

A CASE OF COMPLETE PLACENTA ACCRETA

by

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Introduction

Placenta accreta is one of the serious complications of third stage of labour. This may be partial, which is not uncommonly met with, and may also be complete. The partial accreta is more serious than the complete one because of its immediate post-partum bleeding and consequent shock.

It has been found that there is usually a history of retained placenta in previous confinements with post-partum haemorrhage and a history of manual removal of placenta and sometimes there is difficulty even in manual separation of a part of the placenta which seems to have penetrated in the muscle tissue. In the complete variety, however, there is no immediate post-partum haemorrhage or shock, except perhaps a shock produced by a violent Crede's manouver or an attempt to remove the placenta manually, leading to partial detachment of it and consequent haemorrhage.

Case Report

The patient aged 29 years, after her sixth confinement at home came to the Howrah General Hospital with retained placenta after 2½ to 3 hours of child-birth. The

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patient gave the history of retained placenta with subsequent manual removal in the hospital, on her previous three confinements.

Examination on Admission. The patient was not anaemic and there was no oedema, and no evidence of shock, the B.P. was 110/70 mm.Hg, pulse 100 per minute; there were a few scattered rhonchi in the lungs and nothing abnormal in the heart. Abdominal examination showed that the fundus was at about the level of the umbilicus and firm. On vaginal inspection the cord was found hanging with very little bleeding.

An intra-muscular injection of methergin was given along with an intravenous 5% glucose in normal saline drip. An attempt at expression of placenta by Crede's was tried, but this failed. The patient was then removed to the operation theatre and under general anaesthesia, manual removal of the placenta was tried; the placenta was found to be situated in the posterior wall of the upper uterine segment, no line of cleavage was detected and an attempt at forced separation resulted in a small portion of detachment of placenta from the lower pole and haemorrhage. An intravenous methergin was given with blood transfusion.

The abdomen was immediately opened and a subtotal hysterectomy done very quickly. Post-operative condition of the patient was uneventful and she was discharged after ten days.

Examination of the Specimen —

Undivided Specimen. The outer surface showed no abnormality with the cord hanging through the cervical opening.

Cut Specimen [Fig. 1 (a) and (b)]. The uterus was divided through the implantation site. The whole of the placenta was found firmly adherent to the uterine wall except on the lower pole where it was raggedly torn in a small area due to attempt at manual separation. Strands of placental

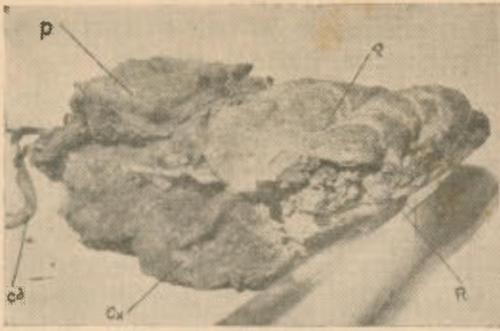


Fig. 1a.

Section of the uterus (complete placenta accreta), P. placenta, Cx. Cervix, Cl. Cord, R. Raggedly torn area.

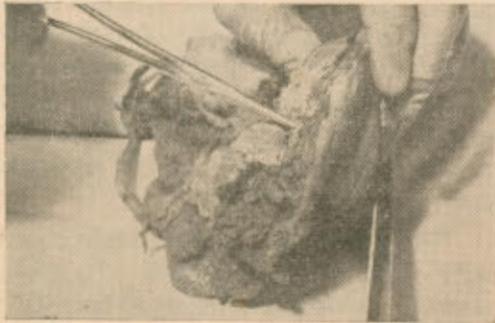


Fig. 1b.

Section of the uterus (complete placenta accreta). The forceps tip shows the penetration of the placental strand in the muscle tissue.

tissue throughout the whole placental area were found to have penetrated into the muscle tissue at varying depths at different planes.

The foetal surface of the placenta showed no abnormality. The cord was centrally placed.

Histology (Figs. 2 and 3). Section was taken through implantation area of the placenta including the placenta and the uterine wall for histological examination which showed no decidual reaction between the trophoblastic cells and the muscle cells (decidua basalis); the trophoblastic cells were directly on the muscle cells and at places penetrated inside. There was no fibrinous layer present between the two types of cells. No abnormal activity of the trophoblastic cells was seen anywhere. The trophoblastic cells were not found to have penetrated through the muscle layer to the serous coat anywhere (Placenta percreta). There was no evidence of any inflammatory reaction.

Discussion

The reason for reporting this case is the rarity of this placental condition, specially the complete placenta accreta as will be evidenced from the following data collected out of the



Fig. 2. Complete placenta accreta. The chorionic villa in direct relation with the muscle tissue no decidual cells are seen 10 x 10 HE.



Fig. 3.

total number of deliveries in this hospital in 1960 and 1961.

Total No. of cases	..	6660
Cases of retained placenta during these years	..	34
Of this, case under review is the only case of complete placenta accreta, giving us an incidence of	1 in 6660

However, the incidence of these cases as recorded in literature is 1 in 6000 deliveries for the partial placenta accreta; much more rare is the complete variety, nearly 1 in 40,000 deliveries, though many cases of partial accreta escape notice, and are labelled as retained bits of placenta with post-partum haemorrhage. The cause of placenta accreta is not definitely known; there is deficiency of decidua basalis exposing the myometrium to the trophoblastic activity. The deficiency of decidua basalis may be partial and patchy as in partial accreta or in a major portion as in complete. As to why this deficiency of the decidua is not very clearly known. Some attribute the cause of deficiency to hormonal deficiency in the development of the proper decidua, but then the patchy deficiency in a partial accreta cannot be explained by this. There is a group who thinks that this is due to a chronic inflammatory change, but no histological evidence of inflammation is found at the implantation site in case of accreta. Then again the overactivity of the trophoblastic cells in absorption of decidua is considered by some as the cause. But this does not explain as to how a portion of trophoblast cell

could have hyperactivity while the other portion as in case of partial accreta has the normal activity.

The cause is still very obscure and no definite conclusion could be arrived at. Post-partum haemorrhage is one of the serious complications of placenta accreta, specially in the partial variety. In the complete variety, however, bleeding is less prominent unless it is induced by the attempt at forcible separation manually.

The mortality rate in these cases is high (near about 66%) the main cause of death being haemorrhage, shock, and sepsis. The mortality rate falls considerably if only supravaginal hysterectomy is done as soon as the condition is recognised with adequate resuscitative measures and measures for combating sepsis.

The problem arises when the uterus is to be preserved. In partial accreta where perhaps a few cotyledons are adherent a careful digital removal may be tried, care being taken not to perforate the uterus, followed by an intravenous injection of methergin, and at times intra-uterine pack. Leaving the placenta in the uterus to be absorbed if there is no haemorrhage as in complete variety, only guarding against sepsis has been tried by some; it needs prolonged observations because of the danger of secondary haemorrhage and sepsis but this is undoubtedly a good method for a young woman having only one or two children. At present, the best treatment of placenta accreta is by subtotal hysterectomy with least interference in order to avoid complication specially in the type of cases described above.

Acknowledgment

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