PLACENTA PRAEVIA ACCRETA

(A Case Report)

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Placenta previa accreta has been reported many times. The salient histologic feature is primarily an absent or almost completely absent decidua, absence of fibrin layer between the chorionic villi and muscle of the uterine wall representing fusion of Nitacbuch and Rohr's striae, absence of a well developed chorionic plate but otherwise normal appearing villi and hyalinisation and vascularisation of the uterine musculature in the area of placental attachment.

The incidence of palcenta praevia accreta cannot be accurately determined. Irving and Hertig in 1937 gave an incidence of 15% placenta praevia accreta. In our institute in the last 10 years there were 71 cases of placenta accreta (0.12%) but no case of placenta praevia accreta has been recorded.

CASE REPORT

M. S., 32 year old, gravida 3, para 2, was admitted in a private nursing home for repeat caesarean section. A history of 2 previous caesarean sections, one for Antepartum Haemorrhage and the other for breech. was given.

A repeat section was performed on admission with labour pain.

The placenta was cut through on making the uterine incision. The patient was delivered of a male child, weighing 2750 gm. The placenta could not be separated. An attempt was made to do a total hysterectomy, but only a part of the cervix could be removed. Immediately following the operation, the patient began to bleed profusely. Vaginally vaginal pack was inserted and the patient was transferred to the general hospital.

In the meantime patient went into hypofibrinogenaemia. 6 gm of fibrinogen, 2 units of fresh blood, and 1 bottle of plasma were infused. The clotting time came to 6 minutes, and a firm clot formed.

Bleeding still continued through the vaginal pack. The pack was removed and sutures were placed at the lateral angles of the cervix to control the bleeding from the cervical branch of uterine artery. Vaginal pack was reinserted. Bleeding was controlled by these means. Patient was given 1 more blood transfusion. Postoperative course was uneventful. Pack was removed after 24 hours and the patient was discharged on eighth postoperative day.

Histopathologically, the section showed placenta accreta.

Discussion

In placenta accreta the cause is basically any factor which interferes with the development of decidua. Usually there is a history of previous trauma to the endometrium, due to lower segment caesarean section or manual removal of placenta or currettage. Primarily, this condition can occur even due to deficient decidual reaction.

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In the literature, it has been described that there is a high incidence of placenta accreta associated with previous caesarean section.

It has been pointed out earlier that, the postpartum haemorrhage in cases of placenta praevia may be due to an accretic tendency of the abnormally situated placenta.

Our patient gives history of 2 previous lower segment caesarean section and hence this may be the reason for placenta previa accreta.

The treatment of choice in patients with placenta accreta is total hysterectomy. This applies not only to placenta previa accreta but also to all types and forms of placenta accreta.

In young primiparous patients, in the absence of excessive haemorrhage, placenta has been left behind with the object that the placenta would get absorbed in due course as in abdominal pregnancy.

Summary

A case report of placenta praevia accreta has been presented with a short discussion.

Acknowledgement

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References

1. Irving, F. C. and Hertig, A. T. Surg. Gynec. & Obstet. 64: 178 1937.