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A CASE REPORT ON PLACENTA ACCRETA

Gynecology

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ABSTRACT

With the increased rate of primary and repeated caesarean delivery, a corresponding increase in the occurrence rate of placenta previa and placenta accreta has been observed.

The purpose of case report is to discuss the obstetric disorder of placenta previa with the concurrent occurrence of placenta accreta.(1)

KEYWORDS

INTRODUCTION

Placenta previa occurs when the placenta is positioned in the lower part of the uterus, close to or involving the cervical os(2,3).

Commonly associated with or suspected in the presence of placenta previa is the disorder of placenta accreta, which is a form of abnormal placentation and occurs when the placenta embeds dysfunctionally into the wall of the myometrium.(4,5)

Placenta accreta is a life threatening condition occurring from morbid adhesion between the placenta and the uterine wall so that the neutral plane of cleavage for placental separation after the birth of the baby is obliterated. Abnormal placental attachments are outlined according to profundity of Invasion.

Placenta accreta- The uterine Decidua is absent and the chorionic villi invades the myometrium directly.

Placenta Increta- The chorionic villi invades into the myometrium.
Placenta Percreta- The chorionic villi encroaches through the myometrium.

It may be associated with placenta previa. Placenta accreta during delivery may cause massive obstetric haemorrhage leading to Dissemination Intravascular Coagulation, The need to Hysterectomy, Injury to the uterus and Bladder, Bowel, Acute Respiratory Distress Syndrome, Electrolyte Imbalance and Renal Failure.

The average blood loss at delivery in women with Placenta Accreta is about 1500-2000ml

The purpose of this case report is to review the management of a patient admitted for elective caesarean delivery with known placenta previa and suspected placenta accreta. The case report will be followed by general discussion related to obstetric patients with placenta previa and placenta accreta

CASE REPORT

A 24 years old married Indian G2P1L1A0 with previous LSCS 3years back came to OPD with no fresh complaints came for routine check up with a USG Obstetric with Doppler suggestive of Single Live Intrauterine Fetus of 35.5 weeks of gestation. Cephalic Presentation with Amniotic Fluid Index of 11cms and with a foetal weight of 2.7 kgs and with Doppler within normal limits and with placenta previa with placenta increta with obliteration of retroplacental clear space and involvement of serodal surface of the urinary bladder and urinary bladder partially distended she was 36.5 weeks by Date and 37.1 weeks by first trimester scan.

She previously had a 3years male child LSCS was done due to Pregnancy Induced Hypertension and failure of induction.

She was Hemodynamically stable with a Pulse- 82 beats per minute blood pressure- 130/80 mmHg no pedal oedema urine protein was +1 on urine protein dipstick. Per abdomen examination was as follows uterus was term size, cephalic presentation, cephalic presentation head was floating and abdomen was relaxed.

She underwent an elective LSCS. Spinal with epidural anaesthesia was given and lower segment caesarean section was done which delivered a female child of 2.3kgs. placenta was lying anterioly reaching up to the internal os Placenta was extracted out but some bits of placenta was seen in posterior wall of the lower uterine segment diagnosis of partial placenta accreta was made bits were easily removed from the posterior wall and sutures were taken on the placental beds. and haemostasis achieved Bladder wall was separated and was not invaded by the placenta

Two pints of Pack Cell Volume was transfused intraoperatively which had significant impact on post-operative recovery she recovered well and was discharged on 8th post operative day and a USG of abdomen and pelvis was done on the 8th postoperative day which was within normal limits.

DISCUSSION

Placenta previa occurs when the location of the placenta is low in the uterus and thus the placenta involves or lies close to cervical OS(2).

This area of the uterus has a comparatively rich blood supply and may account for the abnormal occurrence of implantation in the lower uterine segment(6). Multiple risk factors for the development of placenta previa exist, including multiparity, advanced age, previous caesarean delivery, prior uterine surgery, use of cocaine and smoking.(2) These risk factors are all associated with the generalized effect on endometrial atrophy. Classification of placenta previa is based on the degree of placental overlap into the cervical OS and includes 4 subtypes: total, partial, marginal and low-lying.(3)

Placenta previa is a known associated risk factor for the presence of placenta accreta. Therefore when there is a diagnosis of placenta previa there should be suspicion of placenta accreta.

Wu et al(7) stated that “the risk of placenta accreta with two or more prior caesarean scars is increased by 8-fold. The odds for those with previa are increased 51-fold.....”(8)and “In the presence of multiple prior caesarean deliveries plus previa the odds of placenta accreta might increase up to 400 fold”(9) Additional risk factors for the development of placenta accrete include advanced maternal age , previous uterine surgery and previous uterine curettage.(10).

Placenta accrete is the dysfunctional attachment of the entire placenta into the uterine wall(11) this attachment results in increased placental embedment into the uterine wall and resulting impediment of placental detachment.(3). The resulting impact on maternal fetal risk is multifaceted and in compounded by the commonly co-occurring placenta previa. In general maternal morbidity significantly increases in the presence of placenta accreta.(12,13).

Laboratory tests including maternal alpha fetoprotein and creatine kinase have also shown some usefulness without being exclusive diagnostic for placenta accreta. While placenta accreta is suspected in the presence of placenta previa definitive diagnosis does not always occur before delivery. This is partly due to the limitations of the aforementioned radiologic scans and blood tests in confirming the diagnosis(10)

As with placenta previa ideal anaesthetic management of placenta accrete includes elective caesarean delivery (13). Immediate availability of blood products for treatment of maternal haemorrhage is also required. Because the surgical time may be variably extended because of the process of removing the embedded placenta or for performance of a caesarean hysterectomy may be the method of choice for management of known placenta accrete.

While surgical management can include caesarean hysterectomy ligation of causative vessels and partial uterine segment removal are alternatives that may be used in an effort to maintain fertility vessel ligation and uterine segment removal may be preferentially attempted.(2).

Postoperatively, ongoing vigilance is necessitated. Obstetric patients are commonly young, healthy women and, therefore, may not exhibit hypotension until severe hypovolemia has occurred. Nurse anaesthetists, therefore, must monitor closely for earlier indicators of hypovolemia such as narrowed pulse pressure, skin pallor, decreased urine output, and sluggish capillary refill (14). Minimally, patients will require continuous electrocardiographic and pulse oximetry monitoring, with frequent non-invasive blood pressure and temperature monitoring. (14) The patient is at risk for the development of upper airway and pulmonary oedema when large volumes of crystalloid and blood products have been infused. Therefore, endotracheal intubation, mechanical ventilation, and admission to the intensive care unit may be appropriate. Hemodynamic status and organ system response to haemorrhage, including signs and symptoms of neurologic impairment, renal failure, and the development of Sheehan syndrome, must also continue to be closely observed for by nurse anaesthetists. (16) The development of disseminated intravascular coagulation is also a concern. (15),(14) This concern has even heightened relevance if conservative methods involving leaving the placenta in situ have been used. (15)

The patient was in hemodynamically stable condition with no active bleeding, and, therefore, the decision to use regional anaesthesia was well supported by the literature. Packed red blood cells were immediately available for transfusion before initiation of the procedure, and all disciplines involved in the procedure were well aware of the patient's diagnosis and had agreed on the planned course of anaesthetic and surgical management.

Care of a patient with known placenta previa and known or suspected placenta accreta raises even greater potential for emergency surgical and anaesthetic complications. With proper planning, thorough communication, and constant vigilance, the care of a patient with a dual diagnosis of placenta previa and placenta accreta can be safely accomplished.

Placenta accreta is becoming an increasingly common complication of pregnancy. Prenatal diagnosis seems to be a key factor in optimizing the counselling, treatment, and outcome of women with placenta accreta. Caesarean hysterectomy is probably the preferable treatment. Conservative management should only be used in highly selected cases. Even though there may be a rationale to add adjuvant therapy in such cases, there is no evidence-based proof that such therapy is actually of benefit or that it is not in fact harmful

CONCLUSION .

Placenta accreta is a potentially life threatening condition for both mother and baby. The limited understanding of the nature of this condition means that those likely to develop it must be identified through risk factor analysis. Currently, prompt diagnosis of placenta accreta, followed by the development of a delivery management plan that include several haemorrhage-control contingency options, is the only way to reduce the maternal morbidity and mortality associated with this condition. Therefore, this case highlights the need for further research into the prevention of abnormal placental development, so that treatment of complications is not the mainstay of management in this condition and to reduce the risk of massive haemorrhage or emergency hysterectomy in these women hence USG findings are not conclusive and not that informative hence MRI must be done to conclude the diagnosis as in this case USG was suggestive of placenta increta but intraoperative findings were of placenta accreta hence MRI must be done in such cases.

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