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*J. Clin. Pathol.* 2009;62;794-797
doi:10.1136/jcp.2009.065953

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The number of multinucleated trophoblastic giant cells in the basal decidua is decreased in retained placenta

H J van Beekhuizen,1 I Joosten,2 A N J A de Groot,1 F K Lotgering,1 J van der Laak,3 J Bulten4

ABSTRACT

Aims: Retained placenta (RP) is a major cause of obstetric haemorrhage. The aim of the study was to obtain a better understanding of the mechanisms that cause some placentas to become retained, while most are not.

Methods: 23 RPs clinically diagnosed as placenta adhesive and 10 control placentas (CPs) were examined for differences in trophoblast fusion into multinucleated trophoblastic giant cells (MTGCs), defects in the basal decidua, and decidual attachment of myometrial fibres.

Results: The number of MTGCs in the basal decidua was significantly smaller in RPs (0.23 MTGC/standard length) than in CPs (1.11 MTGC/standard length) (p<0.001). Defects in the decidua were observed in 4% of the RPs and in 0% of the CPs. Myometrial fibres were attached to the decidua in 78% of the RPs and in 0% of the CPs (p<0.001).

Conclusions: In placenta adhesiva compared with CPs, significantly less MTGCs were present in the basal decidua, the basal decidua was intact, and myometrial fibres were more frequently attached to the basal decidua. It is speculated that these findings may indicate that defective fusion of trophoblastic cells into MTGCs plays a causative role in placenta adhesiva.

Retained placenta (RP) is a major cause of postpartum haemorrhage1 and maternal mortality worldwide.2 Several degrees of adherence of the placenta to the uterine wall can be identified: placenta adhesiva, accreta, increta and percreta. The most common type of RP associated with abnormal placental adherence is placenta adhesiva (PA), with an incidence of 1.8% in nulliparous women.1 PA is an abnormal adherence of the placenta to the uterine wall, with a clear separation plane found during manual removal of the placenta.3 The mechanisms underlying abnormal placental adherence in PA are not well understood.

Placenta accreta happens far more infrequently (in 0.014–0.3%) than PA and has two definitions. The clinical definition of placenta accreta is that of an absent clear separation plane during manual removal, resulting in a difficult manual removal in pieces.4 The histological definition of placenta accreta is that of defects in the basal decidua and myometrial fibres attached to the basal decidua.5 Placenta accreta, as demonstrated by (partial) absence of basal decidua,6 is associated with damage caused by prior uterine surgery, including cesarean section and curettage, placenta praevia and advanced maternal age.5 6 Such associations are not clear for PA.10–12

Inhibition of trophoblast invasion is essential for normal adhesion and expulsion of the human placenta after delivery of the infant. The apoptotic rate of invasive trophoblastic cells in term placentas is close to zero.7 8 Frank and Kaufmann postulated that the main mechanism by which trophoblast cells lose their initial invasive character is syncytiotrophoblastic fusion that results in their incorporation into multinucleated trophoblastic giant cells (MTGCs).9–14 This concept was supported by the observation of relative absence of MTGCs in human postpartum hysterectomy specimens of placenta increta and percreta,15 whereas normal placentas contain MTGCs in the basal decidua in 100% and in the myometrium in more than 50% of cases.16

The possible causes of PA, the most common form of RP, have not been studied in any detail. Analogous to the causes of placenta accreta, one might argue that relative absence of syncytiotrophoblastic fusion or absence of basal decidua could play a causative role. Therefore, the aim of this study was to get a better understanding of the mechanisms underlying PA by determining the association of PA with (1) the number of MTGCs, (2) the presence of defects of the basal decidua, and (3) the presence of attachment of myometrial fibres to the basal decidua, as a sign of abnormal adherence.

MATERIALS AND METHODS

Study group and controls

Twenty-three placentas clinically diagnosed as PA and 10 control placentas (CPs) were included in this study. The obstetric history of the study patients is shown in table 1. All women had an uncomplicated pregnancy and a gestational age of at least 37 weeks.

RP was defined as a placenta that had not been expelled at 60 min after the delivery of the infant, despite active management of the third stage with oxytocin, controlled cord traction and catheterisation of the urinary bladder.17 PA was defined as a RP that, during manual removal, was adherent to the uterine wall without clinical signs of placenta accreta (ie, difficult removal of placenta in pieces). The CPs were expelled within 10 min after delivery of the infant. All patients gave their informed consent.

Histology

The placentas were preserved in 4% buffered formalin. From each RP, four sections were taken.
Two sections were taken from the macroscopically damaged basal plate, because it has been shown previously that the junction between the intact and disrupted basal plate is the optimal sampling location for the detection of myometrial fibres. In addition, two random full-thickness sections were taken, containing decidua basalis from the peripheral and central parenchyma. All CPs were macroscopically intact, and four random full thickness sections were taken from each.

The tissue samples were routinely processed and stained with haematoxylin and eosin. Two experienced observers (HvB and JB), blinded to the clinical data, examined the slides together and scored them in consensus. All slides were examined for MTGCs in the basal decidua, defects in the basal decidua, and the presence of myometrial fibres attached to the decidua. MTGCs were identified as large trophoblastic cells with voluminous cytoplasm and three or more nuclei. MTGCs were counted only if positively identified as such by both observers. All MTGCs present in the full thickness of decidua basalis of the placenta were counted in 10 regions of standardised length using a graticule in one ocular of the microscope. The Merz graticule was projected over the decidua basalis (H&E, x200). At the light microscopic level, MTGCs are large cells (compared with the adjacent trophoblastic cells) containing two or more nuclei enclosed in a voluminous cytoplasm.

![Figure 1](https://example.com/figure1.png)

**Figure 1** Multinucleated trophoblastic giant cells (MTGCs) in the decidua basalis (H&E, x200). At the light microscopic level, MTGCs are large cells (compared with the adjacent trophoblastic cells) containing two or more nuclei enclosed in a voluminous cytoplasm.

**DISCUSSION**

As to the cause of abnormal placental adhesion in PA, defects in the basal decidua are unlikely to be a cause because they were absent in 96% of our cases. It is also unlikely that insufficient uterine contractions were the primary cause of retainment as in all our patients active management of the third stage of labour included the use of uterotonics. Our study suggests that abnormally strong attachment is the more likely mechanism by which placenta are abnormally adhesive, as myometrial fibres were found attached to the otherwise intact basal decidua in 78% of Retained placentas in contrast to 0% of CPs. The latter is in line with previous studies showing that myometrial attachment is an abnormal finding with an incidence in randomly examined,

### Table 1 Obstetric history of patients with retained and control placentas

<table>
<thead>
<tr>
<th></th>
<th>Control placentas</th>
<th>Retained placentas</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>10</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Nullipara</td>
<td>4</td>
<td>12</td>
<td>NS</td>
</tr>
<tr>
<td>Multipara</td>
<td>6</td>
<td>11</td>
<td>NS</td>
</tr>
<tr>
<td>Gestational age, weeks*</td>
<td>40.6 (37.9-43.2)</td>
<td>40.3 (37.3-42.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Previous retained placenta, n (%)</td>
<td>0 (0)</td>
<td>5 (45%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Previous caesarean, n (%)</td>
<td>0 (0)</td>
<td>2 (18%)</td>
<td>NS</td>
</tr>
<tr>
<td>Previous curettage, n (%)</td>
<td>1 (10)</td>
<td>3 (13%)</td>
<td>NS</td>
</tr>
</tbody>
</table>

*Median (range); †Percentage in multiparous women; ‡Percentage in all women. NS, not significant.

### Table 2 The number of multinucleated trophoblastic giant cells, defects in basal decidua and myometrial fibre attachment in control placentas and retained placentas

<table>
<thead>
<tr>
<th></th>
<th>Control placenta (n = 10)</th>
<th>Retained placenta (n = 23)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTGCs (number per length of decidua), median (range)</td>
<td>1.11 (0.94-3.75)</td>
<td>0.23 (0-1.26)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Basal decidua defects, n (%)</td>
<td>0 (0)</td>
<td>1 (4)</td>
<td>NS</td>
</tr>
<tr>
<td>Myometrial fibre attachment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present in any of the slides, n (%)</td>
<td>0 (0)</td>
<td>18 (78)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Present in percentage of slides, % (range)</td>
<td>NA</td>
<td>46 (25-100)</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Mann-Whitney U test (two-tailed). NA, not applicable; NS, not significant.
normally expelled, term placentas of 0.2% to 0.9%. Myometrial attachment in term placentas, as in our study group, must be regarded as a diagnostic sign of abnormal adherence.

Myometrial attachment was absent in 22% of our cases of PA. Although one might argue that abnormal adhesion did not exist in these cases, it seems more likely that it reflects that abnormal myometrial attachment in placenta adhesiva is a focal problem, as well as the fact that our way of sampling (four samples of each placenta) was unable to detect the focal problems in all placentas studied. Histochemical staining with, for example, aSM antibody, could have increased the absolute numbers of myometrium-positive slides, because small myometrial fibres are more easily detected in smooth-muscle staining.

Defects in the basal decidua were present in 4% of our cases of RP. Although defects in the basal decidua are a focal problem, it seems unlikely that this was caused by our sampling technique, as two previous studies using comparable sampling technique reported focally absent decidua in 100% of cases of placenta accreta. We feel that our one case of RP with a defect in the basal decidua, and which was clinically diagnosed as PA, should be histologically classified as placenta accreta.

Frank and Kaufmann hypothesised that fusion of trophoblastic cells into MTGCs limits their invasiveness. Our finding of a significantly reduced presence of MTGCs in the basal decidua of abnormally adhesive placentas compared with controls seems to support this hypothesis. However, it does not answer the basic question of whether PA is caused by defective fusion of trophoblast cells into MTGCs in the decidua.

In conclusion, RP caused by PA is associated with a reduced number of MTGCs in the basal decidua and not by defects in the basal decidua. We speculate that these findings may indicate that defective fusion of trophoblastic cells into MTGCs plays a causative role in PA.

Acknowledgements: The authors would like to thank Peter Emmer, PhD, for his support in initiating this research.

Competing interests: None

Ethics approval: Ethics approval was obtained from the Radboud University Medical Ethics Committee.

Provenance and peer review: Not commissioned; externally peer reviewed.

REFERENCES


PANCREATIC PATHOLOGY MEETING

Wednesday 2nd December 2009
St James’s University Hospital, Leeds

This one-day meeting will focus on the reporting of pancreatic cancer specimens (including a live specimen dissection session) in the light of the revised RCPath Minimum Dataset that will be issued later this year. Further topics included in the programme are endocrine pancreatic tumours and their differentials, pancreatobiliary cytology, and discussion of training and research in pancreatic pathology in the UK. The meeting concludes with an Open Forum session, in which difficult cases will be discussed in a multidisciplinary approach. 5 CPD credits have been awarded.

Target audience: specialist pancreatic pathologists, consultants with an interest in pancreatic pathology, senior trainees in pathology and oncology, members of the pancreatic MD Team.

The meeting precedes the Annual Scientific Conference of the Pancreatic Society of GB & Ireland, 3-4 December 2009, Weetwood Hall, Leeds. The conference programme is multi-disciplinary and an impressive faculty of national and international speakers will address clinical, pathology, training and research issues in pancreatic cancer.

To book and for further details, please contact the organizer, Dr C Verbeke (Caroline.Verbeke@leedsth.nhs.uk, tel. 0113 2067802) or visit www.pancsoc.org.uk.