ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

A RARE CASE OF PLACENTA PREVIA WITH PERCRETA WITH BLADDER INVASION

KEY WORDS:

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ABSTRACT

Placenta accreta spectrum (PAS) refers to the abnormal invasion of the placenta to the myometrium, with varying degrees of severity. The condition is linked to deficient decidualization in scarred uterine tissue, and the risk increases when placenta previa is present and with each prior cesarean delivery. In recent times, due to increased incidence of cesareans section, increased IVF procedures and smoking chances of PAS have increased. Placenta previa combined with PAS significantly raises the risk of severe peripartum bleeding, increasing the risk of morbidity and mortality often necessitating operative procedure like caesarean sections and obstetric hysterectomy. Hence, early diagnosis and multiple disciplinary management approach is crucial for such cases

INTRODUCTION

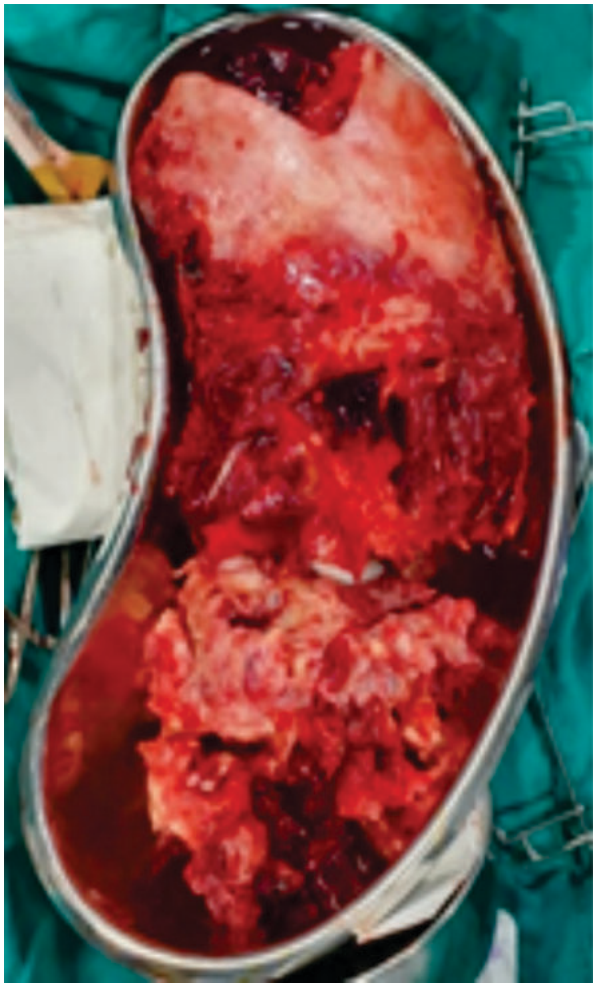
Placenta accreta spectrum (PAS) includes a range of conditions involving abnormal placental attachment and invasion into the uterine wall. The extent of this invasion determines the severity of the disorder. In PLACENTA ACCRETA, the placenta attaches too deeply to the uterine lining without penetrating the muscle. PLACENTA INCRETA is marked by invasion into the myometrium, while the most severe form, PLACENTA PERCRETA, occurs when the placenta penetrates through the uterine serosa and may involve nearby organs such as the bladder, intestines, or surrounding ligaments.

Patients with PAS are at higher risk of prolonged and earlier hospitalization, significant postpartum haemorrhage (PPH), and increased maternal complications, including morbidity and mortality.

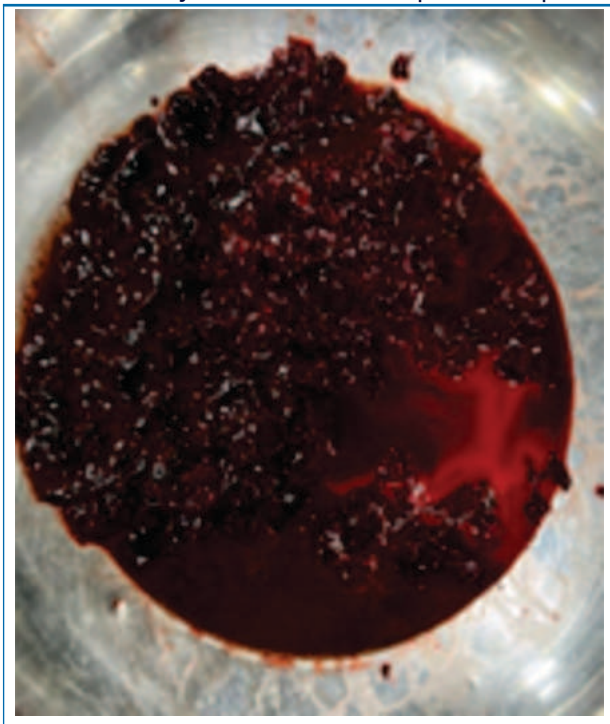
Case Report

30yr/o, G4P3L2D1 (Prev FTVD -> 2LSCS), 33weeks of gestation, outside booked was referred i/v/o USG suggestive of Placenta Previa with Percreta. She presented with complaints of bleeding per vaginum. Patient was vitally stable. On systemic examination uterus was corresponding to the gestational age, fetal heart sound was present. On per speculum examination, bleeding was present. MRI findings were consistent of placenta previa with percreta. Laboratory investigations were normal. Patient was managed conservatively until Day 9 from admission, she went into labour and was taken up for Emergency C-Section. She delivered a healthy Male child with a birth weight of 1.8kg, cried immediately after birth. Intraoperative findings were suggestive of placenta invading the serosal surface of the bladder.

In view of Placenta previa with percreta and due to profuse bleeding (6.5Litres), blood and blood products were transfused and a decision of Obstetric Hysterectomy was made keeping the placenta in-utero. A total of 6 pints blood and 6units of platelets and FFPs were transfused. Immediate postoperatively, patient was shifted to ICU. ICU stay was uneventful and patient was shifted to wards on Day 5. On Day 8, patient had complaints of suprapubic tenderness and hematuria. Urgent ultrasonography and CT scan was done which was suggestive of bladder hematoma. Continuous bladder irrigation was done and patient was taken up for Cystoscopic clot removal. Later, patient had uneventful postoperative period and was discharged on Day 18 after suture removal.



Hysterectomised Specimen



Evacuated Bladder Clots

CONCLUSION

Placenta accreta spectrum disorders occurs due to deficient decidualization in scarred uterine tissue. In addition to these, advanced age, increased incidence of Caesarean sections also are the important factors contributing to the risks. The incidence of Placenta accreta spectrum disorders, increases the chances of Obstetric Hysterectomy leading to higher morbidity and mortality. Hence, timely prenatal diagnosis is crucial for good maternal and neonatal outcome and optimal management at a tertiary care centre where ICU and Blood Bank facilities are available should be done. The management should also include individualized planning of a Elective ceasearn section with multidisciplinary team approach.

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