PLACENTA PRAEVIA ACCRETA

(Report of 2 Cases)

by

RAJ CHEEMA
KUMKUM AVASTHI
and
NAGEEN

Introduction

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 (1957). Because of poor decidual reaction in the lower segment, placenta praevia has greater tendency to accretion. Partial and focal varieties are more common and also more dangerous than complete because of risk of severe postpartum haemorrhage (Kristner *et al* 1952).

Case Reports

Case 1

S.B., 24 years old female, was admitted on 9th November 1982 with history of 35 weeks amenorrhoea and false labour pains. History of previous 2 lower segment caesarean section for C.P.D. and 1 abortion. Uterine height 35 weeks, breech presentation LSA, breech high up. Foetal heart sound 140/mt.

She was kept for elective caesarean. On opening the abdomen lower segment was very thin. Large blood vessels were covering the lower uterine segment. On incising the uterus it was seen that the placenta was lying anteriorly. Healthy male baby weighing 2700 gms was extracted as breech. When placental separation was attempted, no plane of cleavage could be found. Piecemeal removal of placenta was tried. Lower edge of uterine incision was papery thin. Placental cotyledons were burrowing in to the uterine musculature and patient was bleeding profusely. Patient's blood pressure fell to 60 mm of Hg. Sub-total hysterectomy was done. Patient was given 3 units of fresh blood in O.T. At the end of operation patient was in shock and B.P. was 40 mm of Hg. As vaginal bleeding continued, the patient was examined in lithotomy position with large Sim's speculum. The bleeding was coming through cervical canal. The cervix was held with sponge holding forceps and one stich was put at each lateral angle of cervix, tight intra-cervical and vaginal packing was done which was later removed after 24 hours. The patient was given 4 more units of blood in immediate post-operative period. Although she recovered from shock she developed acute renal failure. Later she was shifted to Nephrology Department and Haemodialysis was done twice. Kidneys opened up and she went into diuretic phase. But she developed bronchopneuminia and septicaemia and died on 20th post-operative day.

Case 2

Patient Mrs. S., 32 years, was admitted on 24-4-1985 with the history of amenorrhoea 43 weeks and loss of fetal movement since 1 week. On admission pulse was 80/min., B.P. 120/84. Height of uterus was term. Presentation vertex with rather high head in L.O.A. position. Foetal heart sounds were absent. Hb. on admission was 10.8 gm%. B.P. was 2 mins., C.T. 3 mins. 50 sec., Blood group B +ve. Urine—N.A.D., X-ray abdomen on 25-3-85 showed a single foetus with vertex presentation, maturity 38-40 weeks. She

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was given syntocinon drip with 2 units for induction of labour in 1st two days. The response was not good. On the 3rd day labour pains started and after 4 hours of syntocinon drip patient started bleeding profusely. Vaginal examination revealed 3.5 cms dilatation of the cervix and internal OS was completely covered with placenta. L.S.C.S. was done and still born macreated female baby weighing 3.2 Kg. was delivered. Placenta was posterior. There was difficulty in taking out the placenta which was firmly adherent to the lower segment. No plane of cleavage could be found in the lower segment, attempt was made to remove in piecemeal, but patient started bleeding profusely, and a decision was made to go ahead with hysetrectomy. Subtotal hysterectomy was done. 3 units of blood were given and patient had a uneventful recovery. Histopathological examination of the uterus confirmed placenta accreta (Fig. 1).

See Fig. on Art Paper IV