Placenta Accrete Syndrome: Atypical Presentation

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How to cite this paper: Urvashi Miglani, Poonam Laul, Vinamrata, Puneet Chhibber. (2020) Placenta Accrete Syndrome: Atypical Presentation. *International Journal of Clinical and Experimental Medicine Research*, 4(4), 217-219.
DOI: 10.26855/ijcemr.2020.10.015

Received: August 28, 2020

Accepted: September 20, 2020

Published: September 25, 2020

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Abstract

Placenta percreta, the rarest and most severe form of placenta accrete, can involve the urinary bladder. A case of 25 years G4P3L2D1 is being presented who had an atypical presentation of scar dehiscence with placenta percreta. Obstetric hysterectomy with resection of the involved part of the bladder was done. She was discharged in satisfactory condition on post op day 21. Atypical complaints at early gestation age in this case points that there is a need to keep a high index of suspicion of placenta accreta and uterine rupture in such susceptible cases.

Keywords

Placenta Percreta, Rupture uterus, Hematuria

1. Introduction

Placenta percreta, the rarest and most severe form of placenta accrete, can involve the urinary bladder. Because of its propensity for severe haemorrhage, it is a potentially life-threatening condition. The diagnosis is usually established intraoperatively when attempts to separate the placenta from the uterus fail. This manoeuvre causes massive haemorrhage which poses a challenge for the obstetrician. We report a case of 31-week placenta percreta with history of previous two caesarean sections which highlights the unusual presentation of placenta percreta.

2. Case Report

Mrs. X 25 years G4P3L2D1 presented at 31week+2days gestation 08/01/2020, with chief complaints of mild pain in abdomen for past 2 days, pain during micturition and increased frequency of micturition for past 2 days. Her antenatal period was uneventful till 31 weeks of gestation. She had a infant death (due to pneumonia) after a normal delivery followed by two alive girls (6 and 4 years old) delivered by two lower segment caesarean sections at term. There was nothing significant in her antenatal and postpartum period in the previous pregnancies. Her past medical, personal and menstrual history was unremarkable. On general physical examination, patient was pale, vitals were stable and on per abdomen examination 34-week live foetus with cephalic presentation could be palpated. There was no suprapubic tenderness. She was admitted in labour room. All her routine haematological and biochemical investigations were normal except a low haemoglobin of 7.6 gm/dl for which two units of packed cell were transfused on 09/01/2020. Her ultrasound showed adequate fetal growth with anterior low-lying placenta reaching up to os. There was no evidence of accreta.

The patient was kept under observation and on 10/1/2020 patient developed tachycardia (PR140bpm). On per abdomen examination, no obvious scar tenderness was present. Temperature and hydration status of the patient was normal. Due to persistent tachycardia for around 3 hours not explained by any other cause, a provisional diagnosis of scar dehiscence was made. Patient was taken up for emergency caesarean section after the necessary prerequisites of informed consent and arrangement of bloodproducts. Abdomen was opened by midline vertical incision. Peroperatively, dehiscence of the scar was present at the right angle. A live male baby of 1.5kg was delivered by extending the lower segment incision. Placenta did not separate spontaneously. Thick vessels of placenta were present over lower uterine segment and were perforating bladder serosa. Bladder was advanced, adherent and highly vascular. With an intraoperative diagnosis of placenta percreta, decision for obstetric hysterectomy was taken. Due to technical difficulty in ligating uterine arteries (due to adherent bladder), internal iliac ligation was done before the hysterectomy to control the haemorrhage. Extensive invasion of the bladder was present on the right side (Figure 1). Total hysterectomy with resection of a small segment of the bladder (which was invaded by the placenta) was performed. In coordination with senior surgeons, two layers of haemostatic sutures were taken on the bladder. To control the ongoing haemorrhage from the bladder despite several haemostatic sutures, the pelvis was packed, and compression applied for 30 minutes. Simultaneously multiple blood products were transfused to the patient (9 units packed cell volume, 9 units FFP, 9 units platelet concentrate). Surprisingly urine was clear throughout the preoperative and intraoperative phase. 30 minutes after the compression, bleeding had significantly decreased, and a third layer of haemostatic sutures was successful in controlling the haemorrhage. Due to extensive vascularity, the folds of retroperitoneum (opened for internal iliac ligation) also had to be closed with haemostatic sutures. The integrity of bladder repair was checked by retrograde filling. Postoperatively, patient was shifted to ICU for observation. Intensive care was given to the patient and she was shifted to ward on post op day 6. She was discharged in satisfactory condition on post op day 21.

Figure 1. Hysterectomy specimen.

3. Discussion

Placenta accrete spectrum, formerly known as morbidly adherent placenta, refers to the range of pathologic adherence of the placenta, including placenta accreta, placenta increta and placenta percreta [1]. Placenta accreta (also known as placenta creta, vera, or adherenta) where the villi attach directly to the surface of the myometrium without invading it, placenta increta where the villi penetrate deeply into the myometrium up to the external layer and placenta percreta where the invasive villous tissue reaches and penetrates through the uterine serosa [2]. The true

incidence of placenta accrete spectrum is difficult to ascertain, but likely falls near 1/1000 deliveries. This number seems to have increased along with the rate of risk factors. These include placenta previa, previous caesarean section, use of assisted reproductive technologies, uterine surgeries, and advanced maternal age [3]. Atypical complaints at early gestation age in this case points that there is a need to keep a high index of suspicion of placenta accreta and uterine rupture in such susceptible cases. This enables the treating clinician to be well prepared for complicated surgery by inculcating multidisciplinary approach with adequate blood products in hand. Also, this case highlights the importance of prior ligation of internal iliac arteries and the importance of sustained compression to control haemorrhage in the pelvis. Further despite the presence of placenta percreta, urine was clear throughout the preoperative, intraoperative and postoperative phase reiterating the fact that expected tell-tale signs may be absent in some cases and a high index of suspicion is mandatory for successful management.

This is in continuum to the atypical presentations of placenta accrete where persistent haematuria has been seen in absence of percreta [4].

An informed consent was obtained from the patient for publication of the case.

References

- [1] Placenta accrete spectrum. Obstetric care consensus no. 7. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018; 132: e259-75.
- [2] Allen, L., Jauniaux, E., Hobson, S., Papillon-Smith, J., Belfort, M. A. (2018). FIGO consensus guidelines on placenta accreta spectrum disorders: Nonconservative surgical management. *Int J Gynecol Obstet*, 140: 281-290.
- [3] Carusi D. A. (2018). The Placenta Accreta Spectrum: Epidemiology and Risk Factors. *Clin Obstet Gynecol*. 2018; 61(4): 733-742.
- [4] Miglani U., Laul P., Chhibber P., Kadam V. K., Jain N. (2019). Gross Hematuria in Pregnancy: An Enigma. *The Journal of Obstetrics and Gynecology of India*. 2019 Oct 1; 69(5): 467-9.