

PLACENTA PERCRETA CAUSING INCOMPLETE RUPTURE OF THE UTERUS

(A Case Report)

by

(Mrs.) BARUN KALA SINHA,* M.S.

and

(Mrs.) MALTI ROHATGI,** M.S., F.R.C.O.G.

Placenta percreta is the condition where chorionic villi burrow through the whole thickness of the uterine wall. The villi are demonstrated in the muscular wall of the uterus with absence of decidua basalis. These villi otherwise do not show any neoplastic character. The patients usually present as cases of retained-placenta with or without post-partum haemorrhage. The condition is diagnosed when difficulties are encountered in removing the placenta either vaginally or abdominally.

The present case presented with rather unusual features and therefore we considered it worth reporting.

CASE REPORT

Smt. U. Devi aged about 30 years, gravida 5th was admitted in the labour room on 31-5-79 with history of 9 months amenorrhoea, vague abdominal discomfort and backache for the last 12 hours and watery vaginal discharge for 24 hours.

Her previous menstrual cycles were normal. Her last menstrual period was on August 25th 1978 and accordingly expected date of delivery was calculated to be on 2nd June 1979. She had a poor obstetric record with 3 neonatal deaths and 1 midtrimester spontaneous abortion.

*Assistant Professor.

**Professor.

Department of Obstet. Gynaec., Patna Medical College & Hospital, Patna-800 004.

Accepted for publication on 28-11-79.

Following this abortion she was febrile for 20 days.

On general examination she was an average built woman with pulse 90/mt. B.P. 110/70 mmHg. and moderate pallor, Systemic examination did not reveal any abnormality.

Abdominal examination revealed the uterus to be of 34 week size (smaller than the period of gestation) with longitudinal lie and breech presentation which was not engaged. The foetal heart sound was 114/mt. and regular. The uterus was lax with occasional feeble uterine contractions. There was vague tenderness in the upper part of the abdomen. On pelvic examination the cervix was $\frac{1}{2}$ " long and external os was tightly closed. Presenting part was high up and clear liquor was draining.

The patient was advised complete bed rest. Ampicillin 500 mgm. I.M., 8 hourly was also prescribed. Mistaken dates or small for dates foetus was kept in mind and the patient was transferred to ward for further observation and investigation.

The remarkable change noted the next day was the aggravation in abdominal discomfort and continuous pain all over the abdomen. Her pulse rate was 130/mt. and pallor had increased. On palpation, the abdomen was found to be tender, and foetal parts were felt with difficulty and foetal heart sounds were 164/mt. regular.

With her previous obstetrical history and present maternal and foetal distress, an urgent caesarean section was decided.

On opening the abdomen surprisingly blood clots were found in front of the uterus. The uterus was retracted over the foetus. The lower segment was so thick that the foetus

could only be delivered by extending the original transverse incision into an inverted T.

An alive deeply asphyxiated dysmature male baby with Apgar score of 6 was taken out who was resuscitated with difficulty.

Presence of blood clots and the retracted uterus aroused the suspicion of rupture of uterus, therefore uterus was delivered out. Surprisingly the uterine muscles at the fundus had given way completely and the fundus was covered only by the thin peritoneum. The fundus was also highly vascular and network of dilated blood vessels were seen coursing the entire area. There was continue oozing of blood from this part of the uterus which was responsible for the blood clots seen at laparotomy. Placenta failed to come out spontaneously. A traction on the umbilical cord caused sucking in of the fundus. Even an attempt to deliver the placenta manually was unsuccessful, as there was no plane of cleavage. Placenta was situated at the fundus encroaching on the posterior wall of the uterus. The fundus area was completely eroded by the placental villi.

A diagnosis of placenta percreta was thus established, and we had to resort to hysterectomy despite the young age and poor obstetric carrier of the patient.

Two units of blood was transfused during the operation. Post-operative period was uneventful except wound infection and gaping for which secondary sutures were needed. Patient was discharged on 22nd day of operation in satisfactory health with a healthy baby of 2.25 Kg.

Pathology Report: The placenta was attached to the posterior wall and fundus of the uterus. The fundus was completely eroded by the placenta, which could not be separated from its attachment at the fundal area.

Histology: Several section from different sites confirmed the gross finding of placenta percreta. There was invasion of the whole thickness of myometrium by villous tissue and from partial to complete absence of decidua basalis.

Discussion

Literature on placenta percreta has been reviewed by several workers, Lloyd Jones and Winterton (1961), Sumawong *et al* (1966) and Hassim and Lucas

(1968). One case of placenta percreta diffusa was reported by Dube and Gupta (1976) which was diagnosed, at laparotomy.

Choudhary and Mukherjee (1975) also described a case of placenta percreta causing complete rupture of uterus at 28th week of gestation.

Another case of rupture of the uterus due to placenta percreta in midtrimester of pregnancy is reported by Bhargava (1979). However, in none of these cases the placenta percreta being the cause of rupture was even thought of, leave aside diagnosing the condition before laparotomy.

Our patient came with vague discomfort and mild abdominal pain, along-with features of dysmaturity at term. Here also the diagnosis of placenta percreta causing rupture of the uterus was established only after laparotomy for caesarean section. It was only when the uterus was delivered out for inspection, because of intraperitoneal haemorrhage and severely retracted uterus that the rupture was found to be due to placenta percreta at the fundus of uterus. A very striking feature in our case was the dilated blood vessels just underneath the peritoneal covering over the funds of the uterus.

In most of the reported cases as well as in the present case the site of rupture was at the fundus, although this is the thickest part of the uterus. No plausible explanation can be given for this except that there are greater chances of the fertilised ovum implanting itself near about the vicinity of the fundus of uterus.

Acknowledgement

My sincere thanks are due to Prof. (Mrs.) M. Rohatgi for her proper

guidance and help in preparing this article. I am thankful also to Superintendent, P.M.C.H. for his kind permission to use the hospital records.

References

1. Bhargava, H.: J. Obstet. Gynec. India. 29: 445, 1979.

2. Choudhary, P. K. and Mukherji, A. K.: J. Obstet. Gynec. India. 25: 532, 1975.
3. Dube, S. and Gupta, I.M.: J. Obstet. Gynec. India. 26: 5: 769, 1976.
4. Hassim, A. M., Lucas, C.: Brit. Med. J. 2: 97, 1968.
5. Lloyd-Jones, R. and Winterton, W. R.: J. Obstet. Gynec. Brit. C'wealth 68: 273, 1961.
6. Sumawong et al quoted by Reference 3.