PLACENTA ACCRETA TREATED BY—CAESAREAN HYSTERECTOMY

by

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Introduction

Placenta Accreta is an abnormal adherence of part or whole of the placenta to the uterine wall with partial or complete absence of the decidua basalis, especially the spongy layer and defective decidua vera.

Etiological factor is usually previous uterine trauma, infection associated with gynaecologic disorder or endocrinal imbalance.

Incidence

Keltreider (1945) found 177 cases in literature upto 1945. In Government Kasturba Gandhi Hospital for Women and Children Madras, out of 1,42,143 deliveries for 10 years period, this is the only case encountered during the last 10 years. Hence this case is reported for its rarity.

CASE REPORT

Mrs. A., gravida IV, was hospitalised on 15.11.1971 with history of 9 months' amenorrhoea.

Previous Obstetric History

First delivery was 10 years back, full term, delivered by forceps, female child alive and healthy. Second delivery was 6 years back lower segment caesarean section done, male baby aline and healthy. Third delivery full term, natural, still born 4 years back.

Present pregnancy: L.M.P. not known. Patient had no antenatal care.

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Menstrual History

4/30, regular, painless, moderate flow.

General Examination

Patient fairly well-nourished, slightly anaemic, pulse: volume and tension good. Blood pressure 100/70 mm of Hg. Cardiovascular and respiratory systems, nil abnormal detected. Haemoglobin: 10 grams percent. Urine: Nil abnormal. Blood Group: 'O'.

Per Abdomen

Uterus 38 weeks, breech presentation. Foetal heart good, Right paramedian scar present. No tenderness over the scar area. In view of the previous caesarean section, bad obstetric history and breech presentation, an elective caesarean section was decided.

Patient was posted for elective caesarean section on 19.11.1971.

Operation Notes

Under General Anaesthesia abdomen was opened by a left para-median subumbilical incision. On opening the peritoneal cavity, dilated veins were seen over the anterior surface of the uterus. Lower segment appeared to be ballooned and thinned out, more on the left and lateral side. This was thought to be a haematoma of the broad ligament. A Transverse incision was made over the lower segment and an asphyxiated female baby was delivered by the foot (weight 2.8 Kg) at 11-05 A.M. On removing the placenta, it was found that the placenta was adherent in toto—diagnosed as placenta accreta. It was the placenta which had infiltrated through the lateral surface of the uterus which appeared under the serosal layer as a haemotama. At this stage there was profuse bleeding and the patient went into shock. Patient was resuscitated with two bottles of 'O' group blood, steroids, etc. A quick hysterectomy was done. The left uterine vessels could not be visualised due to distortion of their anatomy. Bleeding was controlled by

purse-string sutures, then the Vagina was closed. Pelvic peritoneum was closed after complete haemostasis. Abdominal wound was closed in layers.

Postoperative period was uneventful. Abdominal wound healed well. Patient was discharged on the 14th day after the operation.

Pathology Report

Picture is compatible with that of placenta accreta.

Discussion

Placenta Accreta is a are variety of adherent placenta where there is no dividing line between decidua compacta and decidua spongiosa, nor can an operation establish any line of cleavage between the placenta and the uterine wall. In some cases there is entire absence of decidua and the chorionic villi penetrate to the hyaline layer of Nitabuch, thereby deeply infiltrating into the muscular wall, resulting in absolute fixation of the placenta (Fig. 1).

This is a case of placenta percreta. A quick hysterectomy saved her life and any attempt to remove the placenta would have been fatal.

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References

1. Kaltreider, D. F.: Bull School of Medicine University of Maryland: 30.1.1945.

See Fig. on Art Paper VII