Management of a complicated case of first trimester missed abortion with adherent placenta

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Missed abortion, diagnosed on ultrasound by the absence of fetal heart activity is treated by immediate evacuation of the uterus, without waiting for spontaneous abortion. Conventional techniques are vacuum aspiration and dilatation and curettage. Very rarely, serious problems at evacuation due to morbidly adherent placenta may be encountered. A rare case of missed abortion in a primigravida referred to us after 4 attempts at uterine evacuation, with history of uterine perforation occurring in two of the attempts, is reported.

A 24 year old primigranda was diagnosed to have missed abortion at 10 weeks of pregnancy. Vacuum aspiration (V.A.) was tried under general anaesthesia (G.A.) at a peripheral hospital, but the products could not be removed. A second attempt at evacuation was done at another hospital after 2 days, and again no tissue could be aspirated or curetted out. The patient was referred to the local district hospital, where evacuation under G.A., two days later again could not result in evacuation of the uterus. Perforation occurred with the sharp curette. The patient however did not have excessive bleeding and she was conservatively treated with antibiotics and bed rest under close observation. After another week, ultrasound guided V.A. was attempted, but again perforation occurred with the No. 4. Hegar's dilator. The procedure was abandoned, and the patient was referred to the All India Institute of Medical Sciences, New Delhi.

On admission, the patient was afebrile, there was no anemia, uterus was 8-10 weeks size, anteverted, mobile, fornices were free. There was no tenderness and no bleeding per vagina.

Transvaginal ultrasound showed a single crumpled fetus, with crenated, irregular gestation sac. The placenta was low lying over the os, and hypoechoic shadows were seen in the endometrium and 5 mm. into the myometrium at the placental site.

Color Doppler did not show any placental flow. She was started on broad spectrum antibiotics and metronidazole.

Clot retraction time was 1 hour, but fibrinogn levels were normal. Adequate fresh blood and fresh frozen plasma were arranged.

Management of this case was a real challenge. It was decided to instill 0.5 mgm Dinoprostone (PGE2) gel intracervically. Consent was taken for laparotomy and hysterotomy.

After PGE2 gel administration, the patient started having slight bleeding per vagina after two hours. Vaginal examination fortunately revealed a dilated cervix and products of gestation were felt in the cervical canal. Under sedation with Intravenous Pentazocaine (15 mgm) and diazepam (5 mgm), the placenta and fetus were removed with ovum forceps. The placenta appeared incomplete, gentle curettage with sharp curette was done very carefully till a gritty sensation was obtained. Bleeding was normal in amount. Ultrasound showed a completely empty uterus.

Histopathology of the tissues removed by curette showed chorionic villi. The patient was observed for 72 hours and then discharged on antibiotics. On follow up at 2 weeks and 6 weeks the patient was healthy, without any complications.

Thus, a case of first trimester missed abortion with morbidly adherent placenta diagnosed at curettage, in a young primigravida, with history of uterine perforation in two of the four prior attempts at evacuation of the uterus, was successfully managed conservatively.