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Case Report

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PLACENTA INCRETA – A CASE REPORT

Dr. Poornima M.*[1], Dr. Rekha G. Daver[2], Dr. Vilas N. Kurude[3]

[1]Resident, [2]Professor and Head, [3]Associate Professor and Unit Incharge, Obstetrics and Gynaecology Department, Grant Government Medical College and Sir JJ Group of Hospitals Mumbai.

***Correspondence for Author: Dr. Poornima. M**
Resident, Obstetrics and Gynaecology Department, Grant Government Medical College and Sir JJ Group of Hospitals Mumbai.

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ABSTRACT

Placenta increta is a rare and often life-threatening complication of pregnancy. Placenta increta is characterized by partial or complete absence of the decidua basalis. Placenta increta usually presents with vaginal bleeding during difficult placental removal in the third-trimester. Although placenta increta may complicate first and early second-trimester pregnancy loss, the diagnosis can be very difficult during early pregnancy and thus the lesion is difficult to identify. We present here the case of a woman who presented to us in 2nd trimester with history of P/V leaking. Initially the patient was managed conservatively ie with tocolytics and rest. Patient responded to tocolytics but 2 weeks later went into spontaneous labour and delivered extremely low birth weight baby (750 gms). In immediate post partum period patient developed Post partum haemmorhage. Later patient was diagnosed to be having placenta increta and a subtotal hysterectomy was done.

KEYWORDS: Placenta Increta, Second Trimester, Subtotal Hysterectomy.

INTRODUCTION

Abnormal invasion of the placental tissue into the myometrium is called Placenta accreta (PA). PA is defined as superficial invasion, placenta increta as middle layer invasion and placenta percreta as deep invasion, which is the most severe form of PA with an incidence of one in 7000. All three types are collectively known as placenta accreta. Previous LSCS is one of the known risk factors for placenta accrete. And LSCS is one of the reasons of increase in the incidence of placenta accrete.[1,2] Placenta increta is one of the severe and in some cases life threatening complication of pregnancy. Maternal morbidity and mortality associated with PA is mainly due to postpartum haemorrhage or obstetric hysterectomy which sometimes may be the only life saving procedure available. PA is often diagnosed during delivery or in immediate post-partum period leading to an obstetric emergency.[3,4] It is of utmost importance that PA be diagnosed early. Early diagnosis of PA may reduce obstetric complications and consequently need of hysterectomy.[5,6] In some cases leaving morbidly adherent placenta accrete is the only available option.[7] Leaving placenta in situ may be the better option in some cases to avoid torrential haemorrhage which may follow removal of morbidly adherent placenta. In other cases subtotal or total hysterectomy can be done. Hysterectomy may be considered in those patients who have severe PPH secondry to placenta accrete specially if she has completed her family.

Case presentation

A 38 year old Gravida 3 Para 1 with 22 weeks 5 days gestation with previous LSCS was admitted with complaints of leaking P/V .On admission patients vitals were stable with PR=82/min , Blood pressure 130/80 mm of hg. There was mild pallor present. Patient initially was treated conservatively with antibiotics, tocolytics and bed rest. An obstetric Ultrasound was done which showed single live intrauterine gestation, cephalic presentation with 23 weeks 5 days of gestational age, AFI-5 cm, internal os was closed. Fetal weight was determined to be 631gms. Complete blood count, Renal function test and liver function tests were within normal limits.C-reactive protein – 1.1(positive). Urine culture showed growth of no organism. High vaginal swab showed normal vaginal flora.

Two weeks later patient went into spontaneous labour and delivered female baby weighing 750 gms. In immediate post partum period Inj pitocin was started. On Per abdomen examination uterus felt well contracted. Despite a well contracted uterus on per abdominal examination there was continue per vaginal bleeding. Blood clots of approximately 200 gms were removed from vagina. There was tachycardia in the form of a pulse rate of 122/min and hypotension with blood pressure falling down to 110/60 mm of hg.In view of continued vaginal bleeding patient was shifted to operation theatre for exploratory laparotomy.

Under general anesthesia, per vaginal examination was done. Placental edges were found to be partially separated. Manual removal of placenta attempted, but plane between placenta and uterus could not be made out. In view of poor general condition of patient, Manual removal of placenta was abandoned and exploratory Laparotomy was done. There was presence of multiple dilated vessels on uterus. A subtotal hysterectomy was done and uterus with palcenta was sent for histopathology.

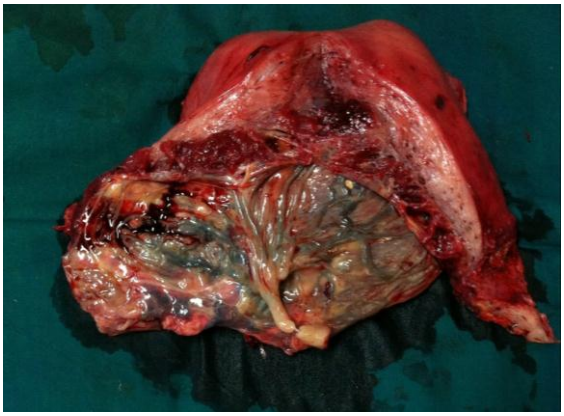

Fig 1: Obstertic Hyterctomy was done. Placenta Increta and Uterus is seen.

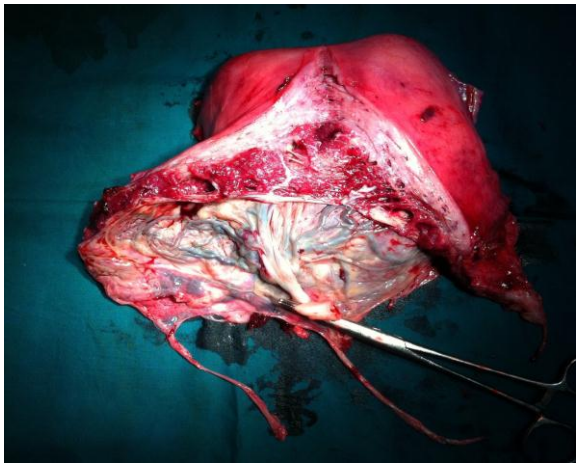

Fig:2 Placenta Increta with uterus.

In view of excessive bleeding 4 unit blood and 4 unit Fresh frozen plasma was transfused. Patient was shifted to ICU and after stabilisation was shifted to ward.

Later histopathological report showed "chorionic villi involving endometrium and myometrium but not involving the serosa, myometrium shows thickened and dilated blood vessels along with few multinucleated gigantic cells suggestive of PLACENTA INCRETA".

DISCUSSION

Placenta accrete is one of the dreadful complications of pregnancy. In some cases it causes fatal post partum haemorrhage. Because of complications it is desirable that it be diagnosed antenatally. Early diagnosis can be done by Ultrasonography though the sensitivity of USG for diagnosis of placenta accrete is low.[8] Other modalities available for diagnosis are Doppler and magnetic resonance imaging.[9] The most common clinical features of placenta accreta are bleeding, uterine rupture, invasion of the bladder, uterine inversion and rupture . The complications depends upon the depth of invasion, site of implantation and the time of diagnosis. Earlier the diagnosis better is the prognosis.[10] Initially the treatment consist of prompt replacement of lost blood. This must be followed by a more definitive treatment like laparotomy and hysterectomy. Earlier patients were managed conservatively by removal of placenta as much as possible followed by packing of uterus but this procedure carried unacceptably high mortality[11] and hence it is no longer recommended. Other modalities of management include uterine or internal iliac ligation. Alternatively angiographic embolization of these vessels may also be tried.[12] In women who have completed their families hysterectomy may preferentially be done.

CONCLUSION

Placenta increta is an obstetric emergency often associated with massive hemorrhage leading to emergency hysterectomy. Early diagnosis of this condition may prevent complications. Immediate blood replacement and if needed prompt hysterectomy is the key to prevent mortality and morbidity.

CONFLICT OF INTEREST: None.

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