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SUSPICION OF PLACENTA ACCRETA IN CASE OF PLACENTA PRAEVIA WITH RISK FACTORS

PREETHA G

Department of Obstetrics and Gynaecology, MADRAS MEDICAL COLLEGE AND OVERNMENT GENERAL HOSPITAL

Abstract : Placenta accreta incidence has increased tenfold due to increasing number of caesarean sections.30 year old G5P3L2A1 Previous 2LSCS,LMP on16.12.13 and EDD on 23.09.2014 admitted with complaints of bleeding per vaginum for past 1 day.Patient afebrile, mild pallor,Abdomen-Uterine size corresponding to 34 weeks, not acting, head mobile,FHR was good, no bleeding per vaginum. CBC, RFT, LFT, bleeding time ,clotting time and Coagulation profile were normal. USG revealed Single Live Intrauterine Gestation with cephalic presentation corresponding to 34 weeks, Liquor adequate, FHR is good, Placenta is central completely covering the OS. MRI Pelvis revealed Gravid Uterus, single term fetus with complete placenta praevia with focal bulge in the posterior wall with loss of myometrial hypointense border suggesting placenta accrete. Antenatal steroid course given, due to another bout of bleeding, Emergency LSCS with total in situ hysterectomy done. The placenta was central completely covering the OS and does not separate after baby delivery and hence proceeded with insitu hysterectomy. Baby is alive, preterm alive and healthy, postoperative period was uneventful. Conclusion Women with previous caesarean scar found to have a placenta praevia especially anterior should suspect accreta. MRI used especially in posterior placenta to rule out local invasion and invasion into the adjacent structures.

Keyword : Placenta accreta, Placenta praevia, Decidua basalis, Amennorhoea, Caesarean section, Hysterectomy.

Introduction

Placenta accreta is a rare incidence with incidence rate of 0.4%.A defect in the dedidua basalis resulting in abnormally invasive implantation of the placenta. The incidence has increased tenfold in the past 50 years due to increasing number of caesarean sections and the maternal age.

Case presentation

30 year old G5P3L2A1 / Previous 2 LSCS ,RH positive , LCB-2 years back, last menstrual period on 16.12.13 and expected date of delivery on 23.09.2014 admitted through casualty with complaints of bleeding per vaginum for past 1 day, no history of pain abdomen or draining per vaginum and she able to perceive fetal movements well.

Marital H/O: Married for past 12 years , non consainguinous marriage. Menstrual H/O: Regular menstrual cycles flow lasting for 3 days, cycles occurring once in 30 days. Obstetric H/O: 1) IUD at 7 months amenorrhoea, preterm vaginal delivery at Thiruvannamalai GH,2)Spontaneous abortion at 3 months amennorhoea and dilatation and curettage done at private hospital,3)Fullterm LSCS – Indication :failed induction , birth weight 3 kg,Female child,alive and healthy ,4)Fullterm LSCS-indication: previous LSCS/Prom in labour , birth weight 2.75kg ,female child 2years alive and healthy. Past H/O: No H/O hypertension, diabetes mellitus, cardiac disease, epilepsy, thyroid disease and no h/o blood transfusion in the past. On Examination Patient afebrile, mild pallor+ no pedal oedema,CVS-S1S2, RS-Normal Vesicular Breath Sounds heard, Abdomen Examination-Uterine size corresponding to 34 weeks, not acting, not tense, not tender, head mobile, Fetal heart rate is good(140/minute).On local examination: no bleeding per vaginum.

Investigations

Haemoglobin -11.7gm/dl, PCV -31%,Platelet count-1,88,000 cells/mm3,blood sugar -105mg/dl, blood urea-27mg/dl, serum creatinine-0.8mg/dl,SGOT-30 IU/L,SGPT-10 IU/L, serum bilirubin -1.0mg/dl, bleeding time -1minute ,30 seconds, clotting time-4 minutes, 45 seconds, Prothrombin time-13.7 seconds, Partial thromboplastin time-21.1 seconds, serum fibrinogen -314mg/dl . Ultrasound Examination revealed Single Live Intrauterine Gestation with cephalic presentation corresponding to 34 weeks ,Liquor adequate , Fetal heart rate is good, Placenta is cental completely covering the OS,MRI Pelvis was done which revealed a Gravid Uterus, single term fetus (Fig; 1) with complete placenta praevia (Fig; 2 & 4)with focal bulge in the posterior wall (Fig; 3) with loss of myometrial hypointense border suggesting placenta accrete (Fig 5).

Management

Antenatal steroid course started and since patient had another bout of bleeding, planned for Emergency repeat LSCS, Proceeded to total in situ hysterectomy (Fig; 6,7) on 14/8/14,10.21 AM , Intraoperatively the uterine incision site was made away from the placental site and the baby was delivered

without delivering the placenta. The placenta was central completely covering the OS and does not separate after baby delivery and hence proceeded with insitu hysterectomy (Fig; 8). One unit of whole blood and 2 units of fresh frozen plasma was transfused intraoperatively. Baby is alive ,preterm boy,2.1 kg ,APGAR of 7/10 in 1 minute and 8/10 in 5 minutes, post operatively 1 unit of packed cell was transfused, postoperative period was uneventful, and patient was discharged on 10th postoperative day.

Conclusion

Women with previous caesarean scar found to have a placenta praevia especially anterior placenta should be suspicious of placenta accreta. Basic grey mode ultrasound with colour Doppler will help in the diagnosis. MRI may be used as a adjunct to ultrasound especially in posterior placenta to rule out local invasion and invasion into the adjacent structures. Patients with previous caesarean section and antepartum diagnosis of placenta praevia are at the highest risk of placenta accreta. The risk increases with the number of previous caesarean sections, increasing from 15% after one caesarean section to 30% after three caesarean sections and the other risk factors are including previous uterine surgery and dilatation & curettage.

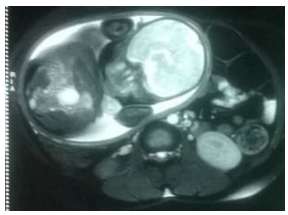

Fig. 1

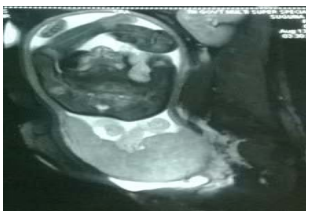

Fig. 2

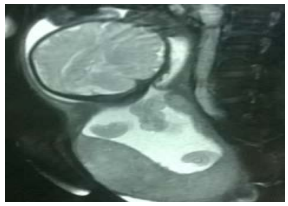

Fig. 3

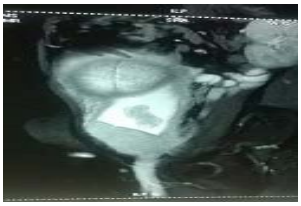

Fig. 4

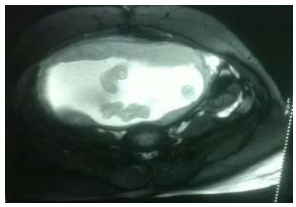

Fig. 5

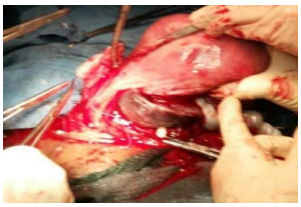

Fig. 6

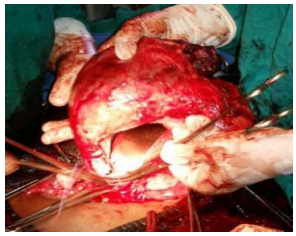

Fig. 7

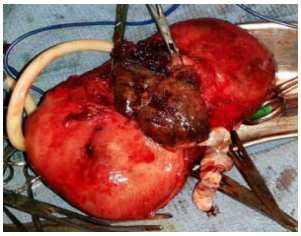

Fig. 8

RESUBMISSION

1)Since the patient had two caesarean scars and one surgical abortion with placenta pravia, MRI was done to rule out placenta accreta.

2)MRI is not necessary for all cases of placenta praevia.

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