

PLACENTA PRAEVIA ACCRETA

(A Review on 8 Cases)

by

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Placenta accreta is a well known clinical entity since a long time. But attention to concurrent placenta praevia and placenta accreta was drawn by Irving and Hertig (1937). Because of poor decidual reaction in the lower segment, placenta praevia has a greater tendency of accretion. The definitive diagnosis depends on histopathologic evidence of complete or partial absence of decidua basalis and fibrin layer (Nitabuch's layer) between villi and myometrium. The villi may invade and penetrate the myometrium giving rise to placenta increta and percreta. When one comes across such abnormal adherence, it should be however, treated as a clinical entity and not as a pathological oddity (Palanichamy, 1976).

Materials and Methods

Eight cases of placenta praevia accreta were treated in Eden Hospital, Calcutta, from November, 1976 to October, 1979, among 26,100 deliveries, an incidence of 1 in 3,262. During the period, 280 cases of placenta praevia and 295 cases of re-

tained placenta were treated. Of 8 cases, 4 were booked. Accretic placenta situated in the upper segment has been excluded in this study. All the cases were detected during caesarean section. Table I shows the incidence of accretion among placenta praevia in different studies.

TABLE I
*Incidence of Placenta Accreta Among
Placenta Praevia*

Authors	Year	Incidence per cent
Irving and Hertig	1937	15
DiMasi <i>et al</i>	1963	5
Topete and Azuola	1968	5.2
Palanichamy	1976	2.7
Present Series	1979	2.8

Results

The average age was 30.8 years and average parity 2.3. As to the etiological factors, 3 cases had previous L.U.C.S., 1 had D.I.C. and craniotomy and 1, manual removal of placenta. One case having expectant treatment went 7 days postdated (Fig. 1). The salient features of the cases are shown in Table II. Four cases (Case 1, 4, 6, 8) had no living issue.

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TABLE II
Salient Features of 8 Cases Etiology

No.	Age	Para	Etiology	Type of Placenta	Delivery	3rd stage management	Blood Transfusion (ML)	Foetal outcome	Maternal outcome
1.	40	1 + 0	P.E.T.	II post	L.U.C.S.	Hysterectomy	600	2.1 Kg., alive	Survived
2.	35	4 + 0	A.P.H.	IV	-do-	-do-	900	1.5 Kg., NND	Survived
3.	30	4 + 0	A.P.H.	III	-do-	-do-	300	3.2 Kg., alive	Survived
4.	30	2 + 2	A.P.H./ post CS	-do-	-do-	Packing	600	1.6 Kg., alive	Died
5.	31	3 + 0	A.P.H./ P.E.T.	IV	-do-	Hysterectomy	600	1.75 N.N.D.	Survived
6.	26	1 + 0	-do-	III Post	-do-	-do-	600	2.75 alive	Survived
7.	35	2 + 0	A.P.H./ Rpt. CS	IV	-do-	-do-	600	1.4 N.N.D.	Died
8.	20	2 + 0	A.P.H./ Post CS	IV	-do-	Mabress stitches	300	2.4 S.B.	Survived

Two mothers died of massive haemorrhage. Details of them are mentioned.

Case 4

L. D., aged 30 years, P₂ + 2 having no living issue and history of L.U.C.S. was admitted on 12-7-78 with occasional spotting. E.D.D.—20-11-78. She had a severe bout of bleeding on 13-10-78. Requisition for blood was sent and immediate L.U., C.S. done. On incision, the worm like tortuous veins started bleeding profusely. Type III posterior placenta was partially adherent. It was removed but bleeding continued from the lower segment. Her condition deteriorated rapidly. The bleeding was arrested to some extent by few mattress stitches, the lower segment was packed and operation completed. 600 ml. of blood was available at the end of operation, vaginal bleeding continued and she died an hour after.

Case 7

R. N. aged 35 years, P₂ + 0 was admitted with A.P.H. on 29-8-79. She had 2 previous sections and was a known hypothyroid having eltroxin for 2½ years L.C.B. 3½ years, E.D.D. 27-10-1979.

Her Hb. was 7.5 gm% and a bottle of blood was transfused. On 6-9-79, she had severe bleeding and immediate L.U. C.S. done. At operation, the lower segment looked congested with engorged veins all over. The baby was taken out quickly, the placenta (Type IV) was partially adherent. It was removed but haemorrhage from lower segment was excessive. The uterine arteries were clamped and subtotal hysterectomy done. Her condition rapidly deteriorated and cardiac massage was continued throughout the operation. One bottle of blood was transfused but she died half an hour after operation. The anaesthetist told later that she had sudden hypotension on induction and cardiac arrest on uterine incision.

Management

Total hysterectomy was done in 3 cases, subtotal in 3 and conservative treatment in 2 cases (Table II). Although total hysterectomy was intended we had to do

subtotal because of unfavourable circumstances and on the advice of anaesthetist. Both treated conservatively had no living issue. The placenta was bigger in size, comparatively thin and partially adherent. Histopathology confirmed placenta accreta in 4 and increta in 2 cases.

The postoperative period was uneventful except pyrexia in 3 cases and urinary tract infection in 2. Maternal mortality was 25% and foetal loss 50%. Four babies were below 2000 gms.

Discussion

Shah and Mehta (1973) reviewed 25 cases of placenta accreta reported in India till then and found 7 of them to be praevia accreta. Abraham (1975) reported 3 cases and Palanichamy (1976) the largest series of 9 in India. In this series, history of previous endometrial trauma was present in 62.5%. This trauma gives rise to formation of increased amount of fibrous tissue which is also responsible for poor decidua formation (Shah and Mehta, 1973). Many of the underlying causes are still debatable and our aim is to discuss the management which is all important to a clinician. Management of placenta praevia accreta taxes one's clinical judgement and often decision in split seconds is necessary. 4 cases in this series had no living issue. Decision in such cases poses a dilemma. Irving and Hertig (1937) recommended immediate total hysterectomy and it is no doubt the safest procedure. This is more so in praevia accreta (Dimasi *et al* 1963) to avoid catastrophic haemorrhage from the portion of lower segment left behind. Subtotal hysterectomy can not be the best treatment as opined by Shah and Mehta (1973). The risk of haemorrhage in some

cases remains as happened in the case of Sathe and Vijaya (1979). Vaginal packing failed and they had to resuture the vaginal angles.

In the present series 37.5% each had total and subtotal hysterectomy and 25% conservative treatment. In young patients, with no living issue conservative treatment (manual removal, piecemeal removal, packing) has a limited scope. Palanichamy (1976) treated 7 of 9 cases conservatively. Two of them died. We lost one of the 2 cases. Perhaps hysterectomy could have saved her.

Summary and Conclusion

(1) Eight cases of placenta praevia were treated in Eden Hospital, Calcutta, from November, 1976 to October, 1979 among 26100 deliveries and 280 cases of placenta praevia. The incidence of accretion among placenta praevia was 2.8%.

(2) 37.5% each had total and subtotal hysterectomy and 25% conservative treatment. Hysterectomy is the treatment of choice.

(3) The maternal mortality was 25% and foetal loss 50%.

(4) The etiological factors and management in particular, have been discussed with a review of the literature.

(5) One must be careful while doing caesarean section in a case of post C.S. placenta praevia and 2 units of blood should be kept reserved even if the patient is not anaemic.

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See Fig. on Art Paper III