



CASE REPORT: UTERUS SAVED IN A CASE OF ANTENATALLY DIAGNOSED PLACENTA ACCRETA.

Dr. Saurabh Shetty

Junior resident, Dept. of OBGYN, MGM medical college & hospital, Navi Mumbai.

Dr. Priya Bagade

Assistant professor, Dept. of OBGYN, MGM medical college & hospital, Navi Mumbai.

Dr. Sushil Kumar

Professor and HOD, Dept. of OBGYN, MGM medical college & hospital, Navi Mumbai.

ABSTRACT

Placenta accreta is one of the serious obstetrical complication faced after the delivery of the fetus. It is one of the causes for severe postpartum haemorrhage leading to a maternal mortality. In case of such an event, an obstetrical hysterectomy remains the ultimate tool to save the mother's life. We present a case of placenta previa accreta diagnosed by ultrasound and magnetic resonance imaging antenatally, in which we accomplished conservative management of postpartum hemorrhage and could save the uterus.

KEYWORDS : placenta accreta, antenatally diagnosed, uterus saved.

INTRODUCTION

Placenta accreta is part of a syndrome in which there is pathological attachment of the placenta to the uterine (cavity) wall. Three variants have been described. In placenta accreta, the placenta is attached to the myometrium due to partial or complete absence of decidua basalis. Placenta incerta occurs when the placenta partially invades the myometrium. Placenta percreta is further invasion of the placenta beyond the myometrium up to the uterine serosa and gets attached to the surrounding structures. [1] Placenta previa and a previously operated or a scarred uterus, are the two causes leading to these syndromes. The incidence of placenta accreta is on the rise due to increasing number of babies being delivered by a lower segment caesarean section. [1]

CASE REPORT

A 29 years old pregnant lady was referred to MGM medical college and hospital, Kalamboli, Navi Mumbai, from a primary health centre. She was Gravida 2, Para 1, Living 1 with previous LSCS with 30 weeks of pregnancy, having a complain of spotting per vagina. She had an ultrasound report which was suggestive of placenta previa. The patient was admitted and was given steroids for fetal lung maturity. She was also put on progesterone support. An ultrasound was repeated after admission which was suggestive of placenta previa with possibility of placenta accreta. These findings were later on confirmed with a 3 tesla MRI which indicated placenta previa with focal areas of accreta. The pregnancy was managed conservatively till 34 weeks. After a rescue dose of steroids, the pregnancy was electively terminated by LSCS with consents and arrangements for hysterectomy and massive blood transfusion. After opening the abdomen in layers, intra-abdominal inspection showed the presence of multiple large vessels near the lower uterine segment. An initial displacement of the bladder was performed and subsequently a transverse uterine incision was made above the lower uterine segment in order to avoid the placental bed. A healthy baby was delivered, weighing around 2 Kilograms which cried immediately after birth. After cord clamping and cutting, it was observed that 50% of the placenta was morbidly adherent to the myometrium near the lower segment. After careful inspection, majority of the adherent placenta was removed with gentle traction. Few chunks of this pathologically attached placenta were left behind. Oxytocics were given to contract the uterus and haemostatic sutures were taken at the open bleeding sinuses and the bleeding was controlled. There was a blood loss of around 1 litre. The procedure was completed uneventfully and the uterus was preserved. 1 pint of PRBC was transfused and the patient had stable vitals post operatively. Patient was monitored for secondary postpartum haemorrhage and sepsis, a broad spectrum antibiotic cover was given. She had an uneventful post-operative recovery

and a subsequent oral iron correction was given. With a healthy suture line, no bleeding per vagina and stable vitals, she was discharged on post-operative day 7 with instructions to follow up if more than average bleeding per vagina. An ultrasound was done after 6 weeks in which no abnormality was detected and showed a normal size, empty uterus. Following treatment modalities: Methotrexate management and serial Beta HCG monitoring were considered but was not done as recent advances showed no improvement in mortality or morbidity. [1]



FIGURE 1: Placenta and bag of membrane visualised through the transverse uterine incision. Fetus approached above the placenta for delivery.



FIGURE 2: Placenta partially adherent to the lower uterine segment.

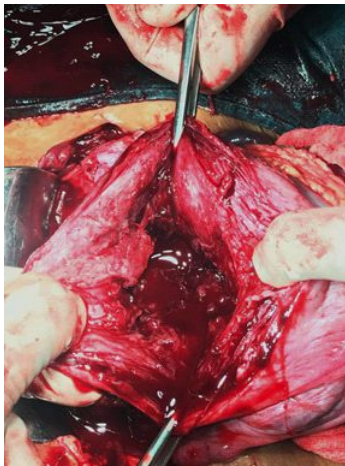


FIGURE 3: Placental bits adherent to the lower segment.

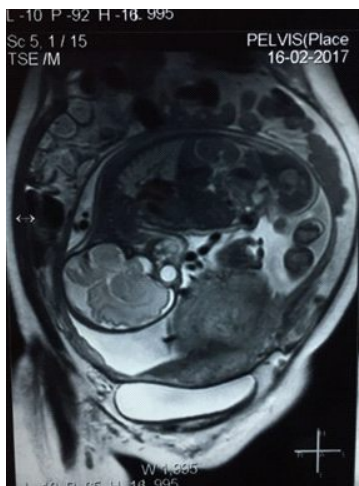


FIGURE 4: MRI showing the loss of three layer appearance of myometrium at some places in the area between the placenta and the bladder.

DISCUSSION

The incidence of placenta accreta syndrome has been on a rise due to the increasing caesarean section rate. American College of Obstetricians and Gynaecologists cites it to be as high as 1 in 533 deliveries. [1] Other factors include history of any gynaecological procedure like curettage, myomectomy, etc. Any history of septic endometritis, previous manual removal of placenta, previous history of trophoblastic disease, uterine malformations and multiparity may also be one of the predisposing factor. A risk of placenta accreta exists in 2 to 5% with any case of placenta previa [2], the risk increases further more if it is a scarred uterus. Magnetic resonance imaging and Doppler ultrasound are the tools that can be used for the antenatal diagnosis of placenta accrete syndrome. However, the diagnostic and confirmatory value of ultrasound in diagnosis of an asymptomatic placenta accrete syndrome may be inferior to magnetic resonance imaging. It is suggested that sonography is able to detect only about 33% of cases of placenta accreta syndromes. [2] In these cases, post-delivery of the baby an urgent hysterectomy appears to be the treatment of choice. When bleeding is minimal and the uterus is adequately contracted the trend is to leave the placenta in situ. Following this the patient has to be monitored to avoid secondary post-partum haemorrhage and puerperal sepsis. [1] Numbers of attempts have been made to treat placenta accreta with various newer modalities so as to avoid a hysterectomy, in patients who wish to retain their reproductive function. Methotrexate, is the drug widely used, although its efficacy is questionable [1], and moreover it is contraindicated during breast feeding, and it will adversely affect her own health.

Other treatment modalities include the use interventional radiology to ligate internal iliac artery. Obstetric hysterectomy as of for today is probably the best option for a long-term outcome. [1]

CONCLUSIONS

Placenta accreta syndromes are not as rare as they used to be. With the advances and an increasing role of MRI in obstetrics, timely antenatal diagnosis and a prompt management is the key to better prognosis. A proper planned antenatal care and termination at a tertiary care centre is necessary, with arrangements for massive blood transfusion, internal iliac artery ligation, interventional radiology and ultimately hysterectomy.

REFERENCES:

- [1] Cunningham F.G., Leveno K.J., Bloom S.L., et al., editors. Williams Obstetrics. 24th ed. New York: McGraw Hill Education. 804-808.p
- [2] Sharma V, Kaur J. Case report on placenta accreta presenting obstetric emergency. Int J Reprod Contracept Obstet Gynecol 2017;6:2112-4.