PLACENTA PERCRETA AS A CAUSE OF SPONTANEOUS RUPTURE OF UTERUS

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Placenta accreta was first described in literature as early as (1536-1614) by Plater. Since 1900 about 40 cases of placenta percreta with rupture of uterus are reported in literature Silber (1973). In placenta percreta chorionic villi completely penetrate myometrium and even serosa with absence of normal clevage of plane. This condition though not a very common but when associated with rupture uterus at any time during pregnancy is one of the most urgent obstetric catastrophae and results in high mortality.

CASE REPORT

Mrs. Nirmal 25 years C.R. No. 47177 was admitted on 25-11-1977 at 4.30 P.M. with history of amenorrhoea of 7 months and acute pain in lower abdomen for the last one hour. Medical aid was sought in her house and she was found to be in shock. About 1cc. of decadron and 1 amp. of coramine was injected and she was shifted to hospital. She was 2nd gravida with previous history of 3 months abortion and had curettage for incomplete abortion. There was no history of pain in abdomen in the past.

On Examination

She was fully conscious, apprehensive, pale, groaning with pain. Pulse—not perceptible, B.P. not recordable. Oedema of feet not present. Heart tachycardia. Lungs normal. On abdominal palpation uterus was 28 weeks and outline of the uterus was well marked. Foetal parts were not made out and foetal heart sound could not be heard. There was marked tenderness and guarding in epigastric region and around the umblicus. She was resuscitated, O_2 was given, foot end raised and blood was transfused immediately. Her blood pressure rose up to 70 mm Hg and pulse became perceptible. Meanwhile surgical opinion was taken for acute abdominal distress. A spinal needle No. 21 was introduced about 4" lateral to the midline into the right hypochondrium. Dark coloured blood was aspirated and diagnosis of rupture uterus was made. Urgent laparotomy was performed.

Laparotomy

Under general anaesthesia on opening the abdomen there was 2000cc. of blood with clots in the abdominal cavity. There was rupture of fundus of uterus from one corner of the uterus to the other involving anterior and posterior walls of uterus. The entire musculature of uterus was penetrated by placenta which was seen directly at fundus. Dead male foetus was delivered through ruptured site. The head was delivered followed by body. The placenta was attached to entire surface of uterus involving lower uterine segment as well (Figs I & II). No cleavage could be made out for placental separation. Subtotal hysterectomy was performed. She was transtused 4 pints of blood. Postoperative period was unevantful and patient left hospital after 12 days in good condition.

Discussion

The liberalization of abortions in India and increased curettage of uterine cavity

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in early pregnancy might increase the possibility of higher incidence of placenta accreta. Various etiological factors responsible for placenta percreta may be constitutional or acquired. The constitutional factors include anatomic defects of endometrium at cornual region Proctor (1922) and lower uterine segment Malkarian (1964). The acquired factors are infection, trauma by manual removal of placenta, curettage, submucous fibroid (Ecke 1926, Polak 1924 and Bjorko 1959), caeserian section (Diamond, 1962 and Manning, 1959) and fundal wedge resection Hogan (1958). Georgakopoulous (1974) reported placenta accreta among patients who conceived after treatment of Asherman's Syndrome. In case under discussion there was previous history of curettage.

Placenta is thinned out in majority of cases and occupies entire uterine cavity. The commonest site of rupture is at fundus which was noted by author also. The other sites could be lower uterine segment Parviz (1970), posterior wall of uterus Ian (1970) or anterior wall Martini (1956). Various authors have reported rupture at different periods of gestation from 16 weeks Manning 1959) to term Lloyed Jones (1961). The case reported by author had ruptured at 28 weeks period of gestation which was observed by Taylor also (1958). Patient can present with various clinical features. Bailo (1956) noted repeated bleeding and hypogastric pain whereas Mckeogh and D'Errico (1951) noted labour like contractions during pregnancy. There can be sudden acute pain in abdomen alongwith associated pain in chest and shoulder, vaginal bleeding and haematuria. The case presented had sudden pain in lower abdomen and revealed features of haemorrhage shock.

Treatment of condition is hysterectomy with survival rate of 100%.

Summary

A rare case of spontaneous rupture of uterus at 7 months of pregnancy due to placenta percreta has been discussed. Fig. 1 and 2 showing gross specimen of uterus along with placenta are also presented.

Acknowledgement

We are thankful to Dr. N. S. Pathania, Principal, Govt. Medical College, Jammu and Dean of attached hospitals for allowing us to publish this paper.

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See Figs. on Art Paper II