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PERIPARTUM HYSTERECTOMY IN MORBIDLY ADHERENT PLACENTA:

Medical Science

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ABSTRACT

Introduction:A peripartum hysterectomy is typically performed as a lifesaving procedure in obstetrics to manage severe postpartum hemorrhage. Placenta accreta and retention of placenta is inevitable to cause PPH. Right decision at right time by surgeon can save mother's life. **Case Summary:** Here we present a case of Gravida 2, para 1, living 1, with 34 weeks of gestation with previous lscs with placenta previa with placenta accreta with cephalic presentation with scar tenderness. And was planned for emergency caesarean section delivered a live female baby of 2kg, due to profuse bleeding and placental adherence, peripartum hysterectomy was done. **Discussion**: A peripartum hysterectomy is defined as the removal of the uterus within a specific time interval after delivering the baby,and it is mainly due to postpartum hemorrhage (PPH) caused by uterine atony and PAS disorders.Acute and planned hysterectomies are performed during childbirth, mainly as a last resort, to stop or prevent massive, potentially fatal hemorrhages. **Conclusion:** In case of morbidly adherent placenta it is necessary for obstetrician to early identify such conditions and timely intervene to save the mother's life.

KEYWORDS

INTRODUCTION:

The increasing cesarean section(CS) rate worldwide is followed by increased maternal morbidity due to pathological placentation and massive obstetric bleeding.[1]

A placenta previa which covers the internal cervical os or a low- lying anterior placenta that reaches the internal cervical os <2cm in combination with a prior C-Section are the main risk factors for placenta accreta spectrum (PAS) disorders. In PAS the placental trophoblasts invade the decidua basalis (placenta accreta), the uterine myometrium (placenta increta), or through the myometrium reaching the uterine serosa and sometimes into adjacent organs such as urinary bladder, parametrial tissue or abdominal wall (placenta percreta)[1]

A peripartum hysterectomy is typically performed as a life saving procedure in obstetrics to manage severe postpartum hemorrhage. Uterine atony placenta accreta spectrum (PAS) disorders and large myomas are main causes of Severe postpartum hemorrhages (PPH).[2]

Postpartum hemorrhage is preventable by actively managing the third stage of labour and with timely intervention. But inconditions like PAS ,it is inevitable leading to PPH. Right decision at right time by surgeon can save mother's life.

Here we present the case of massive postpartum haemorrhage secondary to placenta accreta in 34 year old gravida 2 para 1 living 1 with previous LSCS managed with peripartum hysterectomy.

Case Presentation:

A 34 year old Gravida 2, para 1,living 1 with spontaneous conception, not a booked case came with 8 months of amenorrhea, percieving fetal movements well came with complaints of pain abdomen and bleeding per vagina since 6 hours came to our Obstetric centre at 11pm. Her gestational age at presentation was 34 weeks. 1st and 2nd trimester were uneventful.Patient have obstetric history of previous lscs 7years back.

On initial physical examination,vitals were within normal limits. Obstetric examination showed fundal height of 34-36weeks, longitudinal lie with cephalic presentation, no contractions.

Fetal heart sound was 142bpm and regular.Per vaginal examination was not done in view of placenta previa.The ultrasound reported as low lying bilobed placenta with multiple intraplacental lakes with minimal uterine tissue near the urinary bladder and multiple vascular channels seen at the internal Os-? Plcaenta accreta.

For further evaluation and confirmation MRI was done and it reported as- Low lying placenta in anterior, posterior and lateral wall with complete covering of the internal os features suggestive of placenta previa with placenta accreta and no other significant abnormality.

Patient was admitted with the diagnosis of Gravida 2, para1, living 1, with 34 weeks of gestation with previous lscswith placenta previa with placenta accreta with cephalic presentation with scar tenderness. And was planned for emergency caesarean section.

Under SAB(Subarachnoid block) parts were painted and draped. Abdomen noted enlarged tortous vessels on lower uterine segment, bladder was separated down. Uterine transverse (kerr's incision) incision given and extracted a female baby of 2 kg, cried immediately after birth.

Placenta was morbidly and densely adherent, profuse bleeding was there so the decision to perform peripartum hysterectomy was made and proceeded with that - following delivery of a live female baby, major vessels were clamped quickly, the round ligaments close to the uterus were divided and doubly ligated. The incision in the vesicouterine serosa was extended laterally and upward through the anterior leaf of the broad ligament.

The posterior leaf of the broad ligament adjacent to the uterus was perforated just beneath the fallopian tube,utero- ovarian ligaments and ovarian vessles.Then these are doubly clamped close to the uterus. The bladder was further dissected from the lower uterine segment by blunt dissection with the pressure directed towards the lower segment.Uterine arteries were palpated, clamped and ligated, separation of the cardinal ligaments and uterosacral ligaments was done and vault was closed by no.1 vicryl ,drain was placed inside and abdomen was closed in layers.

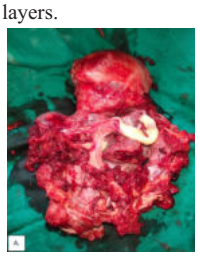

Fig.a: Specimenen Of Peripartum Hysterectomy Of Morbidly Adherent Placenta.

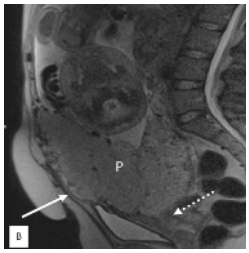

Fig B. Mri Image Of The Placenta Previa With Placenta Accreta.

DISCUSSION:

The incidence of Cesaerean section with Peiripartum hysterectomy due to advanced PAS disorders has increased three-fold during the last few years. The introduction of diagnostic ultrasound and multidisciplinary care was followed by a clear increase in antenatal detection and planned surgery, and evident improvements in maternal perioperative morbidity and early neonatal morbidity. [1]

Peripartum hysterectomy is defined as the removal of the uterus within a specific time interval after delivering the baby,and it is mainly due to postpartum hemorrhage (PPH) caused by uterine atony and PAS disorders.[2]

Acute and planned hysterectomies are performed during childbirth, mainly as a last resort, to stop or prevent massive, potentially fatal hemorrhages. In high-income countries with low maternal mortality rates, obstetric care can be improved by identifying severe acute maternal morbidities, where survival is a "near miss" event.[2]

Placenta accreta is an abnormal invasion of chorionic villi into myometrium, with difficult separation of these two tissues after delivery. The nosologic entity is divided into three grades based on histopathology: placenta accreta, increta and percreta, because they could often not be safely distinguished from one another Macroscopically.The expert hypothesis includes a maldevelopment of decidua, excessive trophoblastic invasion, or a combination of both.[3] However, it is not easy to diagnose PAS prenatally.

Recent meta-analysis study showed only 56.4% of posterior PAS were detected prenatally on ultrasound, and 73.5% of posterior PAS were detected at prenatal magnetic resonance image (MRI).[4]

The reason for increasing rate of placenta accreta is attributed to the increasing rate of caesarean births, uterine currettages and successful treatment of uterine atony withuterine drugs. We observed also that 75 % of patients of PA in this study had a history of previous caesarean section or currettage, and 64 % of patients had a concomitant placenta praevia.[5]

The main histological diagnostic criteria of accreta placentation, that is, absence of decidua between the tip of anchoring villi and the superficial myometrium, is found with increasing incidence with advancing gestation in pregnancies with no clinical evidence of PAS.[5]

Women with PAS were more likely to report grief/ depression, anxiety/worry, and additional surgeries. Decreased quality of life was also reported at 12 and 36months in the PAS group.[6]

Peripartum hysterectomy is the gold standard for the treatment of PAS disorders. However, this radical approach is associated with high rates (40-50%) of maternal morbidity, and 7% rate of maternal mortality[7]

CONCLUSION:

In case of morbidly adherent placenta it is necessary for obstetrician to early identify such conditions and timely intervene to save the mother's life.

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