

Placenta percreta – an obstetrician's nightmare

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Abstract

Placenta percreta is a rare but a life threatening condition. Control of massive haemorrhage is the first priority; however, the patient's desire for future fertility has to be taken into consideration. Nevertheless, in cases of massive haemorrhage, hysterectomy should be carried out without delay to prevent major complications or even maternal death. Here we present a case where we had to do a quick subtotal hysterectomy because of torrential bleed due to placenta percreta.

Key words: Placenta percreta, hysterectomy, haemorrhage.

Introduction

A morbidly adherent placenta attaches itself deeply into the myometrium. The conditions include placenta accreta, increta or percreta and together constitute approximately 1 in 2,500 pregnancies. In placenta accreta, the villi grow into the basal decidua and may be in contact with the myometrium, in placenta increta the villi invade into the myometrium while in placenta percreta the chorionic villi invade deeply up to the serosa and may even attach to surrounding organs such as the urinary bladder and the bowel¹. Placenta percreta constitutes about 5% of all cases of adherent placenta. This is usually diagnosed when usual placental separation is discovered to be absent². The primary concern for the mother is severe and life-threatening haemorrhage during manual attempts to detach the placenta. Hysterectomy is a common therapeutic intervention resulting in inability to conceive again due to loss of the uterus.

Case report

A 25-year old woman in her third pregnancy was admitted to our hospital at 32 weeks of pregnancy

with uterine contractions. Three years ago she had undergone an emergency caesarean section for oblique lie. Six months later, she had an abortion at 3 months of gestation for which an evacuation of retained products was performed under anaesthesia. On admission, her baseline pulse rate was 120 per min and blood pressure was 100/70 mmHg. The uterus was 32 weeks in size with fetal breech presentation. Fetal heart rate was 150 beats/min. Ultra sound revealed a central placenta praevia with breech presentation corresponding to 32 wks gestation. Facilities to do emergency MRI to rule out placenta percreta was not available. The patient underwent emergency caesarean section after making all necessary arrangements. The abdomen was opened through the previous transverse scar under general anaesthesia. Uterovesical pouch was opened. On pushing the bladder down, massive ooze started from the lower uterine segment. A quick incision was made in the lower uterine segment and a live female baby was delivered after cutting through the placenta. The entire lower anterior uterine segment was found eroded by placenta right up to the base of bladder but the urinary bladder was spared. As there was no uterine layer to repair the uterus and because of torrential bleed a quick subtotal hysterectomy was done in order to save the life of the patient. Complete haemostasis was achieved and a drain was inserted into the pouch of Douglas before abdominal closure. Her intraoperative blood loss was approximately 3.3 litres which was replaced with transfusion of 8 units of whole blood, 3 units of fresh frozen plasma and 2 units of platelet concentrates during the per-operative and post-operative period. The patient was monitored constantly by CVP and urinary output. Postoperative period was uneventful and she was discharged with a healthy baby after one week. Histopathology of the specimen was consistent with placenta percreta (Figure 1).

Discussion

The incidence of all forms of placental adhesion (placenta accreta, increta and percreta) has been rising for the past two decades, due to increasing caesarean section rates. Other predisposing conditions are, instrumentation of the endometrium, placenta praevia, uterine malformations, septic endometritis, previous

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manual removal of placenta and multiparity. A risk of placenta accreta exists in 2 to 5% with any case of placenta previa. This risk rises sharply when combined with previous caesarean section, and it may be >40% with two or more prior uterine incisions³. The present case had multiple risk factors that include a history of caesarean section a few years back, short inter-pregnancy interval, and instrumentation for missed abortion. Women with risk factors should be screened by gray scale sonography, colour flow Doppler sonography and MRI^{2,4}.

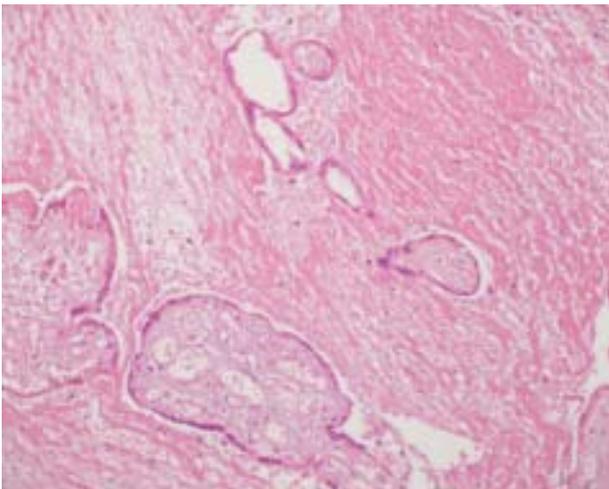


Figure 1. Photomicrograph shows presence of chorionic villi embedded deep in the myometrium.

Treatment for placenta percreta is primarily surgical, with hysterectomy being the treatment of choice in 93% of all cases³. The indexed case too had to be managed by subtotal hysterectomy to save her life. Conservative management is desirable in the rare cases involving adjacent organs such as the bowel or the bladder, because of the increased risk of uncontrollable haemorrhage⁶. A non-surgical conservative method is to leave the placenta in situ to

reabsorb and institute treatment with chemotherapeutic agents, such as methotrexate^{3,4}. Uterine or internal iliac artery ligation and transcatheter arterial embolization has also been described as a choice of treatment⁵⁻⁷.

Maternal death is not an infrequent outcome, ranging from 7-10% of reported cases of placental adhesion^{5,6}. Fetal death occurs in approximately 9% of the cases, usually due to complications of prematurity. Other complications reported are disseminated intravascular coagulopathy, surgical injury to the ureters, bladder and other viscera, adult respiratory distress syndrome, renal failure and infection, usually in the post-operative period

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