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A CASE REPORT OF ACCIDENTAL DIAGNOSIS OF PLACENTA PERCRETA WITH MASSIVE HEMORRHAGE DURING EMERGENCY EXPLORATIVE LAPROTOMY

Anaesthesiology

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ABSTRACT

Here we are describing a case of a 34 year old parturient with 7 months of amenorrhea came for emergency explorative laprotomy with suspecting a gastric bleeding. We had given general anaesthesia. Gastric surgeon was involved. After delivery, a massive hemorrhage was encountered while attempting to separate the placenta from the uterus and that time gynecologist diagnosed that patient was having placenta percreta. Although total hysterectomy was done, but still bleeding was not stopped, so finally urologist was involved and they repair bladder wall, afterwards bleeding was stopped. Total blood loss was 17ooo ml and anaesthesia time was 14 hours. Patient was shifted to ICU and discharged without any complications.

KEYWORDS

placenta percreta, massive hemorrhage, cesarean section.

INTRODUCTION

Placenta accreta is an abnormally firm attachment of placenta to the uterine wall collectively termed "placenta accreta". Accreta is when the placenta is attached directly to the muscle of the uterine wall, increta when the placenta extends into the uterine muscle when the placenta extends through the entire wall of the uterus it is termed placenta percreta. [1] The incidence of placenta accreta ranges from 1 in 530 to 1 in 2500 deliveries, and its incidence have been increased due to an increase in cesarean sections. [2] It is a very high risk surgical condition and requires multidisciplinary approach for the management. It has been reported to have a mortality rate up to 7%.

CASE REPORT

A 34 year old parturient with 7 months of amenorrhea shifted from Gynec ward to operation theatre for emergency explorative laprotomy for gastric bleeding. On clinical examination, she was pale, anxious and she was having acute abdominal pain. Her vitals, pulse rate was 120/min.blood pressure was 100/70 mm of hg. And saturation on air was 100%. Her laboratory investigations were within normal limits except Hemoglobin was 3.4gm. She had history of previous LSCS 7 years back.

We attached all non-invasive monitoring lines and took large bore peripheral intravenous line. We had given general anaesthesia after giving Premedication inj. Glycopyrolate 0.2 mg. inj Ondansatron 4 mg. and inj. fentanyl 100 microgm. For G/A we used inj ketamine 50mg ,inj.thiopental sodium 200mg and inj. scoline 100 mg was given. Patient was intubated with portex 7 no. Endotraceal cuffed tube. The ETT was attached with capnoggraphy. After confirmation, we put her on mechanical ventilation with oxygen, air, and sevoflurane and inj. atracurium as maintenance of anaesthesia. Because of suspecting heavy bleeding, central internal jugular line was secured.

After the incision there was no gastric bleeding but suddenly rupture of uterus occurred, so they delivered the baby immediately. The baby was premature and not cried, so shifted to NICU with Apgar score of 1 at 1 minute. Because of massive hemorrhage, patient's Blood Pressure was dropped 70/40 mm of hg and pulse rate was 180/ min. Peripheral radial arterial pulse was feeble. We were planned for emergency situation but we were not aware about this much massive h'age. We tried arterial line but unable to success. Immediately we informed the blood bank for very large amount of blood and blood products. At the same time we started vasopressur inj. noradrenaline and inj. dopamine in an infusion pump. Simultaneously we send blood sample in laboratory. According to blood reports we had been given 70 blood and blood products. Patient's uterus was removed but still bleeding was not controlled, so finally urologist was joined and he repaired the bladder wall. At last bleeding was stopped and patient's vitals stabilized with supporting catecholamine. Finally we shifted patient to ICU with Bain's circuit. After 8 days she was shifted to room uneventfully.

DISCUSSION

Placenta accreta occurs when the chorionic villi invade the myometrium abnormally. It is divided into three grades based on histopathology: placenta accreta where the chorionic villi are in contact with the myometrium, placenta increta where the chorionic villi invade the myometrium, and placenta percreta where the chorionic villi penetrate the uterine serosa. Once a rare occurrence, placenta accreta is becoming an increasingly common complication of pregnancy, mainly due to the increasing rate of cesarean delivery over the past 50 years. In view of the fact that the indications for cesarean delivery seem to be steadily expanding, including cesarean delivery on maternal request, the incidence of placenta accreta is likely to continue to increase. Wu et al. reported an incidence of 1:533 births for the period from 1982 to 2002, much greater than previous reports ranging from 1:4027 to 1:2510 births in the 1970s to 1980s, suggesting that this increase is mainly the result of the increasing rate of cesarean delivery. Placenta accreta occurs in approximately 1:1000 deliveries with a reported range from 0.04% rising up to 0.9%.[3]Placenta accreta should be suspected in women who have both a placenta previa, particularly anterior, and a history of cesarean or other uterine surgery. The most important factor affecting outcome is prenatal diagnosis of this condition. It gives the opportunity to make a delivery plan that properly anticipates the expected blood loss and other potential complications of delivery. In addition, it gives the opportunity for electively timing the procedure since prevention of complications ideally requires the presence of a multidisciplinary surgical team.[3]

Early diagnosis is important so that the patient can be prepared and adequately counseled for treatment options and their possible consequences. This includes obtaining consent for Caesarean hysterectomy and informing the patient of the risks of sepsis and delayed haemorrhage that may result in situations where the uterus is conserved and the placenta is left in situ.[4]

The multidisciplinary team should include a gynecologist, surgeon experienced in pelvic surgery, a blood bank team prepared to administer multiple blood components, experienced anesthesiology personnel who are skilled in obstetric anesthesia, skilled urologists in case a bladder resection or repair might be required, experienced intensivists for postpartum care, and an experienced neonatologist. In cases where pelvic artery catheterizations are used, an experienced interventional radiologist is also required. Additionally, Eller et al. showed that delivery at a medical center with a multidisciplinary care team resulted in a more than 50% risk reduction for composite early morbidity among all cases of placenta accreta and a nearly 80% risk reduction among those cases wherein accreta was suspected before delivery. [3] Washecka et al carried out a meta-analysis of 54 reported cases of placenta percreta. Even today, the ground reality is that a majority of morbidly adherent placenta are diagnosed during the third stage of labor or during caesarean section and which results in adverse consequences including Exanguinating haemorrhage. [5] Moreover, there is a report that administration of a large quantity of FFP is associated with acute lung injury. Our patient did not develop lung injury.

CONCLUSION

We conclude from this case report that this type of clinical emergency should require the multidisciplinary team work and efficient, effective and skilled work to save the critical patient like preterm parturient with intraoperative diagnosis of placenta percreta.

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Declaration of Conflicting Interests

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