

Placenta accreta: Case report presenting obstetric emergency

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Abstract

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.

In the present study, we report a case of placenta accreta presenting obstetric emergency. A 33-year-old woman, gravida 2 para 2 (G2P2), with previous caesarean section for acute fetal distress, for the second pregnancy, antenatal period was not followed until her presentation at 34 weeks of gestation in the obstetric emergency for bleeding per vaginum. Ultrasound showed low-lying anterior placenta type 2 of Bessis classification. The decision for caesarean section was made for suspicion of dehiscence, and was performed with corporeal incision. A healthy 2900g female newborn was delivered. Placenta increta was thought with intra- operative (figure1) So, it was not removed due to the possibility of bleeding and an Urgent decision of hysterectomy was taken (figure2).

The patient was discharged on the third postoperative day. The placental pathology was reported as a placenta accreta. Antenatal diagnosis of placenta accreta spectrum is critical because it provides an opportunity to optimize management and outcomes with obstetric ultrasonography and color flow Doppler imaging even RMI if it necessary, in our case, the patient present placenta previa and previous cesarean delivery, and should be evaluated by obstetrician gynecologists or other health care providers with experience and expertise in the diagnosis of placenta accreta spectrum, before obstetric emergency. The American College of Obstetricians and Gynecologists (ACOG) generally recommend s cesarean section hysterectomy in cases of placenta accreta because removal of placenta associated with significant hemorrhage. However, conservative and fertility sparing methods can be applied in selected cases. This case highlights need for further research into the prevention of abnormal placental development and to prevent their risk of massive hemorrhage.

Keywords: Caesarean, Hysterectomy, Obstetric hemorrhage, Placenta accreta

Introduction: Placenta accreta is defined as abnormal trophoblast invasion of part or all of the placenta into the myometrium of the uterine wall. Three levels of this abnormal placental attachments are outlined according to the profundity of invasion, namely Placenta accreta - the uterine decidua's 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. Its incidence has been rising in recent years and this appears to correlate with the increase of caesarean section rates.

Maternal morbidity and mortality can occur because of severe and sometimes life-threatening hemorrhage, which often requires blood transfusion.

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.

Case report

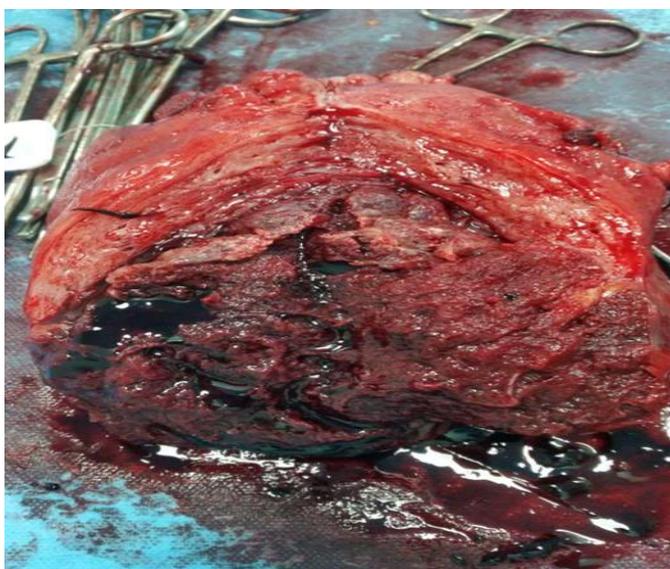
A 33-year-old woman, no pathological antecedents, gravida 2 para 2 (G2P2), one living child, with previous caesarean section for acute fetal distress. For the second pregnancy, antenatal period was not followed until her presentation at 34 weeks of gestation in the obstetric emergency for moderate bleeding per vaginum. She was conscious, very wan and hemodynamically unstable, cold and clammy extremities with blood pressure 80/50 and pulse 120/min. Ultrasound showed low-lying anterior placenta type 2 of Bessis classification. The decision for caesarean section was made for suspicion of uterine dehiscence, and was performed with corporeal incision. Patient was taken to the operating theatre within 30 minutes from the time of admission. General anesthesia was given. A healthy 2900g female newborn was delivered. Placenta increta was thought with intra- operative (figure1) So, it was not removed due to the possibility of bleeding and an Urgent decision of hysterectomy was taken (figure2). The patient was discharged on the third postoperative 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.

Figure1:

Placenta increta was observed in the lower uterine segment



Figure2: Specimens' hysterectomy



Discussion

The incidence of an abnormally invasive placenta is reported to occur in 2–90/10,000 births and has increased over the past 30 years and is still increasing, due to increasing caesarean section rates.

According to a study in our hospital, reported by Slaoui et al, the incidence rate was of 1/5824 or 0.017%. Our lower incidence rate compared to data from the literature can be explained by the fact that screening is more effective in developed countries than in low- and middle-income countries.

Other predisposing conditions for placenta accreta are instrumentation of the endometrium, placenta praevia, uterine malformations, septic endometritis, previous manual removal of placenta and multiparity. The risk of abnormal placentation in subsequent pregnancies increases with the number of previous caesarean sections. This risk 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.

In china, Shi XM et al report that women with a primary elective cesarean section without labor have a higher chance of developing an accreta in a subsequent pregnancy that is complicated with placenta previa.

Antenatal diagnosis of placenta accreta spectrum is critical because it provides an opportunity to optimize management and outcomes.

Doppler sonography and Magnetic resonance imaging can be used for the prenatal diagnosis of placenta increta. 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. The diagnosis of certainty is histological; it is mainly posed per-partum in front of the absence of cleavage zone between the placenta and the myometrium thus making delivery difficult or impossible.

In our case, the combination of placenta previa and previous cesarean delivery, should be evaluated by obstetrician gynecologists or other health care providers with experience and expertise in the diagnosis of placenta accreta spectrum by doppler sonography.

Regarding treatment, 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. However, Segmental uterine resection may be an alternative to cesarean hysterectomy, to preserve fertility or to protect the uterus, in cases in which there is no placenta previa.

Others conservative methods and fertility sparing can be applied, these methods include placenta left in situ, cervical inversion technique and triple-P procedure. Placenta left in situ and methotrexate use have serious risks, such as late postpartum hemorrhage, infection, and pulmonary embolism.

In our case, the diagnosis of placenta accreta spectrum is unexpectedly recognized at the time of cesarean delivery, either

before the uterine incision, the fetus is delivered, without attempts to remove the placenta, and subtotal hysterectomy was done.

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.

Biography:

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