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Case Report

Diagnosis of placenta accreta with postpartum hemorrhage in the case of pregnancy termination

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ABSTRACT

The placenta normally attaches to the uterine wall, however there is a condition that occurs where the placenta attaches itself too deeply into the uterine wall. This condition is known as placenta accreta, increta or percreta depending on the deepness of the placenta attachment. This study aimed to present the patient who induced with prostoglandin E2 (misoprostol) for 22 weeks intrauterine mort fetus and then hysterectomized because of atony and placenta accreta.

Keywords: Placenta accreta, Postpartum hemorrhage, Pregnancy termination

INTRODUCTION

Morbidly adherent placenta is a general term including placenta accreta, increta and percreta. Placenta accreta is an abnormality of placental implantation in which the anchoring placental villi attach to myometrium rather than decidua.

Placenta increta refers to chorionic villi penetration into the myometrium, whereas chorionic villi penetrates through the myometrium to the uterine serosa or adjacent organs in placenta percreta.¹ The underlying pathogenetic mechanism is defective decidualization of the implantation site.² The incidence of placental insertion anomalies is increasing attributed to the increasing prevalence of cesarean delivery in recent years.³

This study aimed to present the patient who induced with prostoglandin E2 (misoprostol) for 22 weeks intrauterine mort fetus and then hysterectomized because of atony and placenta accreta.

CASE REPORT

42-year-old woman with gravida 5, parity 2, abortion 1 and curettage 1 was sent to our clinic from the external center because of intrauterine mort fetus. The vital signs and laboratory values were normal at the first examination of the patient. Ultrasonography revealed 22 weeks of gestation with fetal breech presentation and normal amniotic fluid volume and no fetal heart beat. The distance between the lowest edge of placenta and internal os was 2 cm. The patient was admitted for induction.

100 mcg of misoprostol was administered on a vaginal route at intervals of 6 hours. The patient was taken to the birth room upon the development of spontaneous water and the beginning of bleeding at the end of the day. On follow-up, it was observed that there were malodorous leukorrhoea, a fever of 38 degrees and uterine sensitivity, and antibiotics were started. At the end of the 4th day, the patient was aborted.

While spontaneous separation of the placenta was waiting, sudden massive bleeding began before the curettage. The laparotomy decision was made on the patient's blood pressure 60/40 mm Hg and pulse 150/min. Placenta was still unseparated and bleeding was continuing. On the beginning of the operation, the hemoglobin level was 4.5 g/dL and hematocrit level was 12%. It was observed that the uterus was infected and malodorous (Figure 1). The placenta was adherent to uterine wall starting from the fundus to the cervix. Hysterectomy was decided. During the operation, 5 units of erythrocyte suspension, 3 units of fresh frozen plasma and 2 grams of fibrinogen were transfused. The patient was discharged on postoperative 6th day when her condition became well.



Figure 1: Infected uterus.

DISCUSSION

Placenta insertion anomalies can be confronted with intense bleeding after curettage in the first and second trimester pregnancy losses.⁴ Ultrasonography (USG), 'power doppler' ultrasonography or magnetic resonance imaging (MRI) can be used for diagnosis. Ultrasonography may be helpful in suggesting placental insertion anomalies in the presence of loss of normal hypoechoic zone of retroplacental myometrium, thinning or interrupting of the hyperechogenicity between uterine wall and bladder, presence of focal exophytic mass suggesting the invasion to the peripheral organs especially the bladder.⁵

Intensive bleeding starts with the separation of placenta in placenta insertion anomalies. Successful treatment was provided by emergency blood transfusion and hysterectomy in our case. Conservative treatments can also be used in the management of placenta insertion anomalies. Conservative methods are closure of the uterine defect, B-Lynch suture, uterine 'packing', hypogastric or uterine artery ligation.⁶ If conservative treatments are preferred, physicians experienced in pelvic dissection should be involved because of the frequency of maternal morbidity and mortality.⁷

CONCLUSION

As a conclusion, placenta insertion anomalies should be kept in mind in cases with bleeding after abortion especially in women with risk factors such as previous cesarean section, placenta previa, advanced maternal age, uterine surgery.^{8,9} Findings of placentation anomalies from the first trimester should be investigated by ultrasonography in these women. Hysterectomy may be required after abortion for abdominal bleeding in untreated cases. It should be kept in mind that urgent hysterectomy is more risky than planned hysterectomy, requiring more blood transfusion, resulting in more infection and more harmful to the adjacent organs, especially bladder.

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