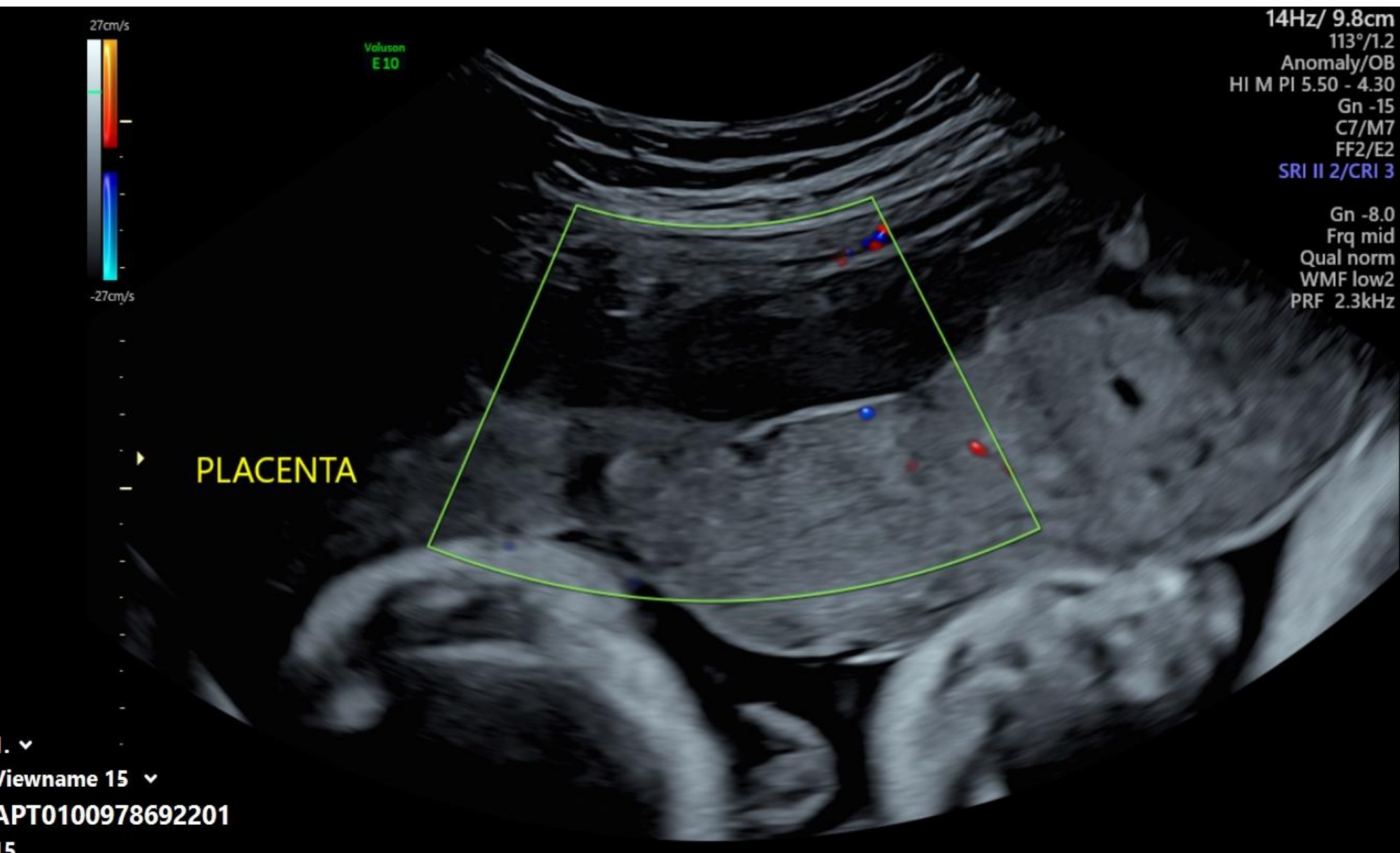
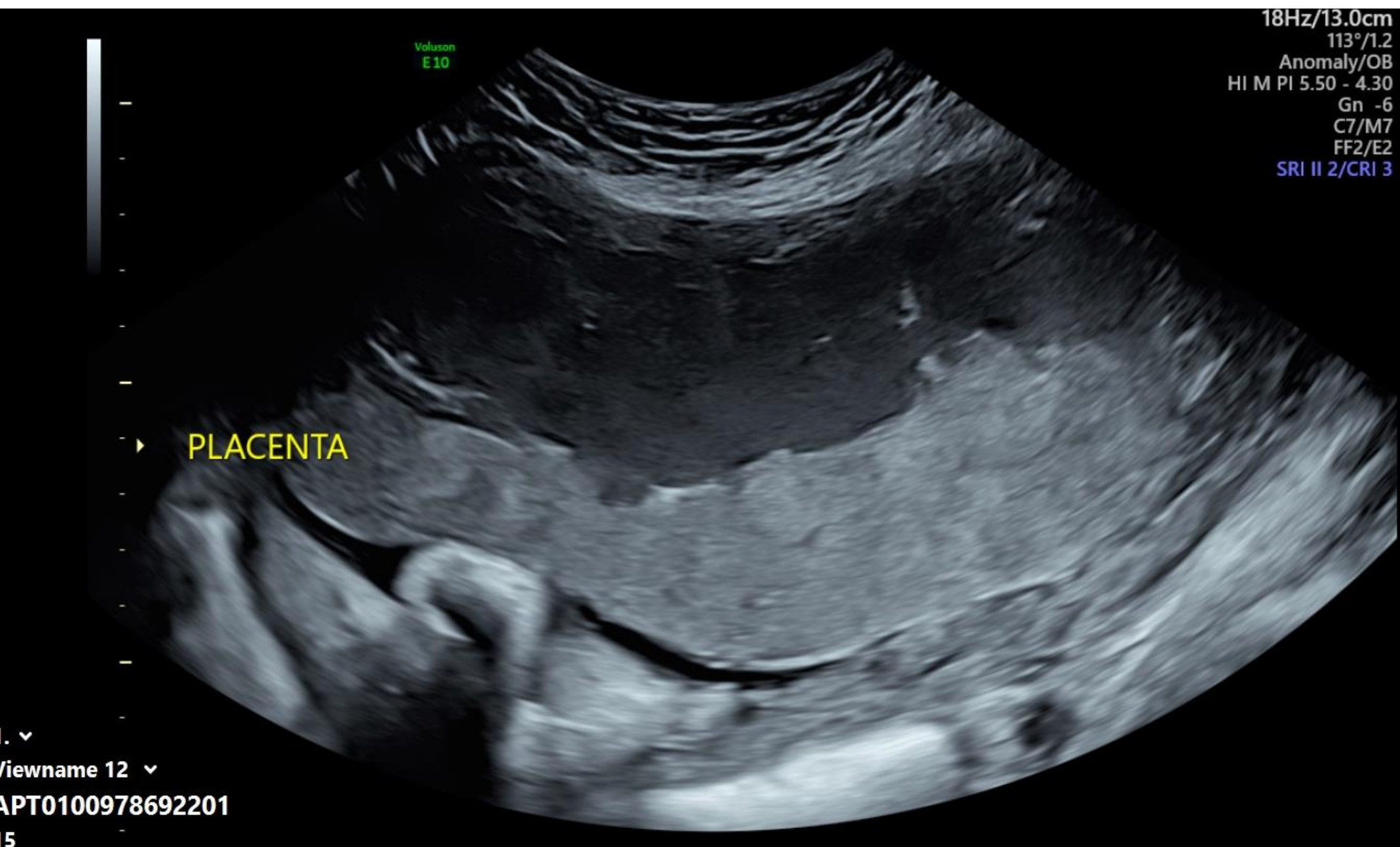
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Objective

Incidental findings of large placental abruption on ultrasound in asymptomatic patients are rare. This case illustrates the rapid onset of fetal distress and emphasizes that timely delivery can lead to favourable maternal and neonatal outcomes.



Case Report

We present a case involving a 31-year-old female (G1P0), Rhesus positive, with a BMI of 18. Serial growth scans at 32, 34 and 36 weeks' gestation indicated estimated fetal weight on 8-10th centile with normal growth velocity, amniotic fluid and dopplers, and an anterior high placenta.

A routine growth scan at 37+6 weeks' gestation revealed a hypoechoic area posterior to the placenta, measuring 15.2 x 4.5 x 8.2 cm, indicative of a substantial retroplacental bleed with a volume of 293ml. The patient reported no vaginal bleeding, abdominal pain, trauma or safeguarding concerns. Fetal movements were normal.

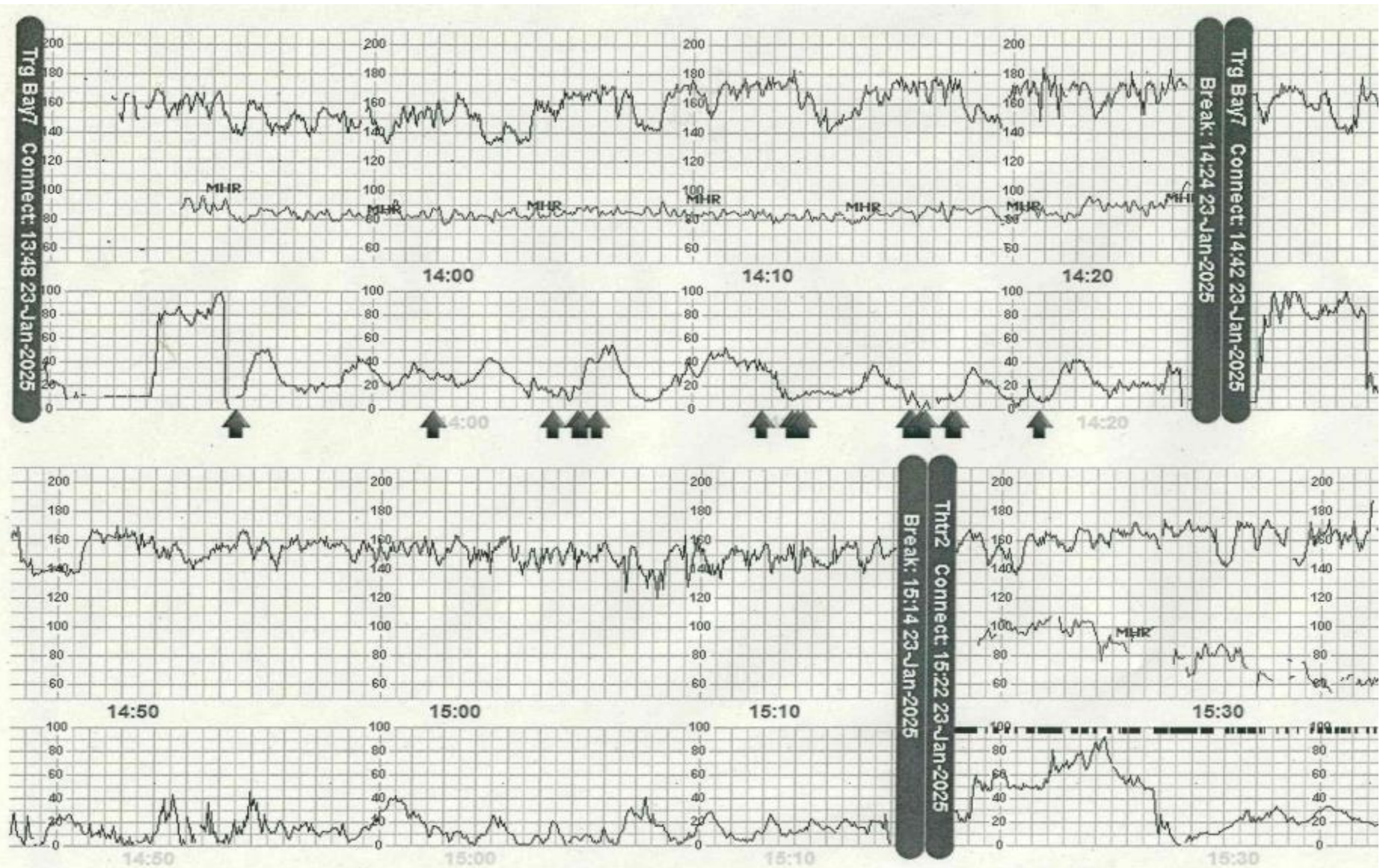
Following consultation with Fetal Medicine, prompt transfer to labour ward revealed normal cardiotocography (CTG). One hour later, CTG indicated fetal tachycardia 160-170 bpm, reduced variability, and shallow decelerations. The patient also reported mild abdominal point at this point.

The neonatal team were notified and preparations made for fetal anaemia. The baby was delivered in good condition by category 2 caesarean section. Delayed cord clamping was practised and the placenta was delivered by controlled cord traction, with small retroplacental clots observed in the uterus. Estimated blood loss was 400mls, cord gases were normal and the baby's haemoglobin was 157g/L. Both mother and baby remain well.

Discussion

Concealed placental abruption accounts for 20-35% of cases and is linked with poorer maternal and perinatal outcomes, including stillbirth. Maternal underweight status and fetal growth restriction are associated with placental abruption (1). The fetal growth restriction observed in this case was likely attributable to chronic placental ischemic disease, which may have led to placental abruption, whether acute or chronic. Histopathology showed macroscopic but no microscopic features of placental abruption.

Despite the low sensitivity of sonographic findings for diagnosing placental abruption (2), it is imperative for sonographers and obstetricians to actively search for signs of placental abruption during routine scans for women with identified risk factors.



Conclusion & Recommendations

Ultrasound plays a limited role in diagnosing and managing suspected placental abruption. The literature contains very few reports of incidental sonographic findings of concealed abruption in asymptomatic women, particularly involving large retroplacental bleeds (3). Upon sonographic identification in asymptomatic patients, it is crucial to ensure prompt admission for maternal and fetal assessment by the multidisciplinary team, with a low threshold for early delivery.

References

1. Deutsch, A.B., Lynch, O.N., Alio, A.P., Salihu, H.M. and Spellacy, W.N., 2010. Increased risk of placental abruption in underweight women. *American Journal of Perinatology*, 27(03), pp.235-240.
2. Glantz, C. and Purnell, L., 2002. Clinical utility of sonography in the diagnosis and treatment of placental abruption. *Journal of ultrasound in medicine*, 21(8), pp.837-840.
3. Sherer, D.M., Kheyman, M., Benayoun, J. and Dalloul, M., 2021. Incidental sonographic finding of a concealed placental abruption leading to delivery at 37 weeks' gestation. *Journal of Clinical Ultrasound*, 49(6), pp.630-631.

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