ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

A CASE REPORT : PLACENTA ACCRETA , NIGHTMARE OF AN OBSTETRICIAN

KEY WORDS: Placenta accreta, Hemorrhage, cesarean Hysterectomy.

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ABSTRACT

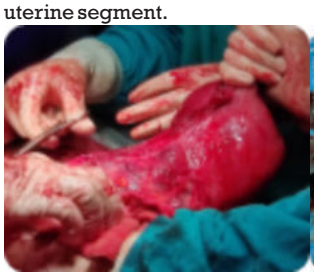
Placenta accreta spectrum has increased as the incidence of cesarean section has increased worldwide and one of the most important cause of fetomaternal morbidity and mortality. In the present study, we report a case of placenta accreta presenting obstetric emergency. A case report of unbooked case who is 29 yr, gravid 2 para 2 with 33 weeks of gestation with one previous NVD followed by one previous caesarean section referred from PHC for bleeding per vaginum and acute fetal distress to our tertiary centre. On ultrasound examination placenta is anterior low lying adherent to myometrium but not invading the myometrium. Immediate caesarean section decision was taken and delivered a preterm healthy female baby weighing 2400 grams. As bleeding was not controlled and an urgent decision of cesarean hysterectomy was taken. Patent was stabilized post operatively and discharged on 8th post operative day after full recovery. Uterus along with placenta sent to histo pathological examination. Later placental pathology came out to be placenta accreta. It is very crucial to diagnose placenta accrete spectrum antenatally by ultrasound with colour Doppler and even with MRI in case of doubtful invasion of placenta into adjacent structures. In our case, patient presents with placenta previa and previous lscs and such a case should be evaluated by multi disciplinary team approach by obstetricians, senior anesthetists and other health care providers. American college of Obstetrics and Gynecologists (ACOG) and (RCOG 2018 Guidelines) recommends cesarean hysterectomy in cases of placenta accreta because removal of placenta leads to massive hemorrhage.. In conditions such as cesarean hysterectomy is unacceptable to women desiring of fertility (uterine) preserving, here placenta is left insitu and regular follow-up is carried out. Hence early antenatal identification of placenta accrete spectrum and its appropriate management is need of the hour.

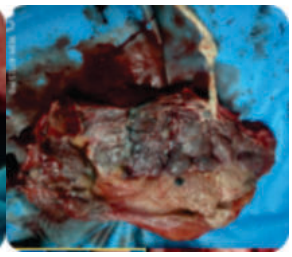
INTRODUCTION:

Morbidly adherent placenta increasing worldwide and accounts for about 7-10%.[1] Placenta accreta spectrum is defined as abnormal invasion of chorionic villi into myometrium. It is classified according to degree of invasion into the myometrium as placenta accreta vera, placenta increta and placenta percreta, with placenta percreta being the most severe but least common one.[2] Placenta accreta - the uterine deciduas' is absent and the chronic villi attaches to the myometrium directly. Placenta increta-the chronic villi invades into the myometrium.[3] Placenta percreta-the chronic villi encroach through the myometrium and may permeate to close by organs. [3] Women who are considered at risk of adherent placenta are those with placenta previa, two or more cesarean sections,[5] advancing maternal age (>35), second trimester serum levels of AFP and free beta HCG greater than 2.5 multiples of median, 3 previous uterine surgeries, previous uterine curettage, multiparity and high gravidity.[6] clinically placenta accreta becomes baffling during delivery when the placenta does not entirely separated from the uterus and is ensued by massive obstetric hemorrhage leading to DIC, need of hysterectomy, surgical injury to ureters, bladder, 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 accreta is 3000-5000ml.[3]

CASE REPORT:

An unbooked case who is 29 yr, gravid 3 para 3, 2 living children, with 33 weeks of gestation with one previous NVD followed by one previous caesarean section referred from PHC for bleeding per vaginum and acute fetal distress to our tertiary centre. Patient was conscious and oriented to time and place. Hemodynamically stable with blood pressure of 90/60 and pulse 96/ min. On ultrasound examination placenta is anterior lowlying adherent to myometrium but not invading into myometrium. An immediate decision of cesarean section was made and delivered a healthy female preterm baby weighing 2400 grams. On placental removal, bleeding was not controlled by all medical and surgical measures. Urgent decision of cesarean hysterectomy was taken and implemented. Meanwhile blood was cross matched and 2 packets of packed red cells were infused. Patent was stabilized post operatively and discharged on 8thy post operative day after full recovery. Uterus along with placenta sent to histopathological examination. Later placental pathology came out to be placenta accreta where placental villi extending deeply into the myometrium of the lower uterine segment, suggestive of placenta accreta in the lower uterine segment.





DISCUSSION:

Incidence of placenta accreta has increased from one in 2500 to one in 533 from 1980s to 2000.[5] Placenta accreta accounts for about 75-80%, placenta increta about 17%, placenta percreta about 5%. Adherent placenta becoming the common indication for peripartum hysterectomy in the last 4 decades, that is from 5.4% to 46.5%. [7] This is mainly due to rising in cesarean section rates. . Prenatal diagnosis helps in optimizing maternal outcome. Ultrasonography is the main tool for diagnosing adherent placenta.[8] Ultrasound findings which are suggestive of morbidly adherent placenta in first trimester gestational sac which is low lying which is attached to uterine scar and thinning of myometrium in the area of scar where it is attached.[9] Such cases should followed up regularly for planning appropriate management.[10] In later trimesters following findings suggestive of placenta accreta : loss of retro placental hypo echoic clear zone , loss of interface between bladder wall and uterus , presence of placental lacunae (vascular spaces) increased vascularity of the interface between bladder wall and uterine serosa on colour Doppler imaging.[11] If USG findings are inappropriate or placenta is located on posterior wall, MRI is recommended. Gadolinium based enhancement in MRI is controversy as it

passes through placenta and enters fetal circulation.[12] Adherent placenta cases should be treated in specialized tertiary care hospital.[13] Multidisciplinary approach by a team of obstetricians , anesthesiologists, neonatologists, and urologists as well as blood banks should be available.[14] ACOG (American college of Obstetrics and Gynecologists) recommends cesarean section for placenta accreta cases as its removal associated with massive hemorraghe.[3] As an alternative segmental uterine resection to preserve fertility can be tried. Other fertility sparing procedures are triple p procedure, cervical inversion technique, placenta left in situ. Placenta in situ and methotrexate use have serious risks such as late post partum hemorrhage, infection, and pulmonary embolism.[3] In this case as it is unbooked case and no antenatal follow-up was done so missed antenatal opportunity to diagnose early and uncontrolled bleeding lead us to do cesarean hysterectomy.

CONCLUSION:

It is life threatening condition for both mother and baby. Antenatal diagnosis may helps in preventing unexpected interventions in emergency situations. Diagnosis is carried out USG mainly sometimes if needed by MRI. Hysterectomy is indicated in majority of cases to prevent major other complications. Antenatal diagnosis with regular follow up and planned elective cesarean sections helps in decreasing maternal and fetal mortality.

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