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Placenta Percreta – A Rare Ostetric Emergency Leading to Hysterectomy

KEYWORDS: percreta, haemorrhage hysterectomy.

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ABSTRACT *G4P1L1A2 with 6 ½ months of amenorrhea had come with complains of spotting per vaginum since 30 days and bleeding per vaginum since 3 days with complains of pain in abdomen. Her ultrasound report was suggestive placenta accreta, patient was posted was emergency caesarean section. Intra operative findings were of placenta percreta. There was massive haemorrhage during the surgery due to atonic uterus hence obstetric hysterectomy was done. Blood and blood products were transfused to the patient to cover the blood loss. She was shifted to ICU in her post operative period for monitoring. She was discharged after suture removal on day 13.*

INTRODUCTION:
Placenta accreta is characterised by abnormal invasion of the placenta into the myometrium, deep invasion is termed as placenta percreta. This is considered as the most severe form of placenta accreta with an incidence of one in 7000. The incidence of placenta accreta has dramatically increased due to increasing caesarean section rates[1,2]. Maternal morbidity and mortality associated with this is mainly caused by massive obstetric haemorrhage and emergency obstetric hysterectomy[1,3,4].

CASE PRESENTATION:
A 29 yr old G4P1L1A2 with 6 ½ months amenorrhea came with complains of spotting per vaginum since 30 days followed by bleeding per vaginum since 3 days with passage of clots, also complaining of pain in abdomen since few hours. She had gone to a local doctor who referred her to a higher institute for further management. She was 27 weeks pregnancy with history of previous LSCS 2 ½ years back, with one abortion done by pills and other one done by D&E.

On examination her pulse-120/min, BP-100/60mmHg, pallor ++, per abdomen ut 26 weeks, tone raised FHS 100bpm, per speculm and per vaginal examination not done due to excessive bleeding. Her ultrasound (fig 1) was done which was suggestive of placenta praevia with accreta with severe oligohydramnios with fetal bradycardia. Counselling of the patient and relatives done regarding the condition of the patient and fetal prognosis. Patient was prepared for emergency LSCS with need for obstetric hysterectomy. Blood and blood products were arranged. Her blood investigations pre-operative were Hb-7.8g/dl, platlets-95000, PT-16, APTT-47.

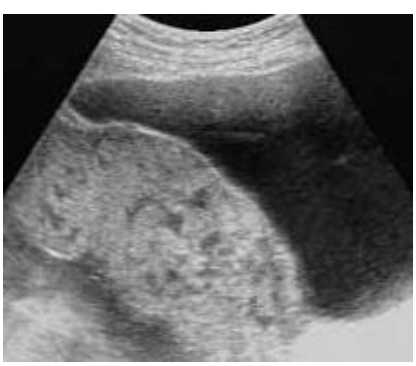

Figure 1

MANAGEMENT:
Intra operative:
Patient was shifted to the operation theatre and 1 PCV was started. Abdomen opened in a midline vertical incision A classical incision was taken on the uterus. The female baby was delivered out and handed to the neonatologist. Baby was declared as a fresh still birth. Soon after that the patient became pulseless on the table for which injection Noradrenaline 20ml/hr and injection Dobutamine 1-4 ml/hr infusion were started. Attempts were made to deliver the placenta but failed due to adherent placenta, as there was placenta percreta. There was atonicity of the uterus for which inj Prostodin 250mcg were given 2 doses i.m.at 20 mins interval, Inj oxytocin 20IU drip was started. Inspite of this, there was persistent bleeding, hence decision of obstetric hysterectomy was taken, bleeding persisted, so bilateral internal iliac ligation was done. There were small bleeders in the placental bed which were sutured. After achieving hemostatis two drains were kept in the abdominal cavity on either sides. Vaginal packing was done. 10

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PCV, 11 FFP, 4 RDP, 4 cryoprecipitate were transfused.

Post operative:
Patient was shifted to ICU for monitoring in an intubated state, was on Inj Noradrenaline 6 ml/hr and Inj Dobutamine 1 ml/hr. On day 1, her Hb-5.1g/dl,platelets-67000, PT-21, APTT-70 for which 4 PCV and 8 RDP were transfused. She was extubated on day 1.On day 2, her Hb-7.5g/dl and platelets- 40000, 2 PCV were transfused. Her vaginal pack was removed on day 2. She was shifted to wards on day 3.Both drains were removed on day 3 and 4. 1 PCV given on day 4. Her latest investigations on day 6 were Hb-10 g/dl, platelets 85,000. Total of 17 PCV,11 FFP, 12 RDP, 4 cryoprecipitate were transfused. Foley's catheter was removed on day 8. Suture removal done on day 12. Patient was stable and was discharged on day 13.

DISCUSSION :
Placenta accreta and percreta causes considerable maternal mortality and morbidity and is a major indication of emergency obstetric hysterectomy. Antenatal diagnosis of placenta percreta is often difficult [3,9]. The management is usually caesarean delivery and hysterectomy, but this causes massive haemorrhage and causes injury of adjacent organs due to the morbidly adherent placenta[8].

CONCLUSION:
Placenta percreta is an obstetric emergency often associated with massive haemorrhage, leading to an emergency obstetric hysterectomy. In this case, there was massive haemorrhage but due to quick availability of blood and blood products, precise and fast decisions by the surgeons and a good anaesthetist team made this a successfully managed case.

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