

# Study of Placental Chorangiomas in Various Pregnancy Outcomes in a Tertiary Care Centre

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## Abstract

**Aim:** To study the demography, maternal and fetal causes of chorangiomas. **Study design:** A retrospective descriptive study. **Place and Duration of Study:** Total of 73 patients with chorangiomas were studied in Department of Pathology Saveetha Medical College, during the period of August 2020 and February 2021. **Methodology:** Study included 73 patients of placental chorangiomas. The clinical history and demographic data was obtained from the patient's medical records. The maternal and fetal causes were studied, and clinico-histopathological correlation was done. **Results:** This study includes 73 postnatal women, of which the rate of cesarean section was noted to be 69.8% and the mean value were obtained showed mean gestational age of 37.5 weeks, 70 live births and 3 neonatal deaths; mean placental weight is 480 grams and birth weight 3970 grams. The mean 1 minute and 5 minutes APGAR score is reduced indicating the disturbance in fetal vitals immediately after birth. **Conclusion:** Chorangiomas is a rare illness, which is associated with an increased risk of prenatal and neonatal morbidity and mortality. So, it should be regarded as a key prognostic indicator of poor pregnancy outcomes and should be essentially reported in the histopathological evaluation.

**Keywords:** Chorangiomas, maternal hypoxia, placental weight, birth weight, APGAR score.

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## 1. INTRODUCTION

Chorangiomas is a condition where the number of vascular channels in the noninfarcted, nonischemic areas of the placenta increases dramatically. More than 10 capillaries in more than 10 villi in several areas of the placenta is the traditional description [1]. It's a rare discovery that's usually described as a compensatory response to chronic hypoxia [1], but it's associated to a variety of illnesses, including diabetes, hypertension, and tobacco use. Incidence is higher in women living at high altitudes, in maternal anemia and in smoking women. Also associated with placental abnormalities such as placental abruption, amnion nodosum, villitis and umbilical cord anomalies. Chorangiomas rarely occurs in normal pregnancies. However, its prevalence is 5–7% of all placentas from infants admitted to newborn intensive care units [7]. This study was aimed at determining the association of chorangiomas with pregnancy complications and perinatal outcomes.

## 2. METHODOLOGY

A retrospective descriptive study was carried out in line with research regulations, including the approval of the Ethical Committee. Total of 73 patients with chorangiomas were studied in Saveetha Medical College, during the period of August 2020 and February 2021. The clinical history and demographic data was obtained from the patients medical records. The maternal and fetal causes were studied, and clinico-histopathological correlation was done.

## 3. RESULTS

Demographic data was obtained from the patient's medical records and clinical findings. The demographic data of the 73 placental chorangiomas cases with complete information is summarized in Table 1. The obstetric outcomes are summarized in Table 2. The rate of cesarean section was noted to be 69.8% with the most common indication being non-reassuring fetal heart rate. Most of the neonates were delivered at term with the average gestational age of 37.5 weeks.

**Table 1: Demographic profile and maternal clinical history**

	Cases (N=73)	Percentage (%)
<b>AGE</b>		
<18 years old	8	10.9
18-34 years	54	73.9
≥35 years old	11	15.2
<b>GESTATION</b>		
PRETERM <37 weeks	8	10.9
TERM 37-40weeks	38	52.2
POST TERM >40 weeks	27	36.9
<b>PARITY</b>		
Primiparous	28	38.3
Multiparous	45	61.6
<b>COMORBID CONDITIONS</b>		
Gestational Hypertension	7	9.5
Gestational Diabetes mellitus	26	35.6
IUGR	25	34.2

**Table 2: Obstetric history**

		Cases	Percentage (%)
Gestational age of delivery	<37 weeks	8	10.9
	>37 weeks	67	91.7
Mode of delivery	Vaginal	22	30.1
	Cesarean	51	69.8
Indication for caesarean section	Malpresentation	6	8
	Previous caesarean section	48	65.7
	Labor abnormality	19	26.0

**Table 3: Mean Values of Placental Weight, Birth Weight and Apgar Score**

	NEONATES (N=73)
Mean 1minute APGAR score	7.2
Mean 5minutes APGAR score	8
Mean Gestational age	37.5
Mean birth weight	3970
Mean placental weight	480
Live births	70
Neonatal deaths	3

**Table 4: Mean Values in Various Gestational Age**

All birth	N	Mean gestational age	Mean Birth weight	Mean Placental weight	Mean Placental weight to birth weight ratio	Mean 1minute APGAR score	Mean 5minutes APGAR score
Gestational age at birth	64	37.5	3450	420	12.17	7.4	8
37	2	37	2480	400	16.12	7.3	8.2
38	1	38	3230	460	14.24	7.2	7.8
39	2	39	3400	500	14.70	7.1	8.1
40	1	40	3650	580	15.89	7.2	8

In Table 3 the mean value were obtained showed mean gestational age of 37.5 weeks, 70 live births and 3 neonatal deaths; mean placental weight is 1890 grams and birth weight 3970grams.

In Table 4 the mean value in various gestational age were given showing placental weight and fetal birth weight increases in higher gestational

age groups. The mean 1 minute and 5 minutes APGAR score is reduced indicating the disturbance in fetal vitals immediately after birth. Moreover, 1 minute APGAR score is less than 5 minute APGAR score.

### 3.2 DISCUSSION

Chorangiosis is a vascular abnormality in the placenta that affects the terminal chorionic villi. It's

caused by long-term, low -grade hypoxia in the placenta, and it is associated with intrauterine growth restriction (IUGR), diabetes, and gestational hypertension throughout pregnancy. Major fetal complications are congenital anomalies or low Apgar index, neuro-compromise, fetal growth restriction, neonatal death.

Maternal complications are placental as well as umbilical cord abnormalities including excessively long umbilical cords, true knots, and excessively twisted umbilical cords have also been associated with umbilical cord thrombus. Most common complications are cord compression and circulatory stasis rather than Umbilical vein thrombosis [3].

These findings are associated with fetal, maternal, and placental disorders including preeclampsia, diabetes, hypertension, major congenital anomalies, air pollution, and smoking and has been correlated with fetal morbidity and mortality rates as high as 42% [1]. In recent studies, the pregnancy outcomes are much improved over those suggested by Altshuler in 1984. Adverse events in our study, such as neonatal death at 24 weeks of gestation, are accounted as prematurity without need to invoke chronic hypoxia

Suzuki *et al.*, found an association between maternal blood oxygen saturation in intervillous gaps and the development of chorangiosis by using placental tissue oxygen index values [2]. They state that low efficiency of oxygen transfer from maternal to fetal circulation causes vascular remodeling in adaptation to low oxygen supply, resulting in chorangiosis.

Placental weight and birth weight of the neonate are widely available measures. The ratio of these two variables is a useful marker of fetal nutrition and utero-placental function [10].

The mean placental weight of 480 g in this study is lower compared to 590 g in Pantti AA *et al.*, study (Nigerian study).

The variations in the mean weight of the placenta may be due to variations in the methodology of weighing the placenta together with cord [13].

The mean birth weight of the neonate in this study (3970g) is higher than 3275g in Pantti AA *et al.*, study (Nigerian study).

These differences in mean birth weight may be due to maternal nutrition and maternal diseases [12].

The mean PBWR (placental weight to birth weight ratio) of 14.6% in this study is lower than 18.2% as reported in Pantti AA *et al.*, study (Nigerian study).

An abnormally high PBWR (i.e., low fetal weight relative to the placental weight) is thought to indicate an abnormal placenta with impaired function as in obesity, maternal anemia, cigarettes smoking and low socioeconomic status [19-21].

We have shown that cesarean delivery is enriched in patients with placental chorangiosis; however, chorangiosis is not the direct cause. Chorangiosis is a placental marker of antepartum low-grade chronic hypoxia; thus, clinical correlation of entities that may contribute to hypoxia is suggested.

### 3.2.1 HISTOPATHOLOGICAL FEATURES

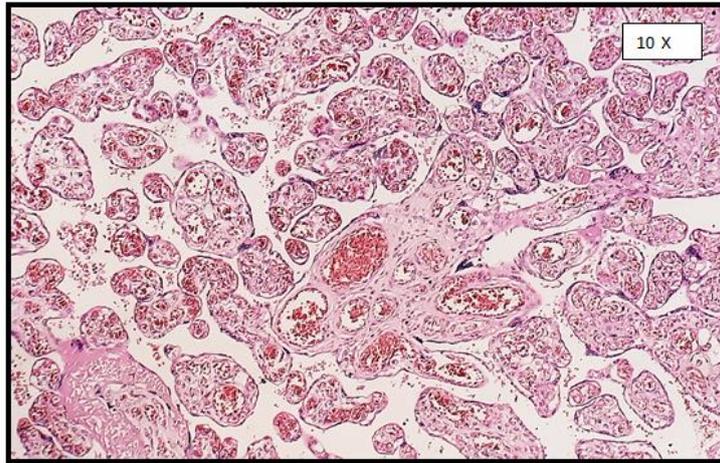
Usually placenta in chorangiosis present as heavy and boggy, weighing about 650 grams, slightly immature placenta; > 90th percentile for 39 weeks gestational age. Longer umbilical cord about 85 cm. Other placental findings are single umbilical artery and other umbilical cord anomalies, retroplacental hematoma.

Prognostic factors in chorangiosis:

- i. Low Apgar scores
- ii. Fetal growth restriction
- iii. Neonatal death
- iv. Congenital malformations

### 3.2.2 MICROSCOPIC FEATURES

Normal placenta has Normal villi rarely having > 5 capillaries / villous. Criteria for chorangiosis is > 10 capillaries in at least 10 terminal villi in  $\geq$  10 non infarcted areas in at least 3 low power fields of the placenta (Fig 1). Capillaries have distinct basement membranes but are not surrounded by a continuous layer of pericytes or associated with stromal fibrosis. Sometimes it may be associated with delayed villous maturation, chorangioma, villitis of unknown etiology, fetal vascular malperfusion.



**Fig 1: Chorionic Villi with Evidence of Chorangiogenesis; More Than 10 Capillaries in At Least 10 Terminal Villi in Low-Power Fields**

#### 4. CONCLUSION

Chorangiogenesis is a rare illness, which is associated with an increased risk of prenatal and neonatal morbidity and mortality. So, it should be regarded as a key prognostic indicator of poor pregnancy outcomes and should be essentially reported in the histopathological evaluation.

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#### STATEMENT OF ETHICS

This study was approved by Ethics Committee of Saveetha Medical and Hospital. As this study was a retrospective study, there was no patient's privacy data such as patient name, ID number, telephone and address were involved.

**DISCLOSURE STATEMENT:** All authors declared no conflicts of interest.

#### AUTHORS' CONTRIBUTIONS

Dr. Vanishree M-Wrote the protocol, performed the statistical analysis, wrote the first draft of the manuscript. Dr. Sonti Sulochana, who had done immense help in collecting data and have access to all data in this study and has contributed for overall research idea. She is also responsible for the research, experimental design and the ethical approval, critical revision of the manuscript. Martin MS Salin<sup>3</sup> helped in data collection and literature search. All authors have reviewed and approved the final version.

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