TWO CASES OF PLACENTA ACCRETA

by

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Placenta accreta is a rare condition and in this hospital these are the only two cases in the last 5 years out of a total of 74,677 deliveries giving an incidence of one in 37,338.

Two cases of placenta accreta, one, associated with a rupture uterus and the other accidentally discovered during caesarean section are being reported here, both cases ended in a subtotal hysterectomy.

CASE REPORT

Case I

A 30 year old 7th gravida was admitted on 31-10-70 with a history of 9 months' amenorrhoea with pain since the morning. Her last menstrual period was during the 3rd week of February and the calculated date of delivery was during the 4th week of November.

Though she was a 7th gravida, she had only one living child. Her other children had died of general systemic diseases after reaching one year. Her pregnancies were uncomplicated and ended in natural deliveries. Her last childbirth was 7 years ago. There was no history of abortions.

General examination, showed a moderately nourished individual with marked bilateral oedema of the lower extremities. She was not anaemic—her blood pressure reading was 160/120 mm of hg. Her cardiovascular and respiratory systems showed nothing abnormal. Albuminurea to the extent of + + + was present.

The size of the uterus was 36 weeks with the breech felt in the left iliac fossa and the head in the right hypochondrium. The foetal heart was heard in the right hypochondrium. The foetal heart was good. The amount of liquor appeared to be scanty since the size of the uterus was smaller than the period of gestation and the whole uterus appeared moulded over the foetus.

Routine investigations done were within normal limits except examination of the stool which showed ascaris ova. The patient had treatment for the same.

A plane X-ray abdomen showed the foetus with an extended breech in an oblique lie.

The patient was treated for toxaemia with restricted salt diet, diuretics and sedatives; no hypotensive drugs were given. The oedema completely subsided and the blood pressure came down to normal 120/90. A vaginal examination done on 23-11-70 showed an uneffaced cervix with a closed os. The presenting part was high up; the pelvis was normal.

In view ol the fact that she was a case of pre-eclamptic toxaemia, with scanty liquor and had only one living child, it was decided not to allow her to go beyond her expected date of delivery.

A laparotomy was done on 27-11-70. A lower segment caesarean section was done. There was no liquor but, only a few m.l. of meconium were present. A female baby (1.6 Kg) was extracted, it was slightly asphyxiated and was revived by the usual methods. As spontaneous separation of the placenta did not occur, a manual removal

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was attempted. The placenta was situated posteriorly, the lower half was densely adherent and could not be removed, hence a clinical diagnosis of placenta accreta was made and a sub-total hysterectomy was done (Fig. 1). Histopathological examination confirmed the diagnosis (Fig. 2).

Case II

A 25 year old second gravida was admitted with a history of 8 months' amenorrhoea with abdominal pain and bleeding per vaginam which had started the day previous.

Her first pregnancy ended in a caesarean section for failed forceps, the type of section was not known. The baby died after one year.

On examination, the patient was in shock. There was marked tenderness over the abdomen, the uterine contour could be made out and shifting dullness was present. The foetal parts were felt superficially and the foetal heart was not heard. Bleeding per vaginam was present.

With the above findings a diagnosis of rupture uterus was made and the patient taken for a laparotomy after taking measures to combat the shock.

On opening the abdomen, the peritoneum was found to be contused and adherent to the abdominal wall on one side. On entering the peritoneal cavity the bag of membranes was found to be bulging with the foetus in situ, the uterus having given way completely in the centre of the upper segment with its right border adherent to the parietal peritoneum and abdominal wall. A premature dead born male baby was extracted. The placenta was found to be lying partly free and partly adherent to the uterine wall at the site of rupture. After removing the placenta it was noticed that the rupture had extended laterally towards the left side. The edges of rupture were ragged and had a bit of placental tissue attached, which on attempting to remove, peeled off a bit of uterine wall with it. The peritoneum was also torn almost upto the left lateral wall of the pelvis. There was no scar seen in the lower uterine segment. A subtotal hysterectomy was done. Her postoperative period was uneventful. The histopathological examination of sections taken from the site of rupture showed evidence of placenta accreta (Fig. 3). The peritoneum showed blood clots but no evidence of placental tissue.

Discusssion

In placenta accreta, the union between the placenta and the uterine wall is very intimate due to deficient or absent decidua, mainly decidua spongiosa, so that the chorionic villi penetrate the decidua and lie adjacent to the myometrium. When the trophoblastic tissue penetrates the myometrium but not the serosa the condition is callel *placenta increta*—and in *placenta percreta* the serosa may be perforated resulting in complete or incomplete rupture of the uterus.

The definite diagnosis of placenta accreta depends upon the demonstration of microscopic evidence of trophoblastic tissue adjacent to the uterine musculature. It is a highly dangerous condition and it is not possible for the obstetrician to anticipate placenta accreta.

There is a wide variation in the quoted incidence of placenta accreta. Miller and Mc. Laurin (1954) quoted an incidence of 1:8032. Bhagoji and Kirloskar (1967) 1:28184, Gogoi and Gogoi (1968) 1:2246. Others have quoted incidence from 1:2000 to 1 in 31,000 pregnancies. In our hospital in the last five years we had only two cases out of (4,677 deliveries. During this period there were 551 cases of manual removal of placenta.

The actual incidence of placenta accreta must be much more than this as several cases of minor instances of partial placenta accreta are missed, the placental bits being removed piecemeal. Moreover, those patients who die of haemorrhage and sepsis with the placenta still in situ are not subjected to routine autopsy and histological examination to confirm the diagnosis.

The reported aetiological factors are

endometrial trauma, infection, repeated manual removal of placenta, and implantation of placenta in the lower uterine segment. Out of ten cases reported by Sumawong *et al* (1966), five had a history of previous trauma to the endometrium, 3 had a history of manual removal of placenta out of which two had undergone intrauterine curettage, one had suffered puerperal infection and one had undergone caesarean section.

In the second case reported here, infection could be an aetiological factor as the section was done for a failed forceps. Here also, the site of placenta accreta was other than that of the scar region. Placenta accreta can be found at any age during the reproductive period of life, and parity has no significance. Begneaud, *et al* (1965) reported a case of placenta accreta associated with pregnancy of 6 weeks' duration. Out of 9 cases reported by Kistner, *et al* (1952), five had previous section and in all areas, other than the scar region were the site of placenta accreta.

This pathological state may involve all or only a part of the placental area of attachment. The prognosis is good when the condition is discovered at the time of caesarean section. A quick subtotal hysterectomy is the treatment of choice. If following vaginal delivery the prognosis depends on the promptness with which the diagnosis is made and upon the amount of bleeding due to partial separation of the placental tissue. Chatterjee (1963) has reported one case and Ghosh (1963) has reported two cases wherein a quick subtotal hysterectomy was life saving. In a case of total placental accreta, the placenta may fail to separate and the condition is diagnosed when the obstetrician fails to find a line of cleavage with ease on attempting manual removal of the placenta.

In the two cases reported here the placenta accreta was partial. In women who are desirous of further child bearing it is worthwhile excising the area of involvement and repair, especially when the abnormal placental attachment is localised in the cornual area Begneaud *et al* (1965).

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See Figs. on Art Paper V