PLACENTA ACCRETA

(2 Case Reports)

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Placenta accreta is a rare variety of adherent placenta in which there is no dividing line between the decidua compacta and decidua spongiosa, nor can the operator establish any line of cleavage between the placenta and uterine wall. In some cases there is almost entire absence of decidua, with the result that the chorionic villi penetrate through the hyaline layer of Nitabuch deeply into the muscular wall and absolutely fix the placenta.

Thus placenta accreta results from a pathological condition and differs radically from ordinary adherent placenta. In complete variety there can be no bleeding from the placental site.

We had two cases of placenta accreta in one year. One case had inversion and rupture following placenta accreta.

Case 1.

Mrs. X., aged 30 years, 8th gravida, was admitted on 31-7-63 at 11-25 a.m. with nine months' amenorrhoea and mild labour pains. She had 6 F.T.N.D. — at home without any complications, 6 children are alive; 7th delivery was in this hospital four years ago when she had severe post-partum haemorrhage. She was treated with oxytocics and blood transfusion at that time.

This time her condition on admission was fairly good. Pulse 96/min., blood pressure 96/72 mm. of Hg. Urine-clear. No-oedema.

On abdominal palpation uterus was full-term, head engaged and F.H.S. — 140/min., regular. On 2-8-63 she started leaking membranes; on vaginal examination cervix was 2 fingers loose. No pains.

On 5-8-63 she delivered a male baby weighing 5 lb. — 13 oz. at 1-50 p.m. Inj. Methergin 0.2 mgm. was given I.M. Placenta did not separate till 2-15 p.m.; there was no fresh bleeding. Pulse was 80/min. B.P. 100/70 mm. of Hg.; glucose saline 5% with 5 units of pitocin was started. Morphia ¼ gr. given. Fundal pressure was tried by the resident to express the placenta. At 3-15 p.m. Pulse was 132/min. Vol. fair. B.P. 60/mm. of Hg.

Vaginal examination revealed inverted ruptured uterus with adherent placenta. Uterus was not palpable per abdomen.

Sub-total hysterectomy was done under general anaesthesia. Only one pint of blood was available. Patient had post-operative fever for 6-7 days. She was discharged in good condition.

Specimen of the uterus showed placenta completely adherent at the fundus; the tear extended from right round ligament, crossing the fundus to the right ovarian ligament.

Cause of inversion and rupture in this case may be fundal pressure or pitocin drip started before separation of placenta or both.

Case 2.

Mrs. Y., aged 25 years, 6th gravida, was admitted on 31-5-64 at 2 p.m. with history of retained placenta after delivery in the village hospital at 3 a.m. Manual re-

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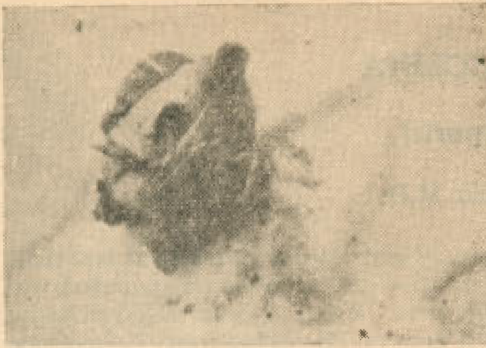

Fig. 1 & 2
Inverted ruptured uterus with placenta accreta.

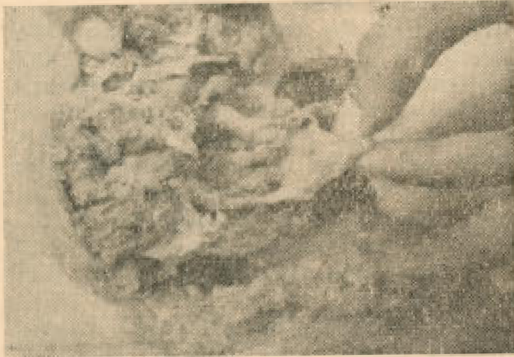

Fig. 3
Placenta found adherent to the uterus — cord is seen which is cut.

Fig. 4
Bulging of left cornual region.

moval of placenta was tried in that hospital without success.

She had 6 F.T.N.D. — at home without complications.

On admission, pulse 134/min., vol. good, blood pressure 75/50 mm. of Hg. tongue-pink and moist.

Abdominal examination revealed uterus, to be 2 fingers below the umbilicus, hard, well-contracted.

On vaginal examination cervix 2 fingers loose, placenta not felt in the cervical canal. There was slight continuous bleeding per vaginam.

Glucose saline 5% I.V. was started and patient was prepared for laparotomy. Before proceeding to laparotomy, vaginal examination was done under general anaesthesia but no clevage was found between the placenta and the uterine wall. Abdomen was opened and sub-total hysterectomy was performed. No blood was available. Post-operative recovery was uneventful.

Uterus, after removal, showed a thinned out left cornual region which was bulging on the peritoneal surface. Placenta was firmly adherent at the fundus nearer the left cornu. Thinned out left cornual region may be due to vigorous attempt at manual removal.

Microscopic appearance of the specimen shows placental tissue down to muscular layer but had not involved the serosal layer. Diagnosis. Placenta increta.

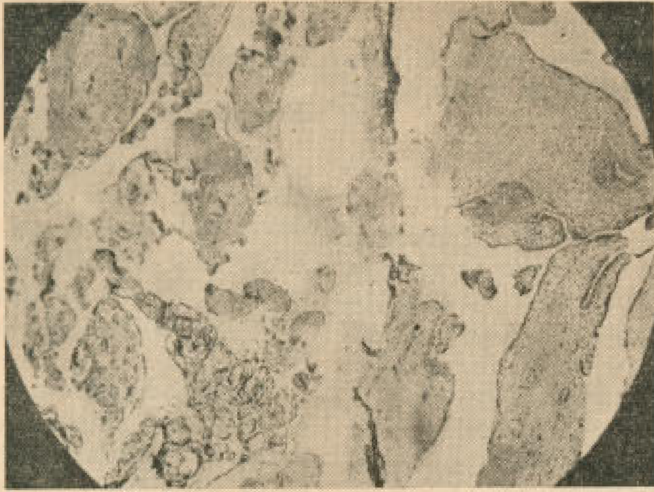

Fig. 5
Placental tissue deep down in muscular layer but has not involved the serosal layer.
Diagnosis — Placenta Increta.

Incidence

In Boston lying — in — hospital placenta accreta occurred once in 1956 deliveries, Nalhanson found an incidence of 1 in 20,000 deliveries.

These 2 cases occurred accidentally within the period of one year, when total number of deliveries was 2626.

Historical

The condition was first described by Plater (1536-1614). It was thought to be a case of retained placenta and the patient died. Post-mortem examination showed firmly adherent placenta.

Placenta accreta was also described by J. R. Sulzmann (1573-1656) and by Bonet (1620-1698). Morgagni (1682-1772) reported a case in which the patient died with the placenta undelivered. At autopsy the placenta was found implanted partly over the internal os and partly at the fundus, and it was firmly attached.

In 1836 Simpson noted that in a few rare instances the whole placenta was connected with the uterus, although more commonly the adherence involved only a lobe or two.

In the year 1900 Alexanderoff reported the first case who recovered, although the diagnosis was not made before operation. Patient was operated for spontaneous rupture and hysterectomy was done.

Aetiology

This condition is usually found in multiparae. Among 18 cases reported by Irving and Hertog all were multiparae except one. In most of the cases on record there is a history of trauma to the endometrium. Among the common findings are, previous manual removal, curettage, sepsis, caesarean section and hysterotomy. Occurrence also has been recorded

on a uterine deverticulum and on a sub-mucous fibromyoma.

Noran reported two cases following application of radium to the endometrium.

Diagnosis

The diagnosis is only arrived at when an attempt is made to remove the placenta. The condition may be suspected when there is previous history of trauma to the endometrium, when placenta resists all attempts at expression, and when retention of placenta is unaccompanied by post-partum haemorrhage. In cases in which some part becomes detached from the uterine wall some bleeding may continue.

In the two cases reported the first one went into shock due to inversion and rupture, but there was no bleeding. In the second case, due to initial attempts at manual removal, some bleeding continued and patient came with fall of blood pressure and fast pulse rate; diagnosis was easy in both cases.

Complications

1. Spontaneous rupture of uterus as reported by Alexandroff and few others.
2. Uterine deverticula.
3. Placenta previa.
4. Inversion of the uterus during an attempt at manual extraction as reported by R. Mayer.

In the series of Irving and Hertog (Boston) one case out of 18 died; she had complete placenta accreta which the operator attempted to seperate and inverted the uterus. In spite of two blood transfusions and hysterectomy patient died of shock and haemorrhage.

Treatment

The total mortality rate in placenta accreta is about 38% and is dependant very largely on the method of treatment employed; in the patient treated by manual removal, with or without tamponade of uterus, it is about 70%.

Vaginal hysterectomy gives a rate of 36% and abdominal hysterectomy accounts for less than 6%. The treatment, therefore, is obvious. If placenta accreta is complete one should resist the usual attempt at manual removal, as there are dangers of severe post-partum haemorrhage and perforation of the uterus, and if removal is not complete hysterectomy may be necessary. When one thinks of manual removal blood transfusion should be freely available.

There are a few who have adopted conservative treatment. The placenta is left in situ, the cord cut short and the uterus is packed for 24 hours. The placenta is left to be absorbed or sloughed of. Schymann reports 14 cases which were treated conservatively. His indication for conservative treatment is absence of bleeding. All his cases recovered but had a stormy convalescence. Dangers of conservative treatment are secondary post-partum haemorrhage and sepsis.

The best and safest treatment in these cases is hysterectomy, the exception being where the patient is young and anxious for children. Hysterectomy with no attempt at manual removal of placenta gives best results.

Summary

(i) Report of two cases of placenta accreta with review of literature on history, pathology and treatment.

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