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Case Report

A Rare Case of Placenta Increta Case Report

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Abstract: The placenta can invade the myometrium up to varied levels leading to morbid adhesions of the placenta. This can present as acute abdomen and rarely with hemoperitoneum which is highlighted in this case.

Keywords: placenta Increta, hemoperitoneum, myometrial lining, sonography.

INTRODUCTION

Placenta percreta, one of the rare and very severe form of the placenta accrete spectrum, occurs when placenta extends through the entire layers of myometrium and uterine serosa. Placenta percreta is with a very low incidence rate of 1 in 21,000 pregnancies and most commonly seen in patients with previous history of LSCS with anterior low-lying placenta. The fundus of the uterus has thick myometrial lining and is seldom or almost never involved in percreta unless there is an history of fundal surgery in the past. Here we present the case fundal placental percreta in woman with previous history of LSCS.

CASE REPORT

Mrs. ANITHA, a 34 years woman, G2 P1 L1 A0 presented to the emergency department of SreeBalaji Medical college and Hospital with complaints of amenorrhea for 30 weeks and acute pain in lower abdomen for 2 days. There was no history of fever or trauma.

On examination: she was averagely built and well nourished. She had severe pallor, a pulse rate of 120bpm and blood pressure of 120/80mmhg. Abdominal examination revealed a tense and tender abdomen and the uterine size and the presentation could not be assessed. FHR was 140bpm. A clinical impression of 30 weeks on going pregnancy with diffuse peritonitis was made. The laboratory investigations shows a haemoglobin of 6.9g/dl. DC with LFT, RFT were normal. Sonography shows a single live viable fetus corresponds to 29 weeks of gestation with excess liquor and with free fluids in peritoneal cavity (hemoperitoneum). She was taken for emergency exploratory laparotomy, which revealed 3 litres of blood and clots. All other abdominal organs including the liver, spleen and gut were explored and found to be normal and proceeded with caesarean section which resulted in still birth, female baby with associated polyhydramnios. The placenta was found adherent to the posterior wall of uterus and no cleavage was found so could not be removed completely. The placental bed continued to bleed continuously, suturing and subtotal hysterectomy was done. The post-operative period was uneventful and discharged the patient from the hospital in a satisfactory condition. This case is being presented because of its unusual presentation.

DISCUSSION

There are three levels of abnormal placental attachments according to the profundity of invasion, namely placenta accrete – the uterine deciduas is absent

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and chorionic villi attach myometrium directly. In Placenta increta, chorionic villi invade into the myometrium. In Placenta percreta, the chorionic villi encroaches through myometrium and permeate to close by organs. Placenta acreta occurs approx in 1 out of 7000 pregnancies. Out of them, 76 to 80% are placenta acreta and 17 percent are placenta increta and rest are placenta percreta.

Many Risk factors associated with placenta percretaincludes previous caesarean section, multiple pregnancies, advanced maternal age, placenta Previa, dilatation and curettage, endometritis and repetitive abortions. Comparing to the rest of uterine cavity, lower uterine segment proximal to the cervical canal contains comparatively less decasualized tissue. In Women with placenta praevia undergoing caesarean delivery,the frequency of PAS increases with an increasing number caesarean deliveries as follow.

The diagnostic value in sonography of prenatal diagnosis of asymptomatic placenta increta is uncertain. A PPV of 76% and negative predictive value of 94% has been reported by Finberg ET al, but some authors suggested that sonography might detect only around 34% of cases of placenta acreta/increta. Placenta lacunae (which appears as a intraplacentalsonolucent space) and disruption of the interface between the bladder wall and uterine serosa (bladder line) are the most reliable diagnostic sonographic findings. Colour follow Doppler demonstrates turbulent (chaotic) flow and/or bridging vessels are confirmatory findings. If the ultrasound studies are inconclusive or ambiguous, magnetic resonance imaging is performed to clarify the diagnosis if this may affect patient's management; however, the utility of additional information gained by MRI is uncertain. The MRI findings may be more useful than USG in two clinical scenarios: (1) evaluation of a possible posterior PAS is because the bladder can not be used to help clarify the placental myometrial interface, and (2) assessment of depth of involvement myometrium and parametrium involvement, and if the placenta is anterior, bladder involvement. However increased accuracy is beyond that noted with ultrasound is unproven. Diagnosis proceeded by histopathology. Postpartum histological findings of placental villi anchored directly on or invading the myometrium without an intervening decidua. Surgical intervention has been suggested as one of the treatment of placenta percreta mostly like hysterectomy is required approximately 94% of the cases. Conservative management is preferred rarely in case of adjacent organ involvement such as bowel or bladder. Chemotherapeutic agents, likely methotrexate have been used with success in many patients. Trans Catheter embolization has been reported as successful nonsurgical treatment of placenta percreta by methotrexate patient with chemotherapy able to carry normal pregnancy 2 years later. In contrast to this study, Butt *et al*., declared that the conservative management with methotrexate is unsuccessful and would end up with subsequent hysterectomy because of postpartum bleeding. In patients with extreme desire of fertility, the functional and anatomical uterine repair may lead to successful pregnancy. But hysterectomy is the one and only lifesaving intervention of the patient with severe internal bleeding. a patient is in non-severe life threatening condition like the small uterine rupture, surgical uterine repair may be more feasible for those who have tendency to remain fertile.

CONCLUSION

Placenta percreta is the most potential life-threatening condition for both mother and the baby. It occurs most commonly at the site of previous sections scar. This case highlights need of detail placental evaluation at 18-20 weeks scan irrespective of the location of the placenta and previous scar. This would enable prenatal screening and diagnosis which would help in counselling the patient and her family regarding the suspected placental abnormality and an appropriate site and plan for delivery. Preoperative preparations includes availability of surgical and radiological expertise, blood components for transfusion and appropriate equipment may improve the maternal and fetal outcome.

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