CASE REPORT

Earliest Presentation of Placenta Accreta – A Case Report

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SUMMARY

Placenta accreta is a serious complication of placenta previa leading to massive obstetric hemorrhage. Prenatal diagnosis of adherent placenta is very important as it significantly affects the maternal and perinatal mortality. It is diagnosed in the prenatal period with ultrasound and more recently by magnetic resonance imaging[1, 2]. When faced with undiagnosed placenta accreta at the time of cesarean section, obstetrical hysterectomy is a lifesaving option. We present an undiagnosed case of placenta accreta, which presented as early as at 15 weeks of gestational age in a patient with previous three cesarean sections.

Keywords: Placenta accrete, prenatal, C-section

CASE REPORT

A 28 years old lady, gravida 4 para 3, having history of previous three cesarean sections, presented on 28th of January 2018 in the emergency department. She was carrying an ultrasound report showing fetal demise. There was no bleeding per vaginum. She gave history of raised blood pressure in the present pregnancy as well as in the previous pregnancy, for which she was only occasionally taking tab Methyl Dopa 250 mg once a day.

Her findings on admission were as follows;

B.P- 130/90 mm of Hg

Pulse-80 beats/min

Abdominal exam- abdomen soft, non- tender

USG report = A single intra-uterine gestational sac of 9weeks and 6 days.

Fetal cardiac activity was absent

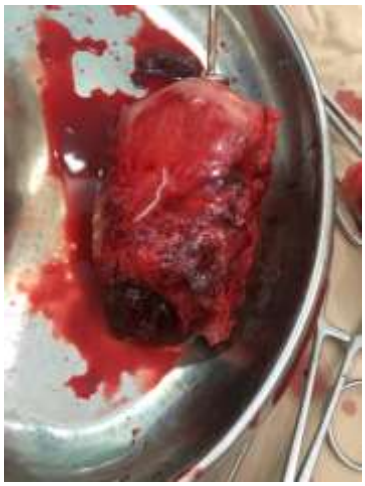
Suggestive of missed abortion.

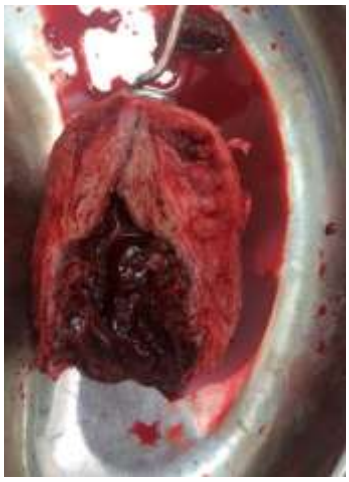
The patient, therefore, was admitted for investigations and suction and evacuation. The lab investigations were as follows;

Blood group - A+ve, Hb -12.7 gm/dl, BSR- 97mg/dl, HbsAg-negative,

Anti HCV- negative,PT/APTT- normal, INR- normal.

There was no comment on placental adherence to previous scars. The decision was taken by Senior Registrar on duty to perform suction and evacuation as patient started having mild contractions. 400 micrograms of misoprostol was placed vaginally for cervical ripening at 7am. Her suction and evacuation was performed at 2:30pm, moderate amount of products of conception were removed but patient continued to have fresh bleeding from the uterus despite the completion of the procedure. Immediate measures taken were – 10 IU oxytocin given stat intravenously, and 40 IU oxytocin were given in infusion form but the bleeding continued. A portable ultrasound scan was performed which showed that the uterine wall was intact with low level echoes. Patient's vitals were; Pulse 74 beats per minute, B.P 100/56mmHg,





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Uterine packing was performed as advised by senior on-call. Bleeding seemed to start settling. Urgent hemoglobin was performed which later on reported as 8.7 gm/dl –much dropped from admission level of 12.7gm/dl. The assistant professor on-call came and assessed the patient, decision to proceed for hysterectomy was taken in light of falling hemoglobin and the suspicion of adherent placenta as the uterine packing failed to control bleeding.
Abdomen was opened, dense adhesions were present between uterine fundus and anterior abdominal wall, adhesiolysis was done, bladder was separated and Subtotal hysterectomy was performed by clamping, cutting and ligating the three pedicles. The placental blood vessels could be seen on the surface of uterus.

Two units of whole blood were transfused intra-operatively. Patient remained vitally stable, she was shifted to ICU for intensive monitoring. Post-operative recovery was un-eventful; she was discharged on 3rd post-operative day with the advice of follow-up with histopathology report. The histopathology report confirmed the diagnosis of placenta accreta.

DISCUSSION

The incidence of adherent placenta is rising with the rising number of cesarean sections and placenta previa[5,6]. Hence the possibility of adherent placenta should be kept in mind even at the booking visit. Had the above mentioned patient been diagnosed as having adherent placenta, her management would have been better planned thus reducing the morbidity, and blood transfusion could have been avoided.

The radiologists also have an equal responsibility to not only have a high index of suspicionof adherent placenta especially in scarred uterus but also report any evidence of adherence or invasion of placenta even at the earliest ultrasound. However, the ultrasound sensitivity and specificity for detecting placenta accreta in the first trimester in one study was estimated 41% and 88%: respectively[3]. There are limited studies conducted in the literature for screening of ultrasound in the first trimester and there are some case studies in which ultrasound diagnostic value has still been unclear at this stage of pregnancy[4]. More studies should be focused in this area to accurately diagnose adherent placenta in first trimester to reduce the morbidity and mortality associated with this serious condition.

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