



A CASE REPORT OF PLACENTA ACRETA, TREATED BY CONSERVATIVE MANAGEMENT OFFERING INTERNAL; ILIAC ARTERY LIGATION TO SAVE OBSTETRIC HYSTERECTOMY

Gynecology

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ABSTRACT

Placenta accreta is a potentially life-threatening obstetric condition that requires a multidisciplinary approach to management. As the incidence of Caesarean have increased, Placenta accreta also has increased and considered as an important cause of maternal and fetal/neonatal morbidity and mortality. Although multiple caesarean deliveries are at the largest risk factor for the placenta accreta, increasing maternal age and parity, as well as other uterine surgeries are also important. In Patient at risk for accreta, obstetrical ultrasonography performed by an experienced provider should be obtained. A multidisciplinary team in a centre with expertise in managing placenta accreta should care for case of suspected accreta.

KEYWORDS

Caesarean, Hysterectomy, Obstetric haemorrhage, Placenta accrete, internal iliac artery ligation

Placenta accreta is a potential grievous obstetric condition that call for a multidisciplinary avenue for timely management. Placenta accreta refers to placenta that abnormally attaches directly onto or into the myometrium.¹ Three levels of abnormal placental attachments are outlined according to the profundity of invasion, namely Placenta accreta - the uterine decidua is absent and the chronic villi attaches to the myometrium directly. Placenta increta-the chronic villi invades into the myometrium. Placenta percreta-the chronic villi encroach through the myometrium and may permeate to close by organs. 2,3 It is also colligated with Placenta previa. Clinically placenta accreta becomes baffling during delivery when the placenta does not entirely as under from the uterus and is ensued by massive obstetric haemorrhage, leading to disseminated intravascular coagulopathy; the need of hysterectomy; surgical injury to the ureters, bladders, bowel, or neuromuscular structures; adult respiratory distress syndrome; acute transfusion reaction; electrolyte imbalance; and renal failure. The average blood loss at delivery in women with placenta accrete is 3000-5000ml.⁴ The incidence of placenta accrete is 1 in 2500 according to Shinder, S et al.² But there is a run-up in the frequency of placenta accreta 3%, 11%, 40%, 61% and 67% in first, second, third, fourth and fifth caesarean it seem to be parallel to the increasing cesarean delivery rate. The ultrasound and magnetic resonance image (MRI) may or may not indicate clearly an invasive placenta, however final diagnosis is made intra-operatively and supported by histopathological examination.

Case Report :

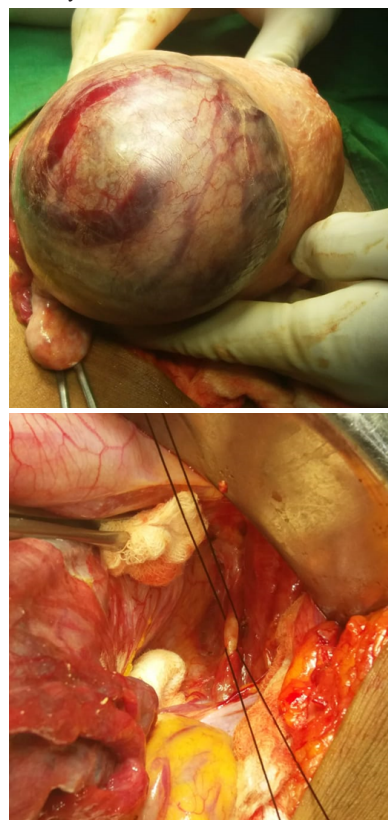
A 30 yrs old married Indian Female, G4P3L3A0 with Previous 3 LSCS was presented with 9 months amenorrhoea with bleeding per vaginum. She had uneventful antenatal period and took regular antenatal care. She was haemodynamically stable with BP 110/78 mm of Hg and pulse of 98/min. On abdominal examination, the contour of the uterus was intact, uterus 36 weeks size with cephalic presentation. The uterus was relaxed, and the foetal heart rate was 146/min, regular. She was investigated for the c/o bleeding p/v by ultrasound, which revealed that the placenta was in the anterior lower segment, reaching up to internal os. The diagnosis of the placenta accreta was suspected due to placenta praevia in the case of previous 3 LSCS, and there was a loss of the retroplacental hypoechoic zone . There was a visualisation of prominent vessels and lakes within the placenta. The decision for the caesarean section was made with the provisional diagnosis of Placenta Acreta in case of Previous 3 LSCS. 5 units of blood and 5 units of FFP were kept crossmatched ready to meet any emergency requirement.

General Anaesthesia was given, and Lower segment caesarean section was performed. Baby was delivered out by breech and a part of the placenta on the upper segment could be extracted out, But the part adherent to the lower uterine segment was densely adherent and was not separated at this stage. The uterus was flabby. There was very active bleeding from the uterus.

The decision for the anterior division of Internal Iliac artery Ligation on bilateral side was taken to prevent the blood loss. The uterus was

delivered out of the abdominal incision. The visceral peritoneal fold between the round ligament and infundibulopelvic ligament was opened and bilaterally anterior division of internal iliac artery ligation was carried out taking care of the ureters medially and internal iliac veins and external iliac vessels laterally. The anterior division of Internal iliac arteries were ligated by No 1 Silk, twice, approximately 1 cm apart. The presence of femoral artery pulse were confirmed bilaterally after ligation of the anterior division of internal iliac arteries bilaterally, to identify and prevent the accidental ligation of the external iliac artery.

Then the separation of the adherent placenta could be done, and few bleeding areas in the placental bed were secured by taking figure of 8 stitches. Satisfactory haemostasis was ensured and the lower uterine segment was sutured to close the uterus. Only 2 BT were given to compensate the blood loss. Postoperatively, she was transferred to postoperative ward. She recovered well and discharged on 4th postoperative day.



Discussion:

There has been rising incidences of all sorts of placental adhesions have risen up due to increased caesarean section rate. Placenta praevia, instrumentation of endometrium, multigravidity, uterine malformation, trophoblastic disease, previous manual removal of placenta and septic endometritis are the important reasons behind the occurrence of adherent placenta. Placenta praevia has the risk of 2 to 5 % having placenta accreta. In such cases, meticulous planning of the management plays a key role. Conservative treatment in form of preservation of the uterus can be accomplished by prophylactic bilateral internal iliac ligation. Alternative interventions include uterine artery ligation and uterine artery embolization.

Magnetic resonance imaging and Doppler sonography can be used for the prenatal diagnosis of placenta increta.¹⁰ However, the diagnostic value of sonography in prenatal diagnosis of an asymptomatic placenta increta is uncertain. A positive predictive value of 78% and a negative predictive value of 94% has been reported by Finberg et al, but some of other authors suggested that sonography might detect only around 33% of cases of placenta accrete /increta. ^{11,12} Regarding treatment, hysterectomy is probably the best option for long-term outcome, as previously reported. ¹³ Numbers of attempts have been made to treat placenta increta with various drugs to allow the pregnancy to continue. ¹⁴ Methotrexate, is the drug most widely used, although its safety and the efficacy in this setting are questionable. ^{15,16}

CONCLUSION:

It is potential life-threatening condition for both mother and baby. In spite of early diagnosis of placenta accrete /increta through MRI, Hysterectomy remains a common procedure. This case highlights need for further research into the prevention of abnormal placental development and to prevent their risk of massive haemorrhage.

ACKNOWLEDGEMENTS

Author would like to thanks to Dr (Col) Rakesh Anand (MS) for the consistent guidance and the successful completion of this research article.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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