ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

RARE CASE OF PREVIOUS THREE LSCS WITH PLACENTA PRAEVIA WITH PLACENTA ACCRETA SPECTRUM.

KEY WORDS:

Dr Mayuri Jain Resident

Dr Ashvini Deshmukh Lecturer

Dr Y.S. Nandanwar HOU

INTRODUCTION

- Placenta accreta spectrum is a rare complication of pregnancy. It's incidence is increased due to increased Caesarean sections.

3 types :

1. placenta accreta : extravillous trophoblast directly attaches to myometrium.
2. Increta : it invades myometrium
3. Percreta : it invades serosa and adjacent structures.

- There's a direct corelation between placenta previa and placenta accreta spectrum.
- Grade 1 or minor praevia is defined as a lower placental edge inside the lower uterine segment
- Grade 2 or marginal praevia as lower placental edge reaching the internal os
- Grade 3 or partial praevia when the placenta partially covers the cervix
- Grade 4 or complete praevia when placenta completely covers the cervix.

Grade 1 and 2 are minor placenta previa whereas grade 3 and 4 are major placenta praevia.

Placenta accreta spectrum is a dangerous condition of the pregnancy, which leads to increased maternal morbity and mortality. Hence early diagnosis and management is essential for the good outcome.

Case Report

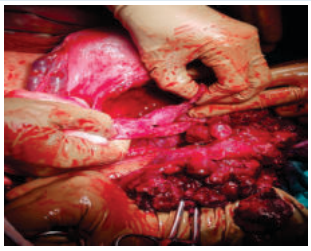
- 34 year old female married since 8 yrs G4p3L3 previous 3 lscs 34.5 weeks by date and by scan came to Opd with complaints of pain in abdomen since 2 days which relieved on rest. No complaints of leaking or bleeding per vaginum. Her recent scan report was suggestive of complete placenta praevia . So patient was admitted and planned for elective lscs after covering steroids.
- Investigations were sent, steroids were given.
- On day 3 of admission, patient started complaining of pain in the abdomen which was not relieved by rest. On examination, her pulse was 110/min BP 100/60 mmhg , per abdo she was having 2 contractions lasting for 30 seconds in 10 minutes, Nst was reactive.

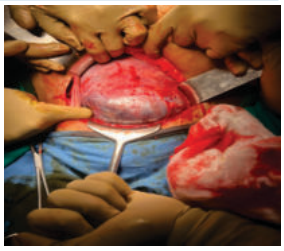
Decision for emergency lscs was made. Adequate blood and blood products were issued.

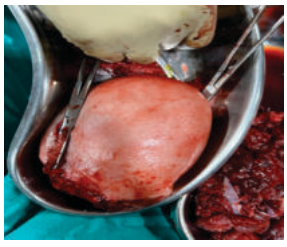
INTRA OP FINDINGS

Complete placenta praevia was seen. Scar dehiscence was present . Placenta was delivered out first manually , baby was delivered via breech extraction.

Focal placenta accreta was present on the lower edge of the uterus which was bleeding continuously. So decision of obstetric hysterectomy was made. Estimated blood loss was about 2.5 litres. 2 PCV 4 FFP 4 platelets were given intra op.







- Post op 2 PCV 4 FFP 4 platelets were given. Patient was kept in ICU for 2 days and was shifted to high risk room once stable. Recovery was uneventful and she was discharged after 7 days. Specimen was sent for HPE which revealed placental villi extending deeply into myometrium of lower uterine segment suggestive of placenta accreta in the lower uterine segment.

Baby cried immediately after birth but was kept in Nicu due to preterm status.

DISCUSSION

The incidence of all sorts of placental adhesions has been rising for the past two decades due to increasing Caesarean section rates. Other predisposing conditions include placenta praevia, instrumentation of endometrium, multiparity, uterine malformations, previous manual removal of placenta. A risk of placenta accreta exists in 2 to 5 percent with placenta previa. Urgent hysterectomy appears to be the treatment of the choice. Conservative treatment can be done in cases of partial placenta accreta with minimal bleeding. Alternative interventions include ligature of uterine artery or internal iliac artery or angiographic embolization. These condition are often missed radilogically. Mri is more sensitive.

CONCLUSION

it's a life threatening condition which has a high maternal and foetal morbidity and mortality rate. Hence it's early diagnosis and proper management is necessary. Proper management and early intervention can prevent rupture and save two lives. Hysterectomy remains the treatment of choice.

REFRERENCES

1. Fox H (1972) Placenta accreata, 1945-1969a. Obstet Gynecol Surv 27: 475-490.
2. Breen JL, Neubecker R, Gregori CA, Franklin JE Jr (1977) Placenta accreta, increta, and percreta. A survey of 40 cases. Obstet Gynecol 49: 43-47.
3. Thia EW, Lee SL, Tan HK, Tan LK (2007) Ultrasonographical features of morbidly-adherent placentas. Singapore Med J 48: 799-802.
4. Thia EW, Tan LK, Devendra K, Yong TT, Tan HK, et al. (2007) Lessons learnt from

two women with morbidly adherent placentas and a review of literature. Ann Acad Med Singapore 36: 298-303.
5. Chou MM (2004) Prenatal diagnosis and perinatal management of placenta previa accreata: Part, present and future. Taiwanese J Obstet Gynecol 43: 6471
6. Rossi AC, Lee RH, Chmait RH (2010) Emergency postpartum hysterectomy for uncontrolled postpartum bleeding: a systematic review. Obstet Gynecol 115: 637-644.
7. Shrivastava V, Nageotte M, Major C, Haydon M, Wing D (2007) Case-control comparison of cesarean hysterectomy with and without prophylactic placement of intravascular balloon catheters for placenta accreata. Am J Obstet Gynecol 197: 402: e1-e5
8. Mok M, Heidemann B, Dundas K, Gillespie I, Clark V (2008) Interventional radiology in women with suspected placenta accreta undergoing caesarean section. Int J Obstet Anesth 17: 255-261.
9. O'Brien JM, Barton JR, Donaldson ES (1996) The management of placenta percreta: conservative and operative strategies. Am J Obstet Gynecol 175: 1632-1638.
10. Tikkanen M, Paavonen J, Loukovaara M, Stefanovic V (2011) Antenatal diagnosis of placenta accreta leads to reduced blood loss. Acta Obstet Gynecol Scand 90: 1140- 1146.