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Case Report

Case report on placenta accreta presenting obstetric emergency

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ABSTRACT

Placenta accreta is a potentially life-threatening obstetric condition that requires a multidisciplinary approach to management. As the incidence of Caesarean have increased, Placenta accreta also has increased and considered as an important cause of maternal and fetal/neonatal morbidity and mortality. Although multiple caesarean deliveries are at the largest risk factor for the placenta accreta, increasing maternal age and parity, as well as other uterine surgeries are also important. In Patient at risk for accreta, obstetrical ultrasonography performed by an experienced provider should be obtained. A multidisciplinary team in a centre with expertise in managing placenta accreta should care for case of suspected accreta.

Keywords: Caesarean, Hysterectomy, Obstetric hemorrhage, Placenta accreta

INTRODUCTION

Placenta accrete is a potential grievous obstetric condition that call for a multidisciplinary avenue for timely management. Placenta accreta refers to placenta that abnormally attaches directly onto or into the myometrium.¹ Three levels of abnormal placental attachments are outlined according to the profundity of invasion, namely 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. Placenta percreta-the chronic villi encroach through the myometrium and may permeate to close by organs.^{2,3}

It is also colligated with Placenta previa. Clinically placenta accreta becomes baffling during delivery when the placenta does not entirely asunder from the uterus and is ensued by massive obstetric hemorrhage, leading to disseminated intravascular coagulopathy; the need of hysterectomy; surgical injury to the ureters, bladders, 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 accrete is 3000-5000

ml.⁴ The incidence of placenta accrete is 1 in 2500 according to Shinder, S et al.² But there is a run-up in the frequency of placenta accreta 3%, 11%, 40%, 61% and 67% in first, second, third, fourth and fifth caesarean it seem to be parallel to the increasing cesarean delivery rate. The ultrasound and magnetic resonance image (MRI) may or may not indicate clearly an invasive placenta, however final diagnosis is made intra-operatively and supported by histopathological examination.

CASE REPORT

A 25 years old married Indian female; G3P2L2A0; with previous two sane vaginal deliveries presented with shock to the emergency department. Her gestational age was 30 wks 6days by LMP. She had a history of loss of fetal movements since 4 days and bleeding per vaginum since 2 days. The antenatal period was uneventful until her presentation at 30 weeks 6 days of gestation with bleeding per vaginum & loss of fetal movements. She was very wan and hemodynamically unstable, cold and clammy extremities with blood pressure 80/50 and pulse 116/min and low volume. On abdominal examination, the uterine contour was intact, uterus 30 wks size, relaxed,

breech presentation. The fetal heart rate could not be localized. The abdomen was mildly distended with muscle guarding present. The decision for caesarean section was made with the provisional diagnosis of placental abruption. She was taken to the operating theatre within 30 minutes from the time of admission. General anesthesia was given. Lower segment caesarean section was done revealing clear amniotic fluid. Placenta was lying posteriorly reaching upto os. An IUD male baby was delivered as breech.

A part of placenta extracted out. But some part of placenta (3x3 cm) was centrally adherent to posterior wall of lower uterine segment and diagnosis of placenta accreta was made. Uterus was flabby irrespective of uterotonics. Urgent decision of hysterectomy was taken i/v/o placenta accreta. Total hysterectomy was done. 2 units of whole blood were transfused intra-operatively. Post operatively, she was transferred to the intensive care unit and received a blood transfusion of 4 units, which had a significant impact on her post-operative recovery. She recovered well and was discharged on 8th post-operative day. The specimen was sent for histopathological examination which reveals placental villi extending deeply into the myometrium of the lower uterine segment, suggestive of placenta accreta in the lower uterine segment.

DISCUSSION

The relative incidence of all sorts of placental adhesion (placenta accreta, increta and percreta) has been up rising for the past two decades, due to increasing caesarean section rates. Other predisposing conditions are instrumentation of the endometrium, placenta praevia, uterine malformations, septic endometritis, previous manual removal of placenta and multiparity. A risk of placenta accreta exists in 2 to 5% with any case of placenta previa. In these cases, resuscitation procedures (when appropriate) and an urgent hysterectomy appears to be the treatment of choice. Antecedently, a conservative treatment, aiming at uterine rescue, was followed to a greater extent, based upon manual removal of as much placental tissue as possible. Fox et al. reported that 25% of the women died during this treatment.⁴ Under these circumstances, the more conservative treatment can be achieved only in cases of a partial placenta accreta/increta, when bleeding is minimal. Alternative interventions include ligation of uterine artery or internal iliac artery, or angiographic embolization.⁵ There are a number of risk factors leading to hemoperitoneum during pregnancy.

Previous gynecological procedures, pregnancies, infections and curettage, trophoblastic disease, and endometrial or cervical malignancies favor such an occurrence.⁶ Spontaneous uterine rupture may also follow adenomyosis, instrumental termination, manipulations during labor, misoprostol-induced labor, or cocaine misuse. In some cases, no cause can be identified, and

these are considered idiopathic.⁷⁻⁹ Magnetic resonance imaging and Doppler sonography can be used for the prenatal diagnosis of placenta increta.¹⁰ However, the diagnostic value of sonography in prenatal diagnosis of an asymptomatic placenta increta is uncertain. A positive predictive value of 78% and a negative predictive value of 94% has been reported by Finberg et al, but some of other authors suggested that sonography might detect only around 33% of cases of placenta accreta/increta.^{11,12} Regarding treatment, hysterectomy is probably the best option for long-term outcome, as previously reported.¹³ Numbers of attempts have been made to treat placenta increta with various drugs to allow the pregnancy to continue.¹⁴ Methotrexate, is the drug most widely used, although its safety and the efficacy in this setting are questionable.^{15,16}

CONCLUSION

It is potential life threatening condition for both mother and baby. In spite of early diagnosis of placenta accreta/increta through MRI, Hysterectomy remains a common procedure. This case highlights need for further research into the prevention of abnormal placental development and to prevent their risk of massive hemorrhage.

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