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# Complex obstetric triad in low resource settings: Placenta previa, succenturiate placenta, and fibroids with lethal fetal anomalies

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## Abstract

**Background:** Placenta succenturiata, placenta previa, and uterine fibroids are individually associated with adverse obstetric outcomes. However, the coexistence of these conditions in pregnancy is rare and may significantly complicate antenatal management and fetal outcome. The presence of congenital fetal anomalies in such pregnancies further worsens neonatal prognosis. This report describes a primigravida with multiple uterine fibroids complicated by placenta previa and placenta succenturiata, associated with severe fetal anomalies and an unfavourable neonatal outcome.

**Case presentation:** A 29-year-old Nigerian unbooked primigravida at 30 weeks' gestation presented with abdominal pain, shortness of breath, insomnia secondary to pain, and vaginal discharge. Ultrasound examination revealed multiple uterine fibroids co-existing with pregnancy. Clinical examination showed stable vital signs with a fundal height of 44 cm, breech presentation, and fetal heart rate of 144 beats/minute. The patient was diagnosed with fibroids in pregnancy complicated by red degeneration and vulvovaginal candidiasis and managed conservatively.

Subsequent Doppler obstetric ultrasound demonstrated a viable intrauterine singleton with transverse lie, oligohydramnios, multiple large fibroids, and a low-lying placenta with an accessory succenturiate lobe. Features of intrauterine growth restriction and suspected fetal renal anomaly were also noted. The patient and her family were counselled regarding the severe fetal anomalies, including the option of pregnancy termination given the likelihood of anomalies incompatible with extrauterine life; however, they opted to continue the pregnancy.

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At 35 weeks' gestation, an elective lower segment caesarean section was performed due to placenta previa type III, persistent abnormal fetal lie, oligohydramnios, and the presence of multiple large fibroids, which increased the risk of haemorrhage and made vaginal delivery unsafe. Intraoperative findings included multiple uterine fibroids, placenta previa type III, placenta succenturiata, and oligohydramnios.

A neonate weighing 2.1 kg was delivered with multiple congenital anomalies including fused lower limbs, absent external genitalia, absence of anal opening, and no identifiable vulvovaginal structures. Apgar scores were 5, 6, and 9 at 1, 5, and 10 minutes respectively. Despite immediate neonatal resuscitation and oxygen therapy, the neonate died approximately three hours after birth due to severe congenital anomalies and associated complications.

**Conclusion:** This case highlights the complex interaction between abnormal placentation, uterine fibroids, and congenital fetal anomalies. Early antenatal diagnosis, close surveillance, and multidisciplinary management are essential to optimise maternal outcomes and prepare for possible adverse neonatal outcomes.

## Introduction

Uterine fibroids are the most common benign tumours of the female reproductive tract. By age 50, it is estimated that up to 70% of women will have one or more uterine fibroids, with approximately 30% being symptomatic and requiring treatment [1,2]. Fibroids occur in women of all races but are more common and develop at an earlier age in women of African origin; by age 35 years, about 60% of African-American women are affected compared to 40% of Caucasian women of the same age [1,2]. During pregnancy, fibroids may lead to complications such as pain from red degeneration, malpresentation, preterm labour, and placental abnormalities [2-4].

Uterine fibroids are the most common benign tumours of the female reproductive tract and occur in approximately 20-40% of women of reproductive age [1]. During pregnancy, fibroids may lead to complications such as pain from red degeneration, malpresentation, preterm labour, and placental abnormalities [2-4].

Placenta succenturiata refers to the presence of one or more accessory placental lobes connected to the main placenta by fetal vessels [5]. It is a rare placental anomaly but is clinically significant because it may predispose to complications such as placenta previa, vasa previa, postpartum haemorrhage, and retained placental tissue [5]. Placenta previa, defined as placental implantation in the lower uterine segment partially or completely covering the cervical os, is another major obstetric complication associated with antepartum haemorrhage, preterm birth, and increased caesarean delivery rates [6].

The coexistence of placenta succenturiata, placenta previa, and large uterine fibroids in pregnancy is uncommon and poses significant diagnostic and management challenges [7]. Furthermore, when associated with fetal congenital anomalies and oligohydramnios, the prognosis for the fetus becomes particularly poor [8].

This report describes a primigravida with multiple uterine fibroids complicated by placenta previa and placenta succenturiata, resulting in severe fetal anomalies and an unfavourable neonatal outcome.

## Case presentation

A 29-year-old Nigerian unbooked primigravida (G1P0+0) presented at 30 weeks' gestation with complaints of abdominal pain, shortness of breath, difficulty sleeping due to pain, and vaginal discharge. An earlier ultrasound examination had demonstrated fibroids co-existing with pregnancy. She had no history of excess alcohol intake or cigarette smoke exposure. She had no personal or family history of diabetes. However, there was a history of using local herbal medication for the treatment of fibroids prior to conception.

On examination, the patient appeared stable. She was afebrile, not pale, and anicteric. Her pulse rate was 92 beats per minute and blood pressure was 122/68 mmHg. Abdominal examination revealed a fundal height of 44 cm. Multiple fetal poles were palpable and the fetus was in breech presentation. The fetal heart rate was 144 beats per minute.

A clinical diagnosis of fibroids in pregnancy complicated by red degeneration and vulvovaginal candidiasis was made. The patient was counselled and commenced on conservative treatment including capsule astypher twice daily for two weeks, paracetamol 1 g three times daily for three days, omeprazole 20 mg twice daily for two weeks, and gestid suspension 10 ml three times daily for one week. She also received intramuscular dexamethasone 12 mg 12 hourly for 24 hours to enhance fetal lung maturity and klovinal pessaries once nightly for 12 days. A repeat ultrasound was scheduled after two weeks.

A subsequent colour Doppler obstetric scan revealed a viable intrauterine singleton fetus in transverse lie with the fetal head positioned to the maternal left. Cardiac activity was normal. Multiple large fibroid masses were seen along the

anterior and fundal uterine walls measuring 106×89 mm at the cervix, 59×35 mm anteriorly, and 132×96 mm in the fundal subserous region. The placenta was anterior with a posterior accessory lobe consistent with placenta succenturiata. Both placental components were low-lying. The internal cervical os remained closed with a cervical length of 4.6 cm. The patient and her family were counselled regarding the severe fetal anomalies, including the option of pregnancy termination given the likelihood of anomalies incompatible with extrauterine life; however, they opted to continue the pregnancy.

There was oligohydramnios with minimal amniotic fluid observed. The biophysical profile score was reassuring for fetal breathing, movement, tone, and fluid. Estimated fetal weight was 2.2±0.3 kg, with an estimated gestational age of approximately 33 weeks. Laboratory investigations revealed a packed cell volume of 30.8%, while screening for VDRL, HIV, hepatitis C virus, and hepatitis B surface antigen were negative.

A further ultrasound evaluation showed a viable intrauterine singleton fetus with oligohydramnios, intrauterine growth restriction, coexisting fibroids, and suspected fetal renal anomalies including hydronephrosis with possible polycystic kidney disease. The estimated fetal weight at that stage was approximately 2.2 kg. The patient was counselled extensively and advised to increase oral fluid intake to 3-4 litres daily. Due to the complex obstetric findings, close monitoring was continued.

At 35 weeks' gestation, an elective lower segment caesarean section was performed due to placenta previa type III, placenta succenturiate, persistent abnormal fetal lie, oligohydramnios, and the presence of multiple large fibroids, which increased the risk of haemorrhage and made vaginal delivery unsafe (Figure 1). The placenta weighed 0.8 kg and estimated intraoperative blood loss was approximately 350 ml.

A neonate weighing 2.1 kg was delivered with multiple congenital anomalies (Figures 2 & 3). These included fused lower limbs, absence of external genitalia, absence of an anal opening, and absence of identifiable vulvovaginal structures. The sex of rearing could not be assigned at birth. Apgar scores were 5 at one minute, 6 at five minutes, and 9 at ten minutes.

The neonate developed perinatal asphyxia thereafter and required immediate resuscitation, including intranasal oxygen therapy. Despite intensive neonatal resuscitation, there was no urine output, as no visible urethral meatus or urinary outlet was identified. Evaluation by a Consultant Neonatologist confirmed the presence of multiple severe congenital anomalies incompatible with life. The neonate died approximately four and a half hours after birth (08:00 to 12:30), despite ongoing resuscitative efforts.

Postoperatively, the mother received intravenous ceftriaxone 1 g daily for 48 hours, intravenous metronidazole 500 mg eight-hourly for 48 hours, rectal diclofenac 100 mg 12-hourly for 72 hours, and intramuscular pentazocine 30 mg six-hourly for 24 hours. The urethral catheter was removed 12 hours after surgery. The postoperative period was uneventful, and the patient was discharged home 72 hours after delivery. Bereavement counselling and psychological support were provided. The parents declined post-mortem examination.

## Discussion

This case illustrates the complex interplay between uterine fibroids, abnormal placentation, and severe fetal congenital

**Figure 1:** Placenta seen at delivery showing placenta succenturiate indicating extra lobe.

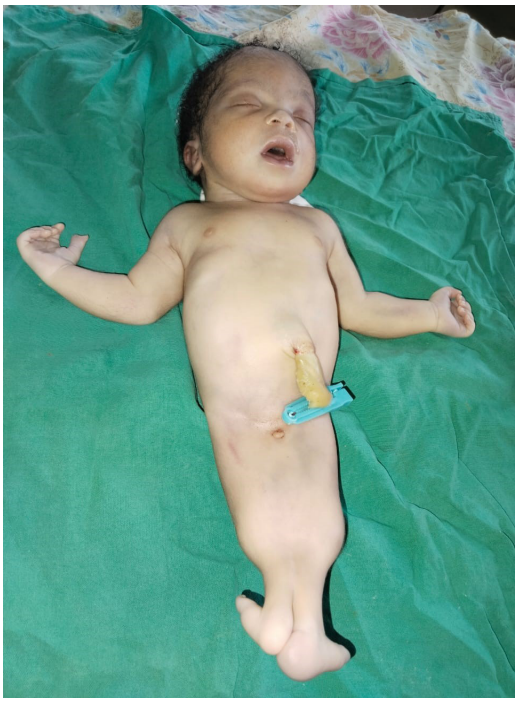

**Figure 2:** Fused lower limbs with visibly separated foot and absent external genitalia.

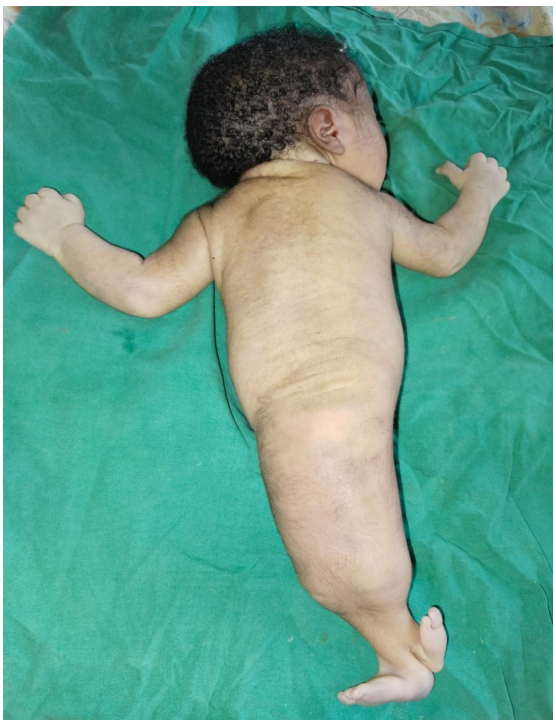

**Figure 3:** Fused lower limbs with visibly separated toes and absent anal orifice.

anomalies. Each of these conditions independently carries significant obstetric risks, and their coexistence can further complicate pregnancy management.

The prevalence of uterine fibroids in pregnancy varies between 1.6% and 10.7%. Pregnancies involving uterine fibroids are generally uncomplicated [2]. However, complications can occur, particularly in cases of multiple fibroids, when the fibroids are larger than 5 cm, or when they are located in the lower uterine segment. Between 10% and 30% of pregnant women with fibroids experience complications during pregnancy, labour, and the postpartum period [2]. The most common complication during pregnancy, which can occur in 8% of women, is red degeneration. Uterine fibroids during pregnancy are associated with complications such as pain from red degeneration, fetal malpresentation, preterm labour, and increased likelihood of caesarean delivery [9]. Large fibroids may also distort the uterine cavity and interfere with placental implantation, potentially contributing to abnormal placentation such as placenta previa [2,9].

Placenta succenturiata is a relatively rare placental abnormality characterized by accessory placental lobes connected to the main placenta by fetal vessels. Its incidence is estimated to occur in approximately 0.6-1% of pregnancies. The condition is clinically important because it increases the risk of vasa previa, postpartum haemorrhage, retained placental tissue, and fetal compromise [10].

In the present case, the coexistence of placenta succenturiata and placenta previa further complicated the pregnancy. In one study, the findings support that there are reported adverse obstetric outcomes in pregnancies with succenturiate lobes of placenta [11]. Placenta previa itself is associated with antepartum haemorrhage, preterm birth, and increased perinatal morbidity and mortality. The presence of large uterine fibroids may have contributed to abnormal placental implantation in the lower uterine segment [12].

The performance of myomectomy concurrently with caesarean delivery presents substantial clinical challenges, primarily due to elevated risks of severe haemorrhage and the potential necessity for emergency hysterectomy. When uterine fibroids coexist with placenta previa, the complexity of surgical intervention intensifies significantly, leading most obstetricians to exercise extreme caution regarding fibroid excision during the procedure. Nevertheless, successful intraoperative myomectomy during caesarean birth has been documented in selected cases without significant adverse outcomes [13]. The effect of prior use of herbal, non-orthodox treatment for the uterine fibroids before conception could not be fully ascertained.

Current clinical practice typically favours conservative approaches to fibroid management during caesarean delivery, especially in the presence of placental complications such as previa. Post-delivery therapeutic options may subsequently include delayed myomectomy, uterine artery embolization, or hysterectomy, with the optimal choice determined by several factors: the severity of patient symptoms, reproductive aspirations, and anatomical characteristics of the fibroid masses [14]. This staged approach allows for more controlled circumstances and reduced operative risks while addressing the patient's long-term clinical needs and fertility goals [14].

The fetus in this case had multiple severe congenital anomalies, including fused lower limbs, absence of external genitalia, and absence of an anal opening. These features suggest complex caudal developmental anomalies such as sirenomelia or caudal regression spectrum, rare conditions often associated with oligohydramnios and renal anomalies [15]. Sirenomelia, also called mermaid syndrome, is characterized by fusion of the lower extremities and occurs in approximately 0.8-4 per 60,000-100,000 pregnancies [15]. The exact cause is unknown, but reported risk factors include maternal diabetes mellitus, teratogenic drugs, genetic susceptibility, vascular hypoperfusion, cocaine exposure, environmental contaminants, and extreme maternal age. Common associated anomalies include absent or ambiguous genitalia, imperforate anus, renal agenesis, absent urinary bladder, single umbilical artery, pulmonary hypoplasia, cardiac defects, diaphragmatic hernia, and skeletal abnormalities [15]. Although its features may overlap with caudal regression syndrome and VACTERL association, sirenomelia is considered a distinct entity [15].

Oligohydramnios observed in this pregnancy may have been secondary to underlying renal agenesis or severe urinary tract malformations, which are commonly associated with these syndromes. The absence of urine output after birth further supports severe urinary tract abnormalities [15].

Early prenatal detection of severe congenital anomalies is crucial for counselling and pregnancy management. However, in some cases, structural anomalies may be difficult to fully characterize until later stages of pregnancy, particularly when complicated by oligohydramnios or maternal conditions such as large fibroids that limit ultrasound visualization. Despite appropriate antenatal monitoring and timely delivery, the neonatal outcome in this case was poor due to the severity of the congenital malformations.

Our study suggests that in cases of early perinatal death associated with multiple congenital anomalies, improvements in emotional and psychological support are necessary to enhance the experience of affected couples. Women often experience significant distress at the time of diagnosis, and for some, the psychological impact may persist, leading to long-term emotional consequences. This burden may be intensified by the limited availability of formal psychological support and structured postnatal debriefing [16]. Existing literature also reports increased rates of antenatal and postnatal anxiety, depression, and Post-Traumatic Stress Disorder (PTSD) among women experiencing complicated pregnancies, raising concerns about whether current psychological support for women with placenta previa and fetal anomalies is adequate [17,18]. Although specific psychological interventions for women with multiple fetal anomalies at birth are not well established, several supportive measures could be incorporated into routine care [19]. These include providing reliable written information, ensuring clear referral pathways to mental health services during the antenatal and postnatal periods, and offering a consultant-led postnatal debrief to better support women and their families [19].

## Conclusion

The coexistence of uterine fibroids, placenta previa, and placenta succenturiata represents a rare and complex obstetric scenario. When combined with severe fetal congenital anomalies and oligohydramnios, the prognosis for the neonate may be extremely poor. This case highlights the importance of detailed antenatal imaging, multidisciplinary care, and early

counselling of parents regarding potential outcomes, including option of termination for anomalies incompatible with life. Prompt recognition of placental abnormalities and congenital fetal anomalies allows for better planning of delivery and neonatal care while ensuring optimal maternal safety.

## Declarations

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**Author contributions:** GUE, ECI, and CAF contributed to surgery while KON contributed to the perinatal management of this patient. ECI, GUE, AVE, GTI, KON, EUN, CGO, OKN, COE, CBO, CAO, GOU and ACE critically revised the report, commented on drafts of the manuscript, and approved the final report.

**Informed consent:** Informed written consent was taken from the mother for possible publication without listing her name or revealing her identity. Patient anonymity has been preserved.

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**Availability of data and materials:** Data sharing is not applicable to this article as no datasets were generated or analysed during this study.

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