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

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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: Twenty-three RPs clinically diagnosed as placenta adhesive 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.

Results: 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. 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.

Conclusions: 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 expansion or presence 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 adhesion.

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.

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Histology

The placentas were preserved in 4% buffered formalin. From each RP, four sections were taken.
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 curtailage, 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.

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.

**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>Present in any of the slides, n (%)</td>
<td>0 (0)</td>
<td>18 (78)</td>
</tr>
<tr>
<td></td>
<td>Present in percentage of slides, % (range)</td>
<td>NA</td>
<td>46 (25–100)</td>
</tr>
</tbody>
</table>

*Mann-Whitney U test (two-tailed).

**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 retention as in all our patients active management of the third stage of labour included the use of uterotonic. 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 RPs 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,

![Figure 1](https://example.com/figure1.png)
Although one might argue that abnormal adhesion did not exist in the basal decidua of abnormally adhesive placentas compared with placenta adhesiva, this may reflect the fact 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, $\alpha$SM$_1$ (an anti-smooth muscle 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.$^{8, 9}$ 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.$^{12}$ 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.

Our study does not provide information on the presence of MTGCs in the deeper layers of the uterus, as we did not take placental bed biopsies. Three previous studies have focused on these deeper layers. One study reported the expected presence of only a few MTGCs in the decidua and myometrium of hysterectomy specimens of placenta creta,$^{6}$ while the two other studies found no significant difference in the number of MTGCs in the myometrium of hysterectomy specimens between placenta creta and controls.$^{10, 15}$ We conclude that although we did not study the MTGCs in the placenta bed and myometrium, in the literature there are no suggestions that fusion of trophoblastic cells in MTGCs takes place in deeper layers of the myometrium in PA compared with CPs.

The cause of defective fusion of trophoblast cells into MTGCs is unknown. Theoretically, the fusion could be impaired by dysregulation through decidua-derived factors. Uterine natural killer cells in the maternal basal decidua have the ability to secrete several cytokines, chemokines and angiogenesis-regulating molecules that regulate trophoblast inhibition and proliferation.$^{21, 28}$ It is conceivable that these factors play a role. More research is needed to disclose the role of decidua-derived factors in RP. Recent studies have suggested that in placenta accreta defective fusion of trophoblast cells into MTGCs is associated with excessive numbers of mononuclear trophoblast cells.$^{15, 23}$ We intend to address these issues in further studies of PA.

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.

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Competing interests: None

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REFERENCES


Take-home messages

1. Placenta adhesiva is not associated with defects in the basal decidua, in contrast to placenta accreta.
2. Placenta adhesiva is associated with the presence of myometrial fibres attached to the basal decidua. This may be regarded as a diagnostic sign of abnormal attachment of the placenta to the uterine wall.
3. Placenta adhesiva is associated with a reduced amount of multinucleated trophoblastic giant cells (MTGCs) in the decidua basalis. This may suggest that defective fusion of extravillous trophoblast cells in MTGCs could play a causative role in this condition.


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, pancreaticobiliary 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 MDT.

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 multidisciplinary 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.