VOLUME-8, ISSUE-12, DECEMBER-2019 • PRINT ISSN No. 2277 - 8160 • DOI : 10.36106/gjra

Original Research Paper

Gynaecology

PLACENTA ACCRETA - A MANAGEMENT ENIGMA

Dr. Bhakti Bawankule*	Resident OBGY,MGM Medical College, Navi Mumbai *Corresponding Author
Dr. Sushree Patra	Resident OBGY,MGM Medical College, Navi Mumbai
Dr. Sushil Kumar	HOD, Department OBGY,MGM Medical College,Navi Mumbai

ABSTRACT

AIMS AND OBJECTIVES: 1. To analyse maternal and foetal outcomes 2. To analyse types of interventions.

MATERIALS AND METHODS: It is a retrospective study conducted over a period of 3years (Jan2017-August 2019), in Department of Obstetrics & Gynaecology at our hospital. Out of 9000deliveries conducted in 3years, 12patients were found to have accreta during caesarean section. Cases were analysed for interventions and maternal and foetal outcome.

RESULTS: The mean age of patient included was 25.7yrs ranging from 21-35 yrs. 7patients were gravida 2, 3were gravida 3 and 2 were gravida 4. The mean gestational age was 34.4 weeks ranging from 27.1 to 37.5 weeks. History of D&C was present in 1case, H/O previous LSCS was present in all cases, H/O placenta previa in current pregnancy was present in7/12 cases. H/O previous caesarean section with placenta previa in this pregnancy was present in 7cases. Hysterectomy alone was done in 9patients. Hysterectomy with Internal Iliac Artery Ligation was done in 3patients. Average blood loss was around 1700 ml & blood transfusion was required in all patients. Total 6 patients required ICU care, with 1maternal death and 2 IUFD.

CONCLUSION: Antenatal diagnosis of placenta accreta is a challenge. With increasing frequency of previous caesarean section and placenta previa the prevalence of placenta accreta is increasing. With advent of newer interventions and availability of interventional radiologists death due to massive haemorrhage is reducing. Obstetric hysterectomy and Internal Iliac artery Ligation still remains the mainstay of treatment. However, morbidly adherent placenta is a threat to both patient and obstetrician.

KEYWORDS : Accreta, Hysterectomy, Interventions

INTRODUCTION:

Abnormal placentation[1] (accreta, increta, percreta) has emerged over uterine atony as leading indication for peripartum hysterectomy.[2]Placenta accrete syndrome 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.[3]These placental abnormalities rarely get detected before delivery. Antenatal diagnosis is crucial in planning its management and has shown to reduce maternal morbidity and mortality. (RCOG 2018) Accurate prenatal identification allows optimal obstetric management, because timing and site of delivery, availability of blood products, and recruitment of a skilled anaesthesia and surgical team can be organized in advance .The clinical consequence of placenta accreta is massive haemorrhage at the time of manual placental separation at the time of caesarean section.At times the haemorrhage is difficult to control and may even result in death on OT table. Mainstay of prenatal diagnosis remains USG, with MRI being used only as an adjunct in indeterminate cases.[4]

SONOGRAPHIC CHARACTERISTICS INCLUDE:

intraplacental lacunae, loss of the normal retroplacental clear space and thinning or disruption of the hyperechogenic uterine serosa-bladder wall interface.[4]

SPECIFIC MRI FINDINGS ARE:

uterine bulging , heterogeneous signal intensity within the placenta and dark intraplacental bands on T2-weighted images

AIMS AND OBJECTIVES:

The objectives of this study is to-

1. To analyse maternal and foetal outcomes. 2. To analyse type of interventions.

MATERIALS AND METHODS:

TYPE OF STUDY: -

Retrospective study. We retrospectively reviewed the medical records of all patients suspected to have placenta accreta.

PLACE OF STUDY: - MGM Hospital, Navi Mumbai

PERIOD OF STUDY: - January 2017- August 2019

STUDY POPULATION: - Out of 9000 deliveries conducted in 32months,12patients were found to have accreta.

Placenta accreta was defined by clinical criteria at the time of delivery and by pathologic findings. The placenta was considered normal if it was easily removed during caesarean delivery without any bleeding complications. Ideally, the standard of reference for the diagnosis of abnormal adherent placenta is confirmation of the final histology after hysterectomy has been performed.

FOLLOWING MATERNAL AND FOETAL OUTCOMES WERE CONSIDERED:

MATERNAL OUTCOMES-

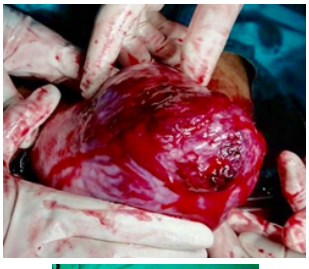
1.Blood loss during surgery 2.Amount of blood transfusion required 3.Admission to ICU 4.Internal Iliac Artery Ligation 5.Uterine Artery Embolization 6.Hysterectomy 7.Maternal mortality

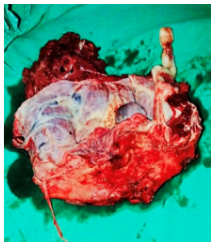
FOETAL OUTCOMES- 1.Live birth 2. IUFD

AGE (in yrs)	Obs formula	Gest Age at delivery (in wks)	Prev lscs	H/O D and C	Placenta location	Blood loss during surgery (in ml)	Blood transfusion	Admitted to ICU	Hysterectomy	Internal iliac artery ligation	Uterine artery emboli sation	Internal iliac artery balloon placement	Maternal outcome	Baby status

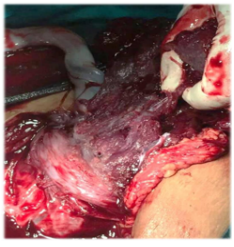
Submitted : 25th July, 2019 | Accepted : 15th September , 2019 | Publication : 15th December, 2019

25	G2P1L1	28.1	1	Nil	Fundal, cornual	2000	4packed cells, 2ffps	yes	Not Done	Yes	No	No	Recovered	IUFD
28	G2P1L1	36	1	Nil	Anterior ,previa	2500	4 packed cells 2 ffp	yes	Done	No	No	No	Expired	Live
29	G2P1L1	37.3	1	Nil	Anterior ,previa	1400	3 packed cells,2ffp	no	Done	No	No	No	Recovered	Live
22	G3P1L1 A1	33	1	1	Posterior,previa	1600	3 packed cells,3ffps	No	Not done	Yes	No	No	Recovered	Live
35	G4P3L2 D1	36.4	2	Nil	Anterior, previa	1400	3 packed cells,1ffp	no	Done	No	No	No	Recovered	Live
26	G2P1L1	35	1	Nil	Anterior, previa	1600	3 packed cells,2ffps	yes	Not done	Yes	No	No	Recovered	Live
22	G3P2L2	34.6	2	Nil	Posterior,previa	1700	2packed cells,4ffps	No	Done	No	No	No	Recovered	Live
24	G2P1L1	34	1	Nil	Anterior, previa	1500	3 packed cells,2ffps	No	Done	Yes	No	No	Recovered	Live
21	G2P1L1	37.5	1	Nil	Posterior,left lateral wall	2000	5packed cells,4ffps	No	Not done	Yes	No	No	Recovered	Live
28	G2P1L1	35.3	1	Nil	Anterior right lat wall	2000	4 packed cells,2ffps	Yes	Done	No	No	No	Recovered	Live
24	G4P1L1 A2	32.1	1	1	Posterior, fundal	1800	3packed cells, 4ffps	yes	Done	yes	No	No	Recovered	Live
30	G3P1L1 A1	37.1	1	2	Anterior,previa	1200	3 packed cells	yes	Done	No	No	No	Recovered	Live





Adherent placenta



Picture of uterus with the adhered placenta at cornua.

RESULTS:

Patients selected were between 21-35 years of age. Seven patients were gravida2, three were gravida3 & 2were gravida4.Average gestational age was between 28-37weeks.History of previous LSCS was present in all cases. History of previous LSCS with placenta previa was present in 7 out of 12 cases(58%).Total 6 patients required ICU care, with 1maternal death and 1 IUFD. Average blood loss in all patients was around 1700ml. Blood transfusion was given in all patients. Internal iliac artery ligation alone was done in 4patients.Internal iliac artery ligation and hysterectomy was done in 2patients.Hysterectomy alone was done in 6patients. 1case of radiological intervention which is not included here was a patient who was diagnosed as Placenta accreta on USG & MRI and was electively taken up for internal iliac artery balloon placement but on OT table patient was not found to have accreta& hence the procedure was abandoned.

CONCLUSION:

Antenatal diagnosis of placenta accreta is a challenge. With increasing frequency of previous caesarean section and placenta previa the prevalence of placenta accreta is increasing. Obstetric hysterectomy & internal iliac artery ligation (Successful in 80-85%) still remains mainstay of treatment. With advent of newer interventions and availability of interventional radiological infrastructure, death due to massive haemorrhage may reduce. However; morbidly adherent placenta is a threat to both patient and obstetrician. Total 6 patients required ICU care, with 1maternal death and 1 IUFD among 12 patients.

DISCUSSION:

Morbidly adherent placenta is one of the most devastating complications in pregnancy .A majority of placenta accreta are diagnosed during the third stage of labour or during caesarean section which results in adverse consequences including exsanguinating haemorrhage .The most important risk factors are previous caesarean delivery and placenta previa. Identification and management of placenta accreta is a clinical and diagnostic challenge that is being encountered with increasing frequency. Apart from risk of massive haemorrhage and associated complication such as consumption coagulopathy, multisystem failure and death, there is also increased risk for surgical complications such as injury to bladder, ureters and bowel and the need for reoperation.Considerable data however ,indicate decreased morbidity and mortality in cases of planned caesarean hysterectomy prior to the onset of labor, rather than emergent delivery, which is often necessitated by con tractions or when clinically significant bleeding occurs. Several adjuvant techniques have also been proposed alongside surgery. These include methotrexate treatment[5] and /or placement of preoperative internal iliac artery balloon catheters for occlusion and/or arterial embolization / internal iliac artery

ligation to reduce intraoperative blood loss and transfusion requirements. Regardless of the management option made, prevention of complications ideally requires a multidi sciplinary team approach. Early planning of arrangements for antepartum and intrapartum management is preferable to late planning, when emergency situations are more likely to occur.

REFERENCES:

1. Wu S, Kocherginsky M, Hibbard JU. Abnormal placentation: twenty-year analysis. Am J Obstet Gynecol 2005;192:1458–61.
2. I.M Usta E.M. Hobeika, A.A. Musa, G.E. Gabriel, A.H. Nassar Placenta previa-accreta: risk factors and complications. Am J Obstet Gynecol, 193 (2005), pp. 1045-1049
3. Placenta accrete spectrum: pathophysiology and evidence-based anatomy for prental ultrasound imaging. Am J Obstet Gynecol, 218(2018), pp 75-87
4. Einerson BD, Silver RM, Rodriguez CE. Reply. Am J Obstet Gynecol 2019;220:127
5. Fox KA, Shamshirsaz AA, Carusi D, Secord AA, Lee P, Turan OM, et al. Conservative management of morbidly adherent placenta: expert review. Am J Obstet Gynecol 2015;213:755–60.