Abnormalities of the placenta pdf

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Am J Obstet Gynecol. 2012, 206 (2): 163.e1-7. 10.1016/j.ajog.2011.12.013.CAS Article Google Scholar Page 2 Go to the main content From: Placenta abnormalities When the placenta is attached too deep into the uterine wall, which is called placenta accreta, calf or percreta, depending on the severity and depths of the placenta attachment. Risks include bleeding and subsequent complications. The baby must be delivered by caesarean section weeks before the due date. And since the placenta will have difficulty separating from the uterine wall, a hysterectomy (removal of the uterus) is often necessary. Placenta Placenta Accret occurs when the placenta attaches too deeply into the uterine wall, but it does not penetrate the uterine muscle. The most severe complications occur during childbirth. During pregnancy without placental abnormalities, the placenta is usually separated from the uterine wall immediately after birth. With placenta accretion, part or all of the placenta residue is attached, which can lead to severe blood loss after delivery. If the condition is diagnosed during pregnancy, patients will most likely need an early C-section followed by a hysterectomy. Placenta accreta is the most common of the three placental disorders, accounting for approximately 75% of all cases. The specific cause of placenta accretion is unknown, but it is often associated with placenta previa and previous caesarean sections. C-section increases the likelihood of future placenta accretion, and the more caesarean section, the greater the increase. The history of several previous caesareans is found in more than 60% of placenta accretion cases. Advanced maternal age and previous uterine surgery risk factors. Symptoms: Placenta accreta often causes no signs or symptoms during pregnancy, although vaginal bleeding during the third trimester may occur. Diagnosis: Placenta accretion is detected during ultrasound. Treatment: When diagnosing placenta accretion, your obstetric care will be given to a team of specialists with a special focus on placental disorders. This team includes specialists in maternal and fetal medicine, urology, gynecology oncology, intervention radiology, obstetric anesthesia, critical care, care and blood bank. At the time of delivery, a hysterectomy is usually recommended treatment. Placenta Increta and Percreta Placenta increta occurs when the placenta grows at least halfway through the uterine wall and attaches to the uterine muscle. Of all cases of accret, spark and percrete, increta occurs about 15% of the time. Placenta percreta occurs when the placenta grows completely through the uterine wall; In some cases the placental tissue will continue to grow in the nearby pelvic organs, including the bladder or colon. Placenta percreta is the least common type of placental disorder, presenting itself in about 5% of all these cases. The most severe complications occur during childbirth. During pregnancy without placental abnormalities, the placenta is usually separated from the uterine wall immediately after birth. When the placenta increta and percreta, part or all of the placenta residue is attached, which can lead to severe blood loss after delivery. If the condition is diagnosed during pregnancy, patients will most likely need an early C-section followed by a hysterectomy. Symptoms for Increta and Percreta: Placenta increta and percreta often do not cause any signs or symptoms during pregnancy, although vaginal bleeding during the third trimester may occur. Diagnosis: These conditions are usually diagnosed with ultrasound. In some cases, the obstetric team may recommend magnetic resonance imaging (MRI). The MRI is painless and safe for you and your child. Treatment: When diagnosing placenta increta or percreta, your obstetric care will be referred to a team of specialists with a specific focus on placental disorders. This team includes specialists in maternal and fetal medicine, urology, gynecology oncology, intervention radiology, obstetric anesthesia, critical care, care and blood bank. During childbirth, a hysterectomy is likely to be necessary. Open Access to the Review-Byscay Roxana Kristina Drushin, Maria zorop-Florea, Ciprian Laurențiu Putru, Lucian Sohr, Christian Marinas, Bogdan Virgiliou zorop, Ryzvan Kepitonescu and Dominique Gabriel IlyscuSubrein: 7 Feb 2018View: 26 Feb 2018 The placenta is considered an important organ that develops with the implantation of blastocyst throughout the explosion The placenta plays an important role in functions such as nutrition, selection, immunological and endocrine function. A normal placenta is a round or oval organ that attaches to the wall of the uterus and has a diameter of about 22 cm and a thickness of about 2-2.5 cm and weighs about one-sixth of the mass of the fetus at birth. Thus, normal placenta development is important for uneven embryonic and fetal development. Consequently, placenta abnormalities can range from structural abnormalities, to function disorders, to the site of implantation abnormalities. The development of the placenta begins with the implantation of blastocyst as a breast in the uterus of the mother, and it develops throughout the pregnancy. At the end of the first trimester of pregnancy, the maternal blood supply to the placenta is completed. The placenta has numerous and complex, strategically important functions for development, such as nutrition, selection, immunological and endocrine function. A normal placenta is a round or oval organ that is attached to the wall of the uterus and has a diameter of about 22 cm. The thickness of the placenta is about 2-2.5 cm and weighs about one-sixth of the mass of the fetus at birth. Thus, normal placenta development is important for uneven embryonic and fetal development. Consequently, placenta abnormalities can range from structural abnormalities to functional disorders, to the site of implant abnormalities. Abnormal placental implantation (accreta, spark and percreta) is described using the general clinical term, respectively, painfully placenta adept (MAP) or abnormal invasive placenta (AIP). If not diagnosed before birth, MAP can lead to catastrophic postpartum hemorrhage, with life-threatening complications. Risk factors include increased maternal age, previous caesarean section or myomectomy, multipleness, and previous intrauterine maneuvers (such as hysteroscopy and multiple enlargement and treatment). The reported incidence ranges from 1:2500-1:7000 pregnancies in 2007 to 1:533 births in 2017. When placental wheelie is attached to myometrium rather than decidua, it is called placenta accreta; when chorionic wheelies penetrate myometrium, it is called placenta increta (e.g. Figure 1), while the placenta percreta extends to the ceros of the uterus or adjacent organs (e.g. Figure 2). Placenta increta and placenta percreta are rare disorders that make up 20% of placenta accretion cases. These varieties can lead to more severe maternal complications (60% maternal morbidity, 7-10% maternal mortality). Most important in reducing these potentially fatal complications is prenatal prenatal Diagnosis. In many cases, the patient's history is very relevant. A key feature of the early first trimester of MAP diagnosis is abnormal neovascularization in an undetermined placental-myometrial denouement found in a color or power doppler (2D or 3D) image, similar to the flow observed in an invasive mole, arterial malzamaformation or preserved conception products. Other aspects may include coordinating or diffuse irregular lacunaric lakes with a high-speed turbulent flow (PSV, zgt;15 cm/s). More lakes increase the risk of placenta accretion. The complete loss or disruption of the echolucent myometyl area between the placenta and bladder is very suggestive of MAP. Using color Doppler study, the sensitivity and specificity of ultrasound scans can be above 80-90% and, respectively, 98%. Magnetic resonance imaging can add precision to MAP diagnostics when assessing lateral enlargement and the depth of the placenta penetration. However, most MAP cases are diagnosed at the third stage of labour or during caesarean section, and about 21% of MAP cases are responsible for peripartum hysterectomy. In general, in the suspected cases with this type of placental pathology, the best approach involves a multidisciplinary team with early prenatal and intranatal management planning, preferable to later planning. Some groups recommend delivery for 34-35 weeks by performing a premature C-section with the placenta left in place. Other somewhat adjuvant methods have been suggested, such as the treatment of methotrexate and/or the placement of internal iliac artery balloon catheters, for occlusion and/or arterial embolization. The aim of the CONSERVATIVE MAP approach is to try to gradually resorpt the placenta or delay the delivery of the placenta. A good prediction of MAP pathology is feasible, with an improvement in maternal and fetal outcome, if the diagnosis is timely and there is adequate preparation of childbirth. These are important keys in managing such cases. The ultrasonic color of Doppler's image of the placenta increta case is diagnosed at the beginning of the second trimester of pregnancy associated with fetal death. Surgical termination of pregnancy was carried out under laparoscopic guidance, without complications. An image of the uterus occupied by the placenta percreta after a postpartum hysterectomy due to important hemorrhagic complications. This type of obstetric pathology was first described in 1685 by Paul Portal, a French physician, as the main cause of hemorrhage, with a potential threat to the life of the mother and fetus. It has been defined as a placenta that overlies completely or partially internal cervical os of the uterus. In full praevia, the internal os is completely covered by the placenta (e.g., figure 3). Placenta Rule in partial praevia (part of the internal os is covered by the placenta), marginal praevia or praevia maginalis (the edge of the placenta extends to the edge of the cervical wasp), and the low-lying placenta is defined as within 2 cm of the CER's cervix without covering it. Reported incidence of the condition 1 in 200-250 pregnancies. Among the risk factors, there are pre-caesarean section, previous abortion, prior to fetal surgery, smoking, multifutal pregnancy, increased parity, and increased maternal age. The risk of developing placenta praevia is 12 times higher in women with a history of placenta praevia in previous pregnancies. Some studies have shown elevated levels of placental insufficiency in women with placenta praevia. However, in a retrospective study of women with complete or partial praevia, no fetal growth restriction was diagnosed. The location of the placenta must be recorded during ultrasound scans during the first and early second trimester pregnancies. If the placenta is much lower, additional ultrasound scans at the beginning of the third trimester allow for a definitive diagnosis. Patients should be aware that nothing can be done to prevent placenta praevia. Appropriate delivery to the placenta praevia is a C-section as the enlargement of the cervix causes the separation of the placenta, leading to bleeding from the open vessels. However, in cases of low-lying placenta, as the bleeding incidence has proven to be limited, vaginal delivery remains an option. Each hospital should have a suitable protocol or algorithm to control the placenta praevia, as it is a condition with high maternal and fetal morbidity and mortality. An ultrasonic image of the full placenta praevia percreta in a patient with a previous caesarean section (color examination of Doppler, showing the penetration of the placenta into the bladder). Vasa praevia is a rare disease in which fetal blood vessels cross the lower segment of the uterus before presenting a part that is not supported by either umbilical cord or placental tissue (e.g. Figure 4). This pathological structure can cause fetal blood loss, with a significant neonatal morbidity or death in the event of a spontaneous rupture of membranes or amniotomy. In addition, the cardiac arrest of the fetus and bradycardia can occur if the compression of these vessels appears, due to the representation of the part . This condition occurs in 1:2500-5000 pregnancies. Prenatal diagnosis is made with high accuracy with ultrasound, with sensitivity of 100% and specificity of 99-99.8%, if transvaginal colored Doppler examination is used. If the birth has not been recognized, the fetal mortality rate ranges from 22.5 to 100%. To improve prenatal diagnosis, prenatal ultrasound should include a standard location assessment Umbilical cord. Umbilical cord. some researchers have demonstrated that general screening for vasa praevia is not cost effective and is not recommended. There are recent reports of two main associations: velamental inserts and vascular crossings between lobes in the sucsenturiat or bilobate placenta. In addition to these strong risk factors, others include placenta praevia and conception using assisted reproductive technologies. If diagnosed with vasa praevia, elective caesarean sections should be offered at 35-36 weeks. Others prefer a planned C-section at 37-38 weeks or when the maturation of the fetus's lungs has been confirmed to be .26, 27. Canadian guidelines for managing prenatally diagnosed vasa praevia include elective C-sections before birth. In addition, since preterm birth is likely to consider the introduction of corticosteroids at 28-32 weeks (to promote fetal lung maturation), and hospitalization at approximately 30-32 weeks is recommended. Continuous electronic monitoring of the fetal heart rate and a rapid biochemical test for fetal hemoglobin can be considered, and if any of the above tests are abnormal, an emergency C-section should be performed. In general, doctors should be vigilant whenever amniotomium is performed as not all cases of vasa praevia are diagnosed antenatal. Any case of suspicion should profit immediately delivery, in order to avoid fetal shock or demise. Ultrasonic color Doppler image showing vasa praevia. The bilobalized placenta (placenta bilobat, bipartite placenta, placenta duplex) is a placental morphological abnormality that refers to a placenta divided into two roughly equal lobes separated by membranes (e.g. Figure 5). If there are more than two lobes, the placenta is called a multi-layered placenta. The estimated incidence is 2-8% of the placenta. Pathology of this type of placenta is considered the result of localized placental atrophy, as a result of poor decisive or vascularization of the part of the uterus (dynamic placentation theory). In addition, genetic origin was considered, as the risk of developing a bipartisan placenta is higher in a woman with a history of bipartisan placenta. It is reported that there is a frequent connection with the umbilical cord veal insertion, as the umbilical cord can be inserted either in the lobes or between the lobes. The diagnosis of the bile placenta is made by ultrasound assessment at the mark of two separate placental discs of almost the same size. In cases of bilobed placenta, there is no increased risk of fetal abnormalities. However, this type of placental abnormality may be associated with first trimester bleeding, polyhydrumnio, sharpness, and preserved placenta. In addition, it can increase the incidence of praevia vase with a high incidence of hemorrhage. taking into account all these risk factors, the bilobed placenta does not have any adverse adverse or long-term pregnancy outcomes. An ultrasonic image (grey scale and color of doppler) of the bile placenta, showing two lobes of the placenta and insertion of the umbilical cord in one of the lobes. Circumvalnat placenta is a type of extrachorial placenta, defined as a ring-shaped placenta with raised edges consisting of double folds of chorion, amnion, degenerate literature and fibrin deposits. Pathologically, the basal plate is larger than the chorion fondose. The incidence of placenta circulating was reported in 0.5-18% of the placenta examined after delivery. There is an increased risk of vaginal bleeding at the beginning of the first trimester, as well as the risk of premature membrane rupture, premature birth, placental insufficiency, and placental sharp (34, 35). The outcome of pregnancy can be very bad. Prenatally, during an ultrasound scan, the circulating placenta can be suspected as peripheral rim chorion tissues appear as an echodens ridge (placental shelf), with a tire sign appearing on a 3D exam. However, the diagnosis is made most often after childbirth, when examining the placenta. If the placenta circumference is suspected of anthenatality, the pregnancy should be classified as a high-risk pregnancy, and special precautions should be considered to prevent preterm birth. A high association between the circular placenta and one umbilical artery and the lack of a link between amniotic band syndrome or complex limb walls and the circular placenta was not reported. Thus, the condition does not carry any risk of fetal deformity. Circummarginate placenta is another type of extrachorical placenta, with no clinical significance, where the transition from membranous to villous chorion is flat. Placenta membranacea is a highly unusual change in placental morphology, in which the placenta develops as a thin structure, occupying the entire periphery of the chorion. This type of placental abnormality is classified as diffuse placenta membranacea (with a willy chorion covering the fetal membrane completely) and partial placenta membranacea. The estimated incidence is 1:20,000-1:40,000 pregnancies (38), with the association abnormal placental joining up to 30% of cases . Ultrasound assessment is useful, but being an extremely rare option, there are no reports of its sensitivity and specificity. A common symptom of this type of placental pathology is vaginal bleeding in the second or third trimester (often painless) or during childbirth. Complications such as prenatal hemorrhage, second trimester miscarriages, fetal death and postpartum hemorrhage were reported during pregnancy with placenta ambivalence. Placenta praevia and placenta accretion or intrauterine growth restriction may also be associated with condition, deterioration and fetal prognosis (30, 40). In the juicy placenta less accessory placental lobe develops in membranes other than the main disc of the placenta. There may be more than one social centuriat share, and this is a smaller version of the bilobed placenta. In the placenta, the suuria has no blood vessels in the interacting membranes. As risk factors, advanced maternal age, in vitro fertilization, primay, proteinuria in the first trimester of pregnancy, and implantation over leiomyomas or in areas of previous surgery were given in the literature. This condition can be diagnosed in 5% of pregnancies, using ultrasound scans, as a smaller individual lobe is similar to the main placental lobe. Caution should be exercised when determining any connective vessels, especially vase-rightia. Differential diagnosis may also include focal myometric contraction and iso-echo hematoma from placental sharpness. Complications may appear as there is an increased risk of praevia vase and postpartum hemorrhage, due to preserved placental tissue. Chronic intervillositis, also known as massive chronic intervilenitis or chronic histiocyte intervillositis, is an exceptionally rare placental abnormality determined by inflammatory placental lesions, mainly diffuse hysthocytic infiltration in the intergenerational space. Risk factors include maternal diabetes, maternal hypertension, intravenous drug abuse, pre-eclampsia and systemic lupus erythematosus. This condition has a perinatal mortality rate of 80%, due to the associated risk of recurrent spontaneous abortion, fetal growth (43) and fetal death. The relapse rate is considered to be above 60%. Placental mesenchymal dysplasia is a rare vascular abnormality of the placenta, characterized by mesenchymal hyperplasia of stem cells. Ultrasound diagnosis includes placental and grape placental appearance, both erroneously clinically and macroscopically for partial hydratyform molyan pregnancy. Differential diagnosis is important as it can lead to termination of pregnancy. However, the final diagnosis is made using placental histology. It has also been reported that this disorder is associated with both intrauterine growth restrictions (IUGR) and fetal death. In many cases, the cause of fetal death is vascular obstructive fetal pathology, which causes a long-standing, severe fetal hypoxia caused by chorionic vascular thrombosis. Beckwith-Videman syndrome has been linked to placental mesenchymal dysplasia. Invasive tests are recommended to confirm normal karyotype and to rule out partial molyan pregnancy. The placenta is a natural selective barrier between maternal and fetal circulation, and it is very sensitive to the hyperglycomistic environment. adaptive changes in structure and function appear. Histological findings are typical: typical: villous fibrinoid necrosis, chorioangiosis, and enlarged angiogenesis. Chronic fetal hypoxia can occur due to placental changes associated with inflammation and oxidative stress. Potential fetal complications include growth restriction, premature birth, pre-eclampsia, risk of oxygen deprivation, low neonatal body temperature, low blood sugar at birth and stillbirth. Chorioangioma is a benign vascular tumor found in about 1% of all pregnancies. It was first described in 1798 by Clark. This pathology is a malformation of the primitive angioblast tissue of the placenta, permeated by the circulation of the fetus. It is rarely clinically significant and is usually detected by accident. Most chorioangio is small. However, large chorioangyomas have been linked to a number of fetal diseases (fetal anemia, thrombocytopenia, hydrops, hydramniosis, intrauterine growth retention), including pretermity and stillbirth. In addition, large tumors can be degenerated by necrosis, calcification, hyalinization or myxomatous degeneration. Typically, on ultrasound, chorioangioma is located next to the insertion of a cord in an amniotic cavity like a hypoeha, a rounded mass with usually anecho-carpal cystic areas with low throbbing flow resistance (e.g. figure 6). In rare cases, tumors are pedunkulized. Subamniotic hematomas, partial hydratyform mole, submuscotic uterine fibroids, placental teratoma and atypical placental venous lake should be considered as differential diagnosis. Ultrasonic colored Doppler image of chorioangiooma is diagnosed in the second trimester of pregnancy. Most infections originate from several infectious substances that can cross into the placenta from maternal circulation. These types of infections can be associated with a variety of developmental consequences, from near-minor to major complications of maternal and fetal development. Placental examination by a pathologist should be taken into account in each case of preterm birth, fetal tachycardia, maternal signs of endomyometriitis (e.g., fever, tenderness of the uterus, leukocytosis, tachycardia), admission to the neonatal intensive care unit, low-aging placenta, preserved placenta or postpartum hemorrhage, as well as stillbirth. However, a specific infectious substance is rarely diagnosed by placental examination. However, placental histology can confirm a clinical diagnosis of infectious etiology in some cases of an uncertain fetal heart rate structure or neonatal morbidity/mortality. The most common placental infections are: Malaria: characterized by the mother's pigmented red blood cells and macrophagues, which are aggregated in the inter-conscientious space. Cytomegalovirus the most common congenital viral infection, mainly subclinical at birth in cases of intrauterine growth and stillbirth restriction. Classic Classic The placenta search involves viral inclusions. They can only be detected by immunohystokhimia. Herpes simplex virus: histopathological features of the placenta may include lymphoplasmapsacyte vilit. Demonstration of the virus by immunohystochmia or molecular methods allows to make a diagnosis, as the above conclusions are non-specific. Listeria monocytogenes is characterized by acute vilitis, with the formation of abscess and damage to the central nervous system of the fetus. Streptococcal infection: Group B streptococcus and group A can cause placental infection. Syphilis: Treponema pallidum infection is defined by chronic vilit (plasma cells, mixed acute and chronic infiltration). Toxoplasmosis implies the risk of placental colonization, depending on the volume of stertoplascent blood flow, the immunocompaence of the mother and parasites. Placental infection described as granulomatous vilitus, cysts, plasma lithium cells, knee sclerosis, and chorionic vascular thrombosis, is more common with increased gestational age during maternal parasites. Chlamydia psittaci: can infect the placenta and can cause significant feto-mother morbidity and mortality by intense, acute intervilositis, perivillous deposition of fibrin with submissive necrosis, and large irregular basophilic intracytoplasmic inclusions in syncytiotrophoblast (60, 61). Fetal membranes (chorion, amnion) are the interface between the foetus graft and the mother's host. The infection can also pass the fetal membrane, especially in the area of excessive cervix. Provides direct access to pathogens, rise from the vagina and cervix. Less often infectious agents enter the uterus as a result of invasive procedures (e.g. amniocentesis, fetoscopy, cordocentesis and chorionic willus sampling) or through the fallopian tubes from the infectious process in the abdominal cavity. Hoorioamnionite is the most common histopathological result of an ascendant transcervic infection and occurs with both symptomatic and silent infections. Histological diagnosis of chorioamnione is allowed if inflammatory infiltration involves either or both chorion and amnion. Acute chorioamnionitis is more common than chronic. As clinical symptoms, chorioamnionitis is characterized by maternal fever, tachycardia, uterine tenderness, or foul-smelling amniotic fluid. However, the culture of amniotic fluid or membranes is unable to document bacterial infection in 25-30% of the placenta with histological oriamniotic. Infection membranes are often polymicrobial, with the most common bacteria: Streptococcus sp., Escherichia coli, Ureaplasma sp., Fusobacterium sp., Mycoplasma sp., and anaerobic . Proper diagnosis and treatment of hoorioamnionite is of paramount importance as perinatal and maternal morbidity and mortality. The main pathological effects of hoorioamnionitis may include premature membrane rupture, premature birth, long-term birth, preterm birth, fetal and neonatal infection, and endomeiometriitis. Hydatidiform mole (HM), also called molyan pregnancy, is a subcategory of gestational tropoblast disease. The origin of the essence of the gestational tissue. The nature of HM is usually benign, but it has a known potential to become malignant and invasive. The incidence of HM is 1:1000-2000 . Risk factors include extreme maternal age (over 35 years and under 20 years), previous moly pregnancies, women with previous spontaneous abortions or infertility, dietary factors and smoking. HM can be a complete mole, with no fetus, or a partial mole with abnormal fetus or fetal demise; rarely a mole coexists with a normal pregnancy. In full HM, 90% of cases of karyotype 46XX diploid, while in partial HM, the karyotype is usually a triploid 69XX . Histopathological event HM is considered to be the spread of the generational trophblast, accompanied by swelling of chorionial willies, which leads to a high level of production of human chorionic gonadotrophin (HCG) (e.g., figure 7). The location of HM is the uterine cavity, with exceptionally rare cases located in the fallopian tubes or ovaries. Clinically, the most common symptom is vaginal bleeding in the first trimester. Sometimes you may encounter an association of hyperemesis (severe nausea and vomiting) or the passage of vaginal tissue, described as grape clusters or bubbles. If not early to be diagnosed, other significant complications may appear, such as hyperthyroidism, including tachycardia and tremor and pre-eclampsia. Usually, on physical examination, there is a discrepancy of the size of the uterus compared with the period of amenorrhea, the uterus is larger in the complete mole and smaller in the partial mole . Ultrasound examination is a heterogeneous mass in the uterine cavity, with several anehoy spaces (e.g. Figure 8). A snowstorm or a bunch of grape appearance is no longer seen with the equipment at present. There is no embryo in full moles and no amniotic fluid is present. In the first trimester, diagnosing a full mole can be difficult; a two-sided lutein cyst can be seen. In partial mole, the molar placenta cannot always be seen; the amniotic cavity is either empty or contains a well-formed but backward fruit, either dead or alive, with hydropical degeneration of fetal parts. Sometimes differential diagnosis between partial moles, full moles, and missed abortion can be difficult. In a moly pregnancy, the first step after staging is a chest X-ray to determine the definition of Computer tomography and magnetic resonance imaging can add valuable additional information for a definitive diagnosis. After careful consultation of the patient, including genetic testing, the best treatment option remains suction and treatment for evacuation. Hysterectomy, however, is an option if fertility preservation is not necessary. When HCG levels remain elevated after proper evacuation of the uterine cavity, gynaecological oncology consultation is necessary to guide therapy and review chemotherapy. Image after a hysterectomy of the uterus invaded the hydatidiform mole in a 48-year-old patient. An ultrasonic image of the hull of the hydatidiform mole. Hokiocarcinoma is a rare aggressive tumor, with highly malignant potential and widespread metastases of spread. It is considered part of the spectrum of gestational tropoblast disease and is called gestational oriocacinoma. The high mortality rate is due to the lack of early diagnosis and appropriate chemotherapy. Approximately 5% of cases of full GM can be complicated with hooriocarcinoma. Only about half of cases of hooriocarcinoma occur from full HM. The diagnosis of the image of horiocarcinoma includes discrete, central, infiltration mass, enlarging the uterus, with a possible invasion of myometrium and beyond (e.g. numbers 9 and 10). The ovaries can be enlarged, due to cysts secondary to elevated HCG levels. If hooriocarcinoma arises from a full HM, the prognosis is usually favorable after proper chemotherapy. On the contrary, other cases of oriocacarcinoma have a less favorable prognosis. An ultrasonic image in a gray and colored Doppler scale shows a rare case of cervical hooriocarcinoma with intense vascularization. An ultrasonic image in the grey and colored Doppler scale showing a case of oriocarccinoma with invasion of myometrium and beyond.1839total chapter downloads1Crossref quotes We Are IntechOpen, the world's leading publisher of open-access books. Created by scientists, for scientists. Our readership includes scientists, professors, researchers, librarians and students, as well as business professionals. We share our knowledge and research with libraries, scientific and engineering societies, as well as working with the corporate departments of research and development and government agencies. Read more about us abnormalities of the placenta ppt. abnormalities of the placenta pdf. abnormalities of the placenta and umbilical cord. abnormalities of the placenta umbilical cord and membranes. top 10 abnormalities of the placenta. structural abnormalities of the placenta. developmental abnormalities of the placenta. list the abnormalities of placenta