



A CASE OF PLACENTA PRAEVA AND PLACENTA INCRETA

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ABSTRACT

Severe bleeding is the single most significant cause of maternal death worldwide. More than half of all maternal deaths occur within 24 hrs of delivery, most commonly from excessive bleeding. It is estimated that worldwide 140000 women dies of postpartum haemorrhage- each year-one every 4 minutes (1).

With the rising incidence of caesarean sections combined with increasing maternal age, the number of cases of placenta praevia and its complication, including placenta accrete, will continue to increase.

KEYWORDS :

CASE REPORT

28 year old G3P2L2 lady with previous 2 LSCS presented to the emergency department with bleeding per vaginum of 6 hour duration. She is a known case of complete placenta praevia under frequent follow up. She was planned for expectant management till 36 weeks. MRI was done in view of previous two caesarean delivery. It showed complete placenta praevia with placenta increta. In view of APH she was taken up for caesarean section with elective hysterectomy.

Intraoperatively after the delivery of fetus through a classical incision, placenta was left in situ and peripartum hysterectomy done. The estimated blood loss was around 1500ml. She was transfused with 2 pints packed cells and 4 pints plasma. Postoperatively mother and baby healthy and discharged on day 3.

DISCUSSION

Placenta accreta is a general term used to describe the clinical condition when part of the placenta, or the entire placenta, invades and is inseparable from the uterine wall (1).

When the chorionic villi invade only the myometrium, the term *placenta increta* is appropriate; whereas *placenta percreta* describes invasion through the myometrium and serosa, and occasionally into adjacent organs, such as the bladder.

Clinically, placenta accreta becomes problematic during delivery when the placenta does not completely separate from the uterus and is followed by massive obstetric hemorrhage, leading to disseminated intravascular coagulopathy; the need for hysterectomy; surgical injury to the ureters, bladder, bowel, or neurovascular structures; adult respiratory distress syndrome; acute transfusion reaction; electrolyte imbalance; and renal failure.

The average blood loss at delivery in women with placenta accreta is 3,000–5,000 mL (2). As many as 90% of patients with placenta accreta require blood transfusion, and 40% require more than 10 units of packed red blood cells. Maternal mortality with placenta accreta has been reported to be as high as 7% (3).

Maternal death may occur despite optimal planning, transfusion management, and surgical care. From a cohort of 39,244 women who underwent caesarean delivery, researchers identified 186 that had a caesarean hysterecto-

my performed (4). The most common indication was placenta accreta (38%).

The value of making the diagnosis of placenta accreta before delivery is that it allows for multidisciplinary planning in an attempt to minimize potential maternal or neonatal morbidity and mortality. The diagnosis is usually established by ultrasonography and occasionally supplemented by magnetic resonance imaging (MRI).

Transvaginal and transabdominal ultrasonography are complementary diagnostic techniques and should be used as needed. Transvaginal ultrasound is safe for patients with placenta praevia and allows a more complete examination of the lower uterine segment.

A normal placental attachment site is characterized by a hypoechoic boundary between the placenta and the bladder. The ultrasonographic features suggestive of placenta accreta include irregularly shaped placental lacunae (vascular spaces) within the placenta, thinning of the myometrium overlying the placenta, loss of the retroplacental "clear space," protrusion of the placenta into the bladder, increased vascularity of the uterine serosa-bladder interface, and turbulent blood flow through the lacunae on Doppler ultrasonography (12, 13).

Overall, grayscale ultrasonography is sufficient to diagnose placenta accreta, with a sensitivity of 77–87%, specificity of 96–98%, a positive predictive value of 65–93%, and a negative predictive value of 98 (13, 14).

The use of power Doppler, color Doppler, or three-dimensional imaging does not significantly improve the diagnostic sensitivity compared with that achieved by grayscale ultrasonography alone (15).

A prospective series of 300 cases published in 2005 showed that MRI was able to outline the anatomy of the invasion and relate it to the regional anastomotic vascular system (16).

In addition, this study showed that using axial MRI slices enabled confirmation of parametrial invasion and possible ureteral involvement.

Generally, the recommended management of suspected placenta accreta is planned preterm caesarean hysterectomy with the placenta left in situ because removal of the placenta is associated with significant hemorrhagic morbidity. However, surgical management of placenta accreta may be individualized.

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