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FUNDAL PLACENTA PERCRETA: A RARE INTERESTING CASE REPORT

Obstetrics & Gynaecology

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ABSTRACT

Placenta percreta is a serious life threatning obstetric complication. Majority of cases are with previous scared uterus which breach endometrium. Antenatal diagnosis of placenta accreta spectrum is of major importance for management. Ultrasound remains the first line of examination for diagnosis of this pathology. Here we present case of fundal placenta percreta in woman with previous scared uterus.

KEYWORDS

placenta percreta, placenta accreta spectrum, hystrectomy

INTRODUCTION

Placenta accreta spectrum (PAS) is a rare complication of pregnancy that occur due to defective decidualization and/or absent of nitabusch membrane. Previously it consists of three types on the basis of invasion of anchoring villi 1) placenta accreta (partially invades myometrium), 2) placenta increta (directly invades to myometrium), 3) placenta percreta (invades serosa and/or adjacent structure). Nowadays we consider this disorder as placenta accreta spectrum. It include both morbidly adherent placenta and abnormally adherent placenta. Previous studies has shown 18-fold rise in maternal morbidity and up to 30% maternal mortality rate especially when there is no prenatal diagnosis%[1].

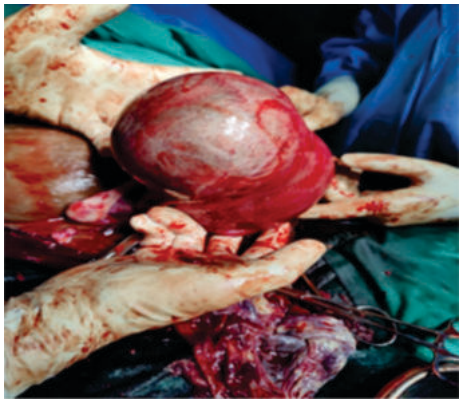

Figure 1.

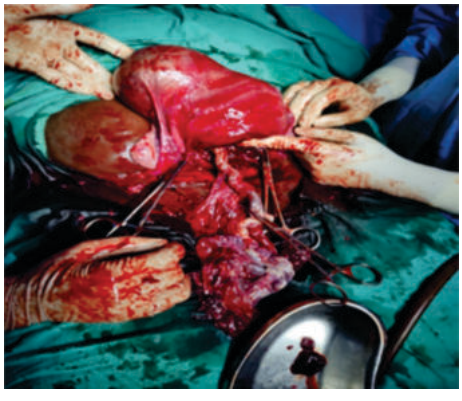

Figure 2.

Case Study

A 24 years G2P1L1 with 38 weeks 5 days of gestation was admitted in labour room in view of abdominal pain since 2 days and raised BP. Her previous LSCS was done 1.5 year back in view of impending eclampsia. There was no history of previous abortion or suction evacuation or any uterine surgeries. She was a booked case at govt hospital at 5 months of pregnancy with no regular ANC follow up.

On Examination, her general condition was moderate, Bp 140/90 mm of mercury in right arm in semirecumbent position, Pulse rate 120/min regular and palpable at all peripheral pulses. There was no pallor, icterus, cyanosis, clubbing or oedema. Per Abdomen examination was suggestive of a single live fetus corresponding to 32 weeks, with podalic presentation and a regular fetal heart rate. Mild uterine contractions were present. Scar site tenderness was present. On per vaginal examination, external Os was closed.

Patient was taken up for emergency LSCS in view of previous LSCS with breech presentation with scar tenderness. Intraoperatively, minimal adhesions were present and scar was thinned out and arcuate uterus with placental attachment in right horn was seen. A live male baby of 2.5 kg was delivered. Baby cried immediately after birth. Placenta did not come out spontaneously. Entire fundus of the uterus was encroached by placenta (Figure 1,2). The serosa of the uterus on fundus on right side was thinned out and attempt to seprate placenta lead to profuse bleeding. No other abdominopelvic organs were involved. Placenta percreta was suspected and in view of the profuse bleeding, blood and blood products were procured immediately and timely decision of obstetrics hysterectomy was made with informed consent. Post operative of patient was uneventful and patient was discharged on 7th post operative day accompanied by her baby. Histopathological report corresponding with intraoperative gross findings, with exaggerated placental site reaction and absence of placental basal plate and presence of trophoblastic tissue in myometrium and serosa.

DISCUSSION

Placenta percreta is a serious life threatning condition with case fatality rate of 7%[2]. It is abnormal invasion of extravillous trophoblast to serosa and or the scarring is formed due to surgical trauma and so on, resulting in local failure of decidualization or poor decidualization, and secondly, the regulation between decidual stromal cells and EVTs is continuously unbalanced, the invasive behavior of villous cells is uncontrolled and the EVTs intensely infiltrate the uterine myometrium to form PAS%[3].

Placenta previa and multiple cesarean sections are currently recognized as autonomous risk factors for PAS%[4,5]. For pregnant women with a history of placenta previa, cesarean sections, and ART, we must be vigilant, select appropriate examination methods, and carefully evaluate whether they have PAS, we should further clarify the degree of placental implantation and fully communicate with patients to inform them of the risk %[6]. Antenatal diagnosis of PAS by ultrasound (transvaginal, transabdominal, and color Doppler) is made during the second trimester of pregnancy when assessing the fetal anatomy and it may be revised again at 32 weeks of gestation%[7,8,9]. On

usg PAS presents as abnormal placental lacunae, loss of retro placental hypoechoic space, abnormalities of uterus bladder interface, myometrial thinning. MRI features of PAS includes uterine bulging, heterogenous signal intensity within placenta, dark intraplacental bands on T2 weighted imaging, focal intrruption of myometrium, tenting of bladder.

Surgical intervention has been suggested as the first line of treatment of placenta percreta as hysterectomy is required in approximately 93% of the cases. Conservative management is exclusively used in rare setting of the adjacent organ involvement such as bowel or bladder. Chemotherapeutic agents, especially Methotrexate, have been used with success in several patients. Furthermore, transcatheter embolization has been utilized%[10]. Neither methotrexate nor arterial embolization reduces these risk and neither is recommended routeinly. Follow up of woman is recommended using usg and serum beta hcg measurement.

CONCLUSION

Ultrasound criteria for placenta percreta should be systematically sought during the second trimester ultrasound as the risk of placenta accreta spectrum is increasing. There should be detailed placental evaluation in patient with previous history of uterine surgeries inspite of placental location. Proper antenatal councelling of patient and relatives should be done in diagnosed case of placenta percreta for planned caesarean delivery followed by hysterctomy.

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