PLACENTA ACCRETA

(Report of 4 Cases)

by

PREETI MISRA,* D.G.O., M.S.
RANJANA JAIN,** M.S.
and
JYOTSNA OJHA,*** M.S.

Placenta accreta is a rare, but an important cause of retention of placenta. Incidence of this condition varies from 1 in 900 to 1 in 16000 deliveries as quoted by different workers (Irving and Hertig, 1937; Cunningham, 1942; Aaberg and Reid, 1945 and Burke, 1951). Association of placenta praevia with accreta is frequently seen (Miller, 1959). Partial and focal varieties are more common and also more dangerous than complete one because of risk of severe post-partum haemorrhage (Kistner *et al* 1952).

Four cases of placenta accreta are being described which were observed during 12 years period (1968-1979) at P.B.M. Hospital, Bikaner.

Case 1

Mrs. J., aged 40 years, para 8 + 0, an unbooked case, was admitted on 30-11-1968 at term pregnancy with onset of labour pains. On examination, her general condition was fair, pulse 100/min., respiration 20/min., B.P. 104/70 mm of Hg. with normal findings in cardio-respiratory system. On abdominal examination, uterus was found to be term size, acting very mildly, head floating, foetal heart sounds present, regular 136/min., tone good. Pelvic examination revealed acquired type of contracted pelvis with evidence of cephalo-pelvic disproportion. Therefore, immediate lower segment caesarean section was done. After the delivery of alive healthy foetus, no plane of clevage could be found between the placenta and uterine wall, so subtotal hysterectomy was performed. Patient had uneventful recovery and was discharged on 13th post-operative day. Histopathological report confirmed the diagnosis of placenta accreta.

Case 2

Mrs. M., aged 24 years, para 2, was admitted on 12-12-1969 at 3 P.M. with the history of spontaneous full term delivery at home 3 hours back, but the placenta was retained. On examination, her general condition was fair with normal vital parameters. On abdominal examination, uterus was about 20 weeks size and well contracted. On vaginal examination, the entire placenta was felt adherent to the uterine wall with no plane of clevage, bleeding was very little. The cord was clamped as close to the placenta as possible and left as such. Following this conservative treatment, patient had uneventful puerperium and started having normal menstrual periods after 2 months with normal uterine involution.

Case 3

Mrs. J., aged 35 years, para 2, was admitted on 8-6-1977 for retained placenta. She had spontaneous home delivery 6 hours prior to admission, but the placenta could not be delivered inspite of all efforts made by midwife. On examination, she appeared to be in fair condition, pulse 96/min, B.P. 110/70 mm of Hg., temperature 37°C. Abdominal examination reveal-

*Reader.
**Research Officer.
***Lecturer.
Department of Obstetrics and Gynaecology, Sardar Patel Medical College, Bikaner.
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ed uterus to be enlarged about 20 weeks size and well contracted. On vaginal examination, cord was not felt as it had been already broken, placenta felt in the uterus, but no plane of separation could be found. Bleeding was minimal, so the patient was put on conservative treatment. She was discharged in satisfactory condition on 17th puerperal day. On further follow ups at post-natal clinic, patient was found to make good recovery and uterus had involuted satisfactorily.

Case 4

Mrs. L., aged 28 years, para 3 and one abortion, was admitted on 14-6-1978 as a case of inevitable abortion. Duration of pregnancy was 24 weeks. She aborted an alive foetus which succumbed immediately after birth. Placenta was not expelled spontaneously and there was minimal bleeding. Exploration of uterus was attempted, but due to firm attachment to uterine wall, placenta could not be removed. Patient was kept on conservative treatment. Her lying-in period was uneventful and she was discharged on 15th day in satisfatory condition. Patient came for follow up after 3 months. . She regained normal menstrual periods and pelvic examination was normal.

Discussion

Placenta accreta represents a specific abnormality of placentation in which placental villi attach directly to the myometrium without intervening decidua (James *et al* 1977). Absent or poorly developed decidua is a constant pathologic feature suggesting that any event which adversely affects the endometrium could result in placenta accreta. Predisposing factors include previous dilatation and currettage, endometritis, submucous leiomyomata, uterine scars-post caesarean or post hysterotomy, Asherman's syndrome, manual removal of placenta, multiparity and adenomyosis.

Placenta accreta is recognised only when one tries and fails to remove manually a retained placenta or during caesarean section (Gogoi, 1968). Out of 4 cases presented here, the condition was recognised during manual removal of placenta in 3 cases and in 1 during caesarean section. In complete variety, there is no bleeding unless forcible manual separation is tried.

Whenever placenta accreta is diagnosed it is best to do a hysterectomy rather than to attempt conservative treatment (Rubenstein and Lash, 1962). Manual removal may lead to perforation of uterus, inversion and profuse bleeding (Irving and Hertig, 1937; Dyer *et al*, 1954 and Gogoi, 1968). Our results were, however, good even when hysterectomy was not performed suggesting that conservative treatment may be considered in special circumstances. Miller (1959) has stated that when placenta accreta which is not associated with placenta previa is encountered after vaginal delivery and if the bulk of the placenta seems firmly attached, a conservative attitude may be adopted with the realization that there is calculated risk of sudden haemorrhage or infection and hysterectomy may be necessitated later.

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