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Case Report

Unexpected intraoperative recognition of placenta accreta spectrum

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ABSTRACT

The worldwide incidence of placenta accreta spectrum (PAS) is increasing day by day, mostly due to the increasing trends in cesarean section rates. Although standard ultrasound is a reliable and primary tool for the diagnosis of placenta accreta, the absence of ultrasound findings does not preclude the diagnosis of placenta accreta. Therefore, clinical evaluation of risk factors is equally essential for the prediction of abnormal placental invasion. The accurate and timely diagnosis of placenta accreta is important to improve the feto-maternal outcome.

Keywords: Placenta accreta spectrum, Pregnancy, Feto-maternal outcome, LSCS, Cesarean hysterectomy

INTRODUCTION

Placenta accreta spectrum (PAS) is described as aberrant placentation characterized by abnormally implanted, invasive and adherent placenta.[1]

Over the last 40 years, cesarean delivery rates around the world have risen from less than 10% to over 30%, and almost simultaneously a 10-fold increase in the incidence of PAS disorders has been reported. The FIGO (International federation of gynecology and obstetrics) proposed a nomenclature grading system under the umbrella diagnosis of PAS disorders, that replaced the old categorical terminology (placenta accreta, increta, and percreta).[4] Most common risk factor of PAS is number of previous caesarean delivery. Other risk factors are surgical termination of pregnancy, dilatation and curettage, myomectomy, endometrial resection, Asherman's syndrome and nonsurgical scar including IVF procedures, uterine artery embolization, chemotherapy and radiation, endometritis intra-uterine device, manual removal of placenta and previous accrete.[6,7]

The loss of the plane of placental cleavage from the uterine wall and the excessive vascular remodeling can explain increased risk of hemorrhage when manual removal of an undiagnosed placenta accreta is attempted. Invasive PAS is the major concern for maternal morbidity and mortality from uterine rupture, catastrophic postpartum hemorrhage, and urinary tract injury.[5]

CASE REPORT

A 28 years old pregnant female (G3P1A1L1) with POG 34 weeks 4 day reported in LR with chief complaint of pain in lower abdomen. Previous LSCS was done 10 years back due to non-progress of labour and 3 years back at 4 months of amenorrhea she had spontaneous abortion which was followed by check curettage. Her ultrasound report was normal. On general-physical examination pallor was there. Her BP within normal limits but tachycardia was noted. On per abdomen examination fundal height corresponding to POG, uterus was irritable, scar tenderness was there and FHR:156 bpm. On per vaginum examination: cervix was 3-4 cm dilatated, 60-70% effaced, membranes were intact, vx at (-2) station. No fresh BPV noted. Ob-Gyn on duty made decision of emergency LCSC. Lower segment was vascular noted during operation. Incision was made over less vascular plane, delivery of female baby (2 kg). After delivering baby, there was abnormal purplish blue, vascular bulge observed over left lateral aspect of uterus. Suggestive of PAS. So operating obgyn didn't try to deliver placenta. Profuse bleeding was there and intra op

BP falls upto 80/50 mmHg and heart rate was 110 bpm. Decided to do cesarean hysterectomy and specimen of uterus with placenta in situ sent for histopathology examination. Intra op: 2 unit packed red cell blood transfused. Pt was shifted to tertiary care hospital just after cesarean hysterectomy for further treatment and ICU care. Histopathological findings confirmed absence of placental basal plate and presence of fibrin and extra villous trophoblast between villi and myometrial fibers along with thinning of myometrium. Histological features of placenta increta.

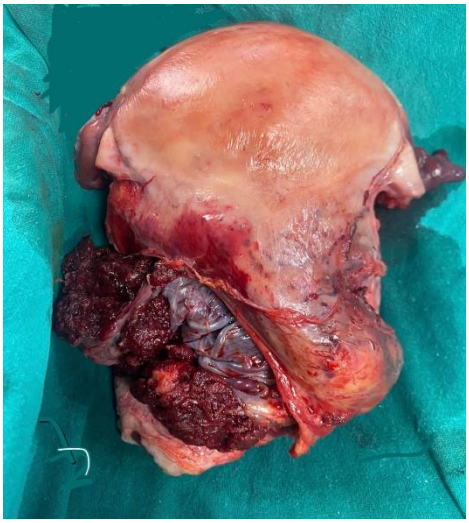

Figure 1: Hystrectomy specimen showing cesarean incision with adherent placenta.

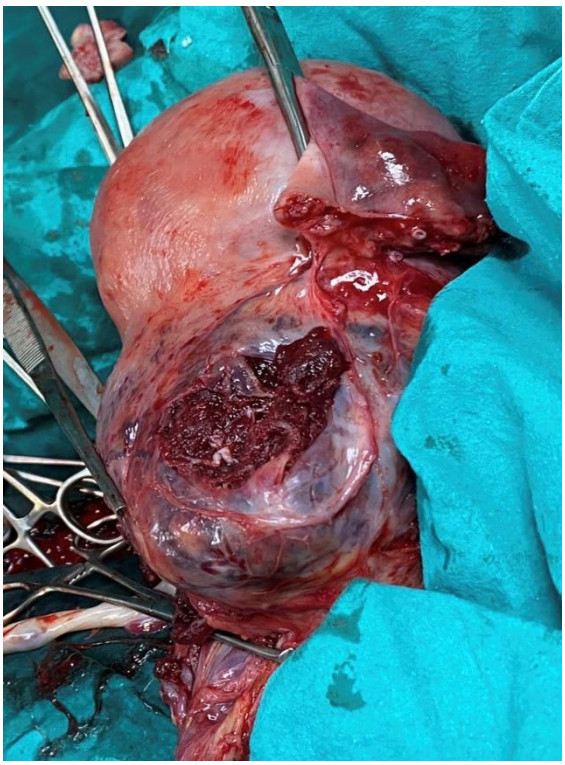

Figure 2: Specimen of total hysterectomy showing adherent placenta at left lateral aspect of uterus.

DISCUSSION

Sometimes placenta accreta spectrum is unexpectedly recognized at the time of cesarean delivery, either before or after the uterus is opened, the fetus is delivered, and attempts to remove the placenta have failed. It is also possible to make the diagnosis of placenta accreta spectrum after vaginal delivery. The level and capabilities of the response will vary depending on local resources, timing, and other factors. It is important, however, that all facilities performing deliveries have considered the possibility of a case of placenta accreta spectrum and have plans in place to manage or rapidly stabilize patients in anticipation of transfer to a higher level facility.

The American college of obstetricians and gynecologists (ACOG) generally recommends cesarean section hysterectomy in cases of placenta accreta because removal of placenta associated with significant hemorrhage.[2,3]

To preserve fertility, conservative and fertility sparing method can be applied, in these method placentae left in situ and use methotrexate. Which have serious risks, such as late postpartum hemorrhage, infection, and pulmonary embolism.[8]

In our case, the diagnosis of placenta accreta spectrum is unexpectedly recognized at the time of cesarean delivery, the fetus is delivered, without attempts to remove the placenta, and total hysterectomy was done.

CONCLUSION

Placenta accreta spectrum is becoming increasingly common and is associated with significant morbidity and mortality. Knowledge of risk factors and antenatal imaging expertise can help guide the diagnosis. Thus, good antenatal care including more frequent antenatal check-ups, correction of anemia during antenatal period, educating the patient's regarding the complications like prematurity, need for blood transfusions and its products and rarely hysterectomy and taking the pediatrician help will definitely reduce the perinatal complications associated with it. A multidisciplinary approach is the best way to reduce morbidity and mortality.

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