PLACENTA PRAEVIA ACERETA

by

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Introduction

The combination of placenta accreta with placenta praevia is uncommon. There have been periodic reports of this association in the literature which have salutary effects in reminding us that there is a high incidence of placenta praevia associated with placenta accreta (Donald 1969). Although the patients usually have an uneventful pregnancy, occasionally catastrophic maternal haemorrhage may occur during intra and post partum period. The reported incidence of post partum haemorrhage is 40 per cent in cases of placenta praevia accreta which would invariably require emergency hysterectomy to save the life of mother.

Placenta accreta has been defined as the abnormal adherence of the placenta, to the uterine wall totally or in part, due to a complete or partial absence of decidua basalis, often with deficient Nitabuch's layer separating villi from myometrium. Further, the placental villi may invade and even penetrate the myometrium, conditions known as placenta increta and placenta percreta, respectively.

The case recorded in this report, is an example which demonstrates the difficulties in the management of placenta accreta.

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CASE REPORT

K; a 32-year-old woman who had 3 full term alive domicilliary confinements, and a stillbirth during the preceding pregnancy 2 years back, was referred from Primary Health Centre to medical college and SMGS hospital Jammu on July 20, 1978, for the management of retained placenta and profuse post partum haemorrhage. Four hours prior to admission the patient had domicilliary confinement aided by an untrained 'Dai' who had attempted manual removal of placenta. The patient had one termination of pregnancy 3 years ago, prior to the stillborn delivery.

The course of present pregnancy was uneventful until the 32nd week when the patient had mild vaginal bleeding which responded to conservative treatment. On admission the patient was administered ¼th grain morphine intravenously. A marginal placenta praevia was observed. The placenta was adherent so that no plane of separation was found. Patient was infused 2500 ml of 5% dextrose and 4 bottles of blood. She was administered 32 mg of dexamethasone intravenously. Oxytocin and ergometrin did not control the bleeding. Inspite of vigorous conservative treatment, the blood pressure and haematocrit values were low. Hysterectomy was planned. The anaesthetists refused to administer any anaesthetic agents and the subtotal hysterectomy which was completed (Fig. 1) immediately by infiltrating

the abdominal wall with 60 ml of 1% xylocaine. The patient tolerated operative procedure very well. She received 2 bottles of blood during the operation. She had uneventful post operative period except abdominal wound infection which was treated by systemic antibiotics. She was discharged on 25th postoperative day.

Discussion

It is not our intention to discuss the etiology of placenta praevia accreta. The underlying causes of this are still somewhat debatable, except in the instances where there is a specific antecedent history of an event which may have produced endometrial trauma. Previous history of dilatation and curettage has been a contributory factor in our case. In the literature, the incidence of associated placenta praevia with accreta is 15%. This may be because the decidual formation in the lower uterine segment is deficient as compared to the upper segment where the degree of decidual deficiency is less. Dyer (1954) documented 2 cases of partial placenta accreta with pathological area occurring in those parts of the placenta lying in the lower uterine segment.

It would be difficult to make a definitive diagnosis of this pathology prior to operation but one can assume the diagnosis in those patients who have had previous uterine surgery and present with antepartum spotting.

It would be logical to remove the source of bleeding, and abdominal hysterectomy whether total or subtotal would be an ideal treatment because maternal mortality is remarkably lowered in these patients, even then exceeding 6 per cent (McHattia 1972; Fox 1972; Tamis and Tamis 1965). There are reported cases of successful conservative management (Rivlin 1967; Torbet and Tsoutsaplides 1968) but the associated mortality increases 5 times than that of immediate hysterectomy. In young primiparous women one would adopt conservative attitude but the inability to check post partum haemorrhage in such cases would make it mandatory to resort to hysterectomy.

Although improved conditions of blood bank and anaesthetic techniques would give courage to the obstetrician, but on some occasions, it becomes a challenge to the obstetrician to face the situation when an anaesthetist would absolutely refuse to co-operate, because of the low condition of the patient.

Surgery generally is performed in instances where the patient is in severe shock and an immediate hysterectomy by infiltration of the abdominal wall with 1% xylocaine would prevent a fatal outcome.

We do not know how many will favour our contention, but when we face a challenge, we must perform a quick operation even without the help of an anaesthetist.

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See Fig. on Art Paper IV