Introduction. Placental choriangiomas are rare benign tumours of the placenta with an estimated rate of 1:9,000 to 1:50,000 (1). Choriangiomas are described as abnormal differentiation of placental tissue with an excessive proliferation of chorionic villi resulting in the size of the choriangioma appearing to correlate to the clinical significance for the foetus (2). A systematic review of the literature reports that choriangiomas over 5cm in diameter appear to have greater effect on the foetus (1).

Case. This report is a discussion of a large choriangioma incidentally diagnosed on bedside ultrasound in a 31+3 primagravida who presented with premature prelabour rupture of membranes (PPROM). Dysuria and lower abdominal pain, Ultrasonography revealed fetal growth restriction and an avascular tumour within the placenta. CTG (cardiotocography) of the fetal cardiac activity revealed an abnormal trace indicating potential fetal distress. An emergency caesarian section was performed due to the abnormal cardiotocogram and a growth restricted preterm neonate was delivered, weighing 1.430kg. Post caesarean section histopathological examination of the placenta revealed a large choriangioma (Fig1, Fig 2).

The neonate post-delivery was found to have cardiomegaly, hepatomegaly, splenomegaly and anaemia which are clinical features consistent with the effects of a large placental choriangioma (2).

Conclusion. The placental tumour was diagnosed by bedside ultrasound during an emergency presentation for PPROM. This case highlights the classical presentation of a large placental choriangioma and the resulting effects on the fetus.

Discussion

Large choriangiomas can have potentially detrimental effects on both mother and fetus. It is understood that tumours of less than 5 cm are usually missed, have no clinical features and are unlikely to cause maternal and fetal complications. Choriangiomas greater than 5cm are associated with fetal and maternal complications.

Choriangiomas are often diagnosed on ultrasound. The classical ultrasound findings include a well-defined complex echogenic mass different from the rest of the placenta, where the tumour protrudes into the amniotic cavity near umbilical cord insertion (11). Placental choriangiomas are usually managed with expectant management, as they usually occur asymptomatic. Small tumours <5cm are usually monitored with ultrasound every 6-8 weeks, whilst large tumours >5cm are monitored with more frequent imaging (approx.) every 1-2 weeks (11). Wolter et al published a critical appraisal and systematic review of the literature regarding clinical interventions of complications arising from, and the treatment of, large placental choriangiomas. There are several potential treatments for complications arising from placental choriangiomas: responsible for maternal or fetal complications (12). These interventions vary depending on the complications arising, but generally involve reducing the placental tumour or treating the arising fetal or maternal complications. These interventions include, but are not limited to, serial fetal transfusions, fetoscopic coagulation of vessels supplying the tumour, chemosclerosis with absolute alcohol and endoscopic surgical devascularization (12).

In this case the choriangioma was initially diagnosed at morphology scan but was not appropriately followed up after diagnosis. The patient was, at that time, only under low-risk, midwife-led antenatal care. Escalation of care at initial diagnosis, appropriate investigations and interventions may have improved fetal outcome. Regular fetal monitoring was ideally indicated in this case.

This case highlights the importance of careful clinical handover and communication of clinical care of a patient and the recognition of a deteriorating patient and to react accordingly.

References