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Case Report

Successful management of a rare case of placenta percreta

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ABSTRACT

Placenta accrete syndromes describe abnormally implanted, invasive or adhered placenta. Placenta percreta defines villi that penetrate through the myometrium and to or through the serosa. This abnormal placental in growth is identified, antepartum, by sonography. MR imaging can be used as an adjunct to sonography to define anatomy, degree of invasion, and possible ureteral or bladder involvement. A major decision concerns ideal institution for delivery. Planned delivery in a tertiary care facility is recommended. Timely antenatal diagnosis, plan and management can help prevent maternal morbidity and mortality.

Keywords: Placenta, Percreta, Diagnosis, Syndromes

INTRODUCTION

Placenta accreta spectrum

Accreta, increta and percreta have a very rare occurrence.³ Placenta accreta is abnormal adherence of the placenta to the uterine wall and the most common cause for emergency peripartum hysterectomy.¹ The incidence of placenta accreta has increased recently with increasing caesarean delivery rate. It was 1 in 533 pregnancies for the period of 1982-2002.⁸

Placenta percreta, in which trophoblastic tissues penetrate the serosa of the uterus and may extend directly to adjacent structures, is even more rare and is potentially life threatening.² Placenta percreta may lead to massive obstetric haemorrhage, haemodynamic decompensation, and ultimately death.⁶ The diagnosis is usually established when attempts are made to separate the adherent placenta from the bladder. The management of placenta percreta with invasion into urinary bladder is not well established due to lack of randomized controlled

trials of this uncommon but increasingly significant abnormality. For effective management, familiarity with this condition is crucial.⁷

Informed consent has been obtained from the patient.

CASE REPORT

30 year old gravid 3 para 2 live 1 with previous normal vaginal delivery 6 year back (female baby) expired d/t pneumonia at 2 years age (uneventful anc, pnc period) f/b lscs 3 years later in v/o cpd in labour, male baby alive and healthy, presented to gynaecology opd at 40 weeks POG with Pain lower abdomen. On GPE, patient was conscious oriented to time place person. BP 120/84, PR 100/minutes, afebrile, pallor present. Chest, CVS, CNS examination unremarkable. Per abdomen examination fetus is term size cephalic presentation, FHR 144 bpm along right spinoumbilical line, uterus is irritable, scar tenderness present. On PV examination Os is one finger tight, uneffaced, and central, show present.

Single ANC ultrasound available showing SLF, cephalic presentation, 36 weeks POG placenta anterior, not low lying, liquor adequate. Pt admitted to labour room and planned for emergency LSCS in v/o previous LSCS at 40 weeks POG with scar tenderness.



Figure 1: Placenta invading anteriorly into urinary bladder.

Per-operative findings

Bladder adherent to lower uterine segment, separated via blunt and sharp dissection, LUS incised, placenta cut through, baby delivered as cephalic (female baby, bwt 2.5 kg), cord clamped and cut, baby handed over to Paediatrician, Apgar Score (9,9,9). Spontaneous separation of placenta did not occur and placenta noted to be adherent to lower uterine segment and extending into bladder. Bleeding present.

Emergency peripartum hysterectomy with repair of bladder injury with suprapubic cystostomy performed haemostasis ensured and patient rescued. One PRBC given.

Intra-abdominal drain removed on day 3, SPC removed on day 14, and Folle's catheter removed on day 21. Post op course up till 6 months (on OPD Follow up) is Uneventful.

DISCUSSION

Placenta accreta has been increasing steadily in incidence owing to an increase in cesarean delivery rate.³ Women who had a previous caesarean delivery, other previous uterine surgery, an IVF pregnancy and placenta praevia diagnosed antepartum had raised odds of having placenta accreta/increta/percreta.⁶ Obs USG can be used to diagnose placenta accreta antenatally, which allows for scheduled delivery at multidisciplinary center for excellence. Controversies exist regarding optimal

management, including optimal timing of delivery, surgical approach, and use of adjunctive measures.³ Patients with placental adhesive disorders frequently require urological Intervention to prevent or repair injury to the urinary tract.⁵

CONCLUSION

If when unsuspected, Outcome can be catastrophic to pregnant woman timely diagnosis during ANC period, allows for optimal planning of a multidisciplinary management approach and delivery at a tertiary care institution, USG imaging remains the modality of choice for diagnosis.

Patients with high risk previous LSCS especially should be got an ANC scan from a good USG centre to avoid maternal morbidity and mortality due to adherent placenta.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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