Original Research Paper

Volume - 12 | Issue - 09 | September - 2022 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Obstetrics & Gynaecology

UNPLANNED CAESAREAN HYSTERECTOMY FOLLOWING PLACENTA ACCRETA - A NIGHT MARE

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ABSTRACT Placenta accreta is a clinical condition when part of placenta or entire placenta invades and is inseparable from uterine wall. Most common indication for Caesarean Hysterectomy is placenta accreta (nearer to 38%). Maternal mortality due to placenta accreta is 7%. Here we are presenting a case of 37yr old elderly multiparous G4P3L3 with 38wk + 2days gestational age with 3 previous LSCS and gestational diabetes complicating pregnancy and its timely management in order to reduce the maternal mortality and morbidity.

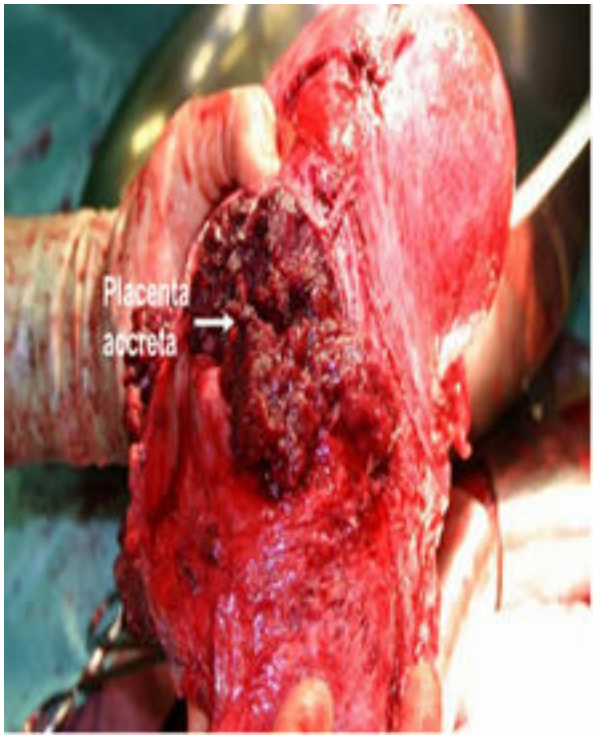
KEYWORDS : Placenta accreta, percreta, increta, Caesarean hysterectomy, Maternal mortality, Gestational diabetes

INTRODUCTION:

Placenta accreta is a clinical condition when part of placenta or entire placenta invades and is inseparable from uterine wall. Risk factors include previous LSCS, placenta previa, uterine curettage, increased maternal age, multiparity, myomectomy, asherman's syndrome, submucosal leiomyomas, thermal ablation, uterine artery embolization. Maternal mortality due to placenta accreta is 7%. Most common indication for Caesarean Hysterectomy is placenta accreta (nearer to 38%).

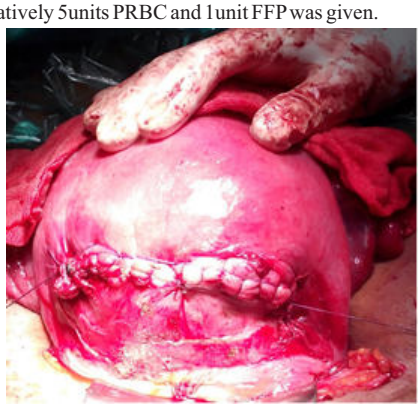
CASE REPORT:

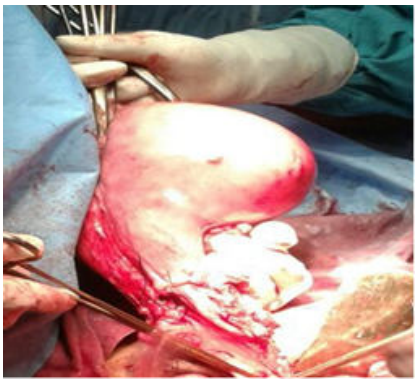
A 37yr old elderly multiparous lady G4P3L3 with 3 previous LCSC with Gestational age 38wk + 2days LCB 5yrs came to our hospital. She had H/O GDM on insulin from 8th month with uneventful antenatal period. Her last ultrasound scan at third trimester showed findings of placenta previa grade 2, type 2 anterior, oblique lie with 36wks GA. Her blood reports were Hb 9.4gm/dl, platelet count 1.6lakh/cumm, 'A' positive blood group, BT, CT normal. With well controlled blood sugar levels she was posted for Elective LSCS + sterilization.

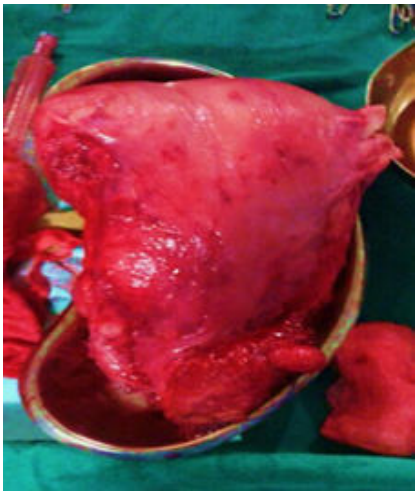


INTRAOPERATIVE FINDINGS:

Following delivery of a male baby at 12:10pm on 4/10/17 of wt 3.1kg spontaneous placental separation did not occur. After a reasonable period of waiting manual separation of placenta was tried but was not successful with some left-over placental bits. Uterus was atonic, giving rise to PPH, patient started collapsing with falling BP 100/60mmHg then 80/40 mmHg.Immediately we called for help of another senior obstetrician,surgeon, urologist, and whole team of anesthetist.Following uterine exteriorization incision site closure was done.Then Internal iliac artery ligation was done bilaterally and then proceeded to caesarean hysterectomy with ongoing blood transfusion. Intraoperatively 5units PRBC and 1unit FFP was given.







POST-OP MANAGEMENT:

Post operatively 1 PRBC ,1 FFP given within 24 hrs with adequate input output. Her Hb was 10.6gm/dl.Drain was 100ml within 24hrs next day it was removed.Along With ongoing parenteral antibiotics and iv fluids patient was managed for first three days then shifted to oral antibiotics from day 4 and continued upto7 days and patient was discharged on day 8th.

DISCUSSION:

Placenta accreta is a rare condition seen in majority of scarred uterus such as those who have undergone CS/myomectomy. Risk of placenta accreta in presence of placenta previa in 1st,2nd,3rd,4th,5th CS is 3%,11%,40%,61%,67% respectively. TVS/TAS gray scale showing high specificity 96-98% and 77-87% sensitivity regarding diagnosis of placenta accreta. In this case late on table diagnosis of placenta accreta following failed manual separation and removal of placenta leading to massive obstetric hemorrhagic shock landed up in emergency caesarean hysterectomy.

CONCLUSION:

This case is an example of irregular ANC and failure of usage of available family planning methods. Planned, Preterm Caesarean hysterectomy without attempting to remove the placenta at the time of surgery is the current ACOG recommended method for management of placenta accreta (including increta, percreta). Each case is different in managing. We have to cautious and careful in quick decision making in order to reduce maternal mortality.

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