ORIGINAL RESEARCH PAPER

Gynaecology

A CASE REPORT OF PLACENTA PERCRETA WITH RUPTURE AT FUNDUS OF UTERUS

KEY WORDS: placenta percreta , caesarean hysterectomy

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ABSTRACT

Placenta percreta is a serious pregnancy condition in which chorionic villi penetrates through myometrium, that occurs when blood vessels and other parts of the placenta grow deeply into uterine wall. it is a rare but life threatening condition. Control of massive haemorrhage is the first priority; the patient desire for future pregnancy has to be taken into consideration. Here we present a case where we had to do a quick total hysterectomy because of torrential bleed and shock due to placenta percreta.

INTRODUCTION

Placenta normally implants in upper uterine segment till the baby is delivered. During third stage of labour placenta separates from uterine wall and delivered, this is called after birth.

In adherent placenta chorionic villi invades into the uterine wall and gets attached to the uterus. Three grades of abnormal placental attachment are defined according to the depth of invasion into the muscle layers of uterine wall. Accreta in which chorionic villi attached to the myometrium rather than being restricted within the decidua basalis, it accounts for 75-78% of abnormal placental invasive diseases. Chorionic villi invades into the myometrium in case of increta which accounts for 17% of all placental invasive diseases .with placenta percreta part or the entire placenta remains firmly attached, and penetrates through myometrium upto or through the serosa , 5% of placental invasive diseases are percreta, this can cause severe blood loss after delivery, which may cause haemorrhagic shock and sometimes leading to death. placenta accreta is associated with major pregnancy complications,spontaneous uterine rupture including life-threatening maternal hemorrhage,large volume of blood transfusion,and peripartum hysterectomy,causing a significant maternal and fetal morbidity and even mortality.[1-4]. While treating these cases the doctor looks for the risk to benefit ratio and counsel regarding hysterectomy.

Incidence of adherent placenta in 1980 is 1 in 2500 deliveries, incidence increased to 1 in 533 deliveries in 2002;[2,5] main reason being increased caesarean section rate.

RISK FACTORS: It is thought to be related to abnormalities in the lining of the uterus , typically due to miscarrying(Dilatation and curettage) , after a LSCS(Classical hysterotomy incision has higher risk) or other uterine surgeries[6,7,8,]. This might allow the placenta to grow deeply into the uterine wall, however percreta occurs even without a history of uterine surgeries risk of adherent placenta increased with MSAFP level greater than 2.5 MOM and beta hCG level greater than 2.5MOM.

Pathology:

Abnormally adherent placenta is because of partial or total absence of decidua basalis and imperfect development of fibrinoid or nitabuchs layer. It is characterized by transmural extension of placental tissue across the myometrium with serosal breach. Placental invasion of the myometrium is related to a thinned decidual endometrium at the site of implantation and this can after the above said risk factors.

Diagnosis:

It is diagnosed by the radiological tests like ultra sound, MRI, NT scan[9]. Doppler color flow maping is highly predictive of myometrial invasion. MRI defines anatomy, degree of invasion and possible bladder and ureteric involvement.

Case history:

A 29yrs G3P2L1D1 with 33weeks of gestation referred from area hospital Rajahmundry in view of abdominal pain with bleeding P/V for safe management. At the time of admission patient is grossly pale with BP of 80/60 and heart rate of 128/min. On examination abdomen was tense, size of the uterus was 34wks, uterine contour is maintained, cephalic presentation, with fetal heart rate of 102/min.USG suggestive of heamoperitoneum. Case posted for emergency LSCS in view of? uterinerupture. on opening of abdomen 1lit of hemoperitoneum present with 200 ml of clots. After delivery of the baby placenta is found to be densely adherent to the anterior wall at fundus of the uterus without any plane of separation. Uterus is papery thin and highly vascular with actively bleeding vessels at fundus with 1-2 cm of rupture. Placenta invaded into the myometrium and came out of the rent. Total hysterectomy was done. 3 points blood and 4 points FFPs transfused. Post operative period was uneventful and case discharged after 2 wks.

HPE: serial sections shows features suggestive of placenta percreta. Rupture site shows chorionic villi and trophoblastic tissue on serosal aspect , suggestive of placenta percreta with rupture uterus.

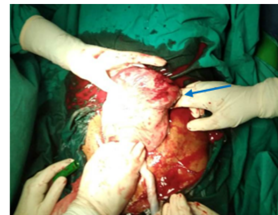

Fig.No.1

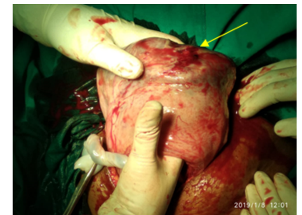

Fig No.2

Figure 1 & 2 shows rupture of uterus at fundus

DISCUSSION:

Placenta percreta cases are increasing from the past 2 decades due to high caesarean section rate. Other conditions are instrumentation of endometrium, uterine malformations, septic endometritis, previous manual removal of placenta and multiparity.

Treatment of placenta percreta is primarly surgical with hysterectomy being the treatment of choice in 90% of cases. Conservative management is desirable in rare cases involving the adjacent organs like bowel and bladder. Non surgical

management includes to leave the placenta in situ to reabsorb and start treatment with chemotherapeutic agents, such as methotrexate. Uterine or internal iliac artery ligation and trans catheter arterial embolization has also been described as a choice of treatment[10,11].

Maternal mortality ranges from 7-10% mainly due to haemorrhage, perinatal mortality accounts for 9% cases mainly due to complications of prematurity[11] . other complications are DIC, injuries to the other abdominal organs, ARDS, renal failure and infection. Psychological counsellig required to prevent depression.[12]

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