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Placenta Percreta – An Unusual Case

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A 22 years old woman was referred from outside by an obstetrician to our institute on April 7, 2001 with history of preterm delivery before 17 days and retained placenta and altered plasma fibrinogen and fibrinogen degradation product.

She was a primipara and had delivered spontaneously at 28 weeks, a male child of 1.5 kgs (who died after 3 days of delivery). After delivery of the baby placenta was not expelled out inspite of every effort including manual removal of placenta by the attending physician. Placenta was found to be morbidly adherent to the right cornual side of the uterus.It was also confirmed by sonography. As there was no bleeding and she was primipara, conservative approach with antibiotics, ergometrine and methotrexate with regular follow up of BT, CT, plasma fibrinogen and a fibrinogen degradation products was planned. Initially her all reports were within normal range except her plasma fibrinogen which was decreasing gradually. After 15 days of delivery it was 180mg% from 380mg% of initial level. There was also presence of fibrinogen degradation products (16mg/ml) and as she had off and on fever and subinvoluted uterus, she was admitted to our hospital.

Examination of the case on admission was normal except that her uterus was subinvoluted-about 20-22 weeks size, no tenderness or rigidity. Cervix one finger open and products felt in right cornual part of the uterus. There was no bleeding. Her blood investigations were also within normal range except low plasma fibrinogen and high fibrinogen degradation products. Sonography also reported morbid adhesions of placenta towards right side of uterus. Removal of placental tissue by dilatation and evacuation with all preparation for laparotomy was planned on April 9.2001, D and E was done under anaesthesia and about 200gms of placental tissue was evacuated. Few bits of placenta were still adherent, but there was no active bleeding and further management was planned with methotrexate.

She was alright except spikes of fever off and on. She was discharged after 7 days. She came back after 13 days with severe pain in abdomen. On examination – she had tachycardia, 103°F temp. Per abdomen – uterus subinvoluted about 18 weeks size, illdefined mass on right side of uterus which was tender. There was no bleeding per vagina. Sonography confirmed ill-defined mass attached to the uterus and collection of thick fluid in the mass and few bits of placenta in uterine cavity. Clinical dignosis of peritonitis and abscess formation was made and laparotomy, undertaken.

There was a lump of transverse colon, small intestine, omentum and uterus. Gentle separation revealed cavity full of pus and placental tissue. Placental tissue was coming out from the uterine wall and was adherent to it. No evidence of perforation was found. It was a case of placenta percreta with superimposed infection. Part of the uterus with attached placental tissue was excised and sutured in layers. Pus was drained. Post operative period was uneventful and all her blood reports including β-hCG were within normal limits. Though she is primi she was advised not to become pregnant and come for regular follow up.

Discussion

Placenta accrete, increta or percreta are rare but potentially lethal obstetric emergencies. Removal of abnormal growth of the placenta from the uterine wall is difficult or impossible and results in massive blood loss. Hysterectomy may be necessary to save the mother's life. The common predisposing factors in development of

placenta percreta are repeat caesarean and placenta previa. The diagnosis of placenta percreta may remain undiagnosed until delivery. Pelosi (1999) has reported a case of placenta previa percreta with bladder invasion which required a modified caesarean hysterectomy at 34 weeks with profuse haemorrhage. The bladder was partially mobilized beneath the percreta invasion site via the paravesical spaces. Descargues et al (2000) have managed a case of placenta percreta with bladder invasion by arterial embolization and manual removal after caesarean. Placenta percreta may present in the second trimester with signs and symptoms of uterine rupture. The diagnosis of this event may be difficult because of mild abdominal discomfort often associated with normal pregnancy. When a woman with risk factors for abnormal placentation presents with abdominal pain and/or vaginal bleeding in the second trimester of pregnancy, the diagnosis of placenta percreta should be considered. Placenta percreta in the second trimester is a potentially life-threatening condition that warrants expeditious diagnosis to limit maternal postoperative morbidity (Zeeman et al 1999).

In case of placenta percreta, it is essential to prepare adequate volume of blood for transfusion at the start of the surgery and secure large bore intravenous lines. A rapid transfusion device may be recommended. General anaesthesia is preferable in consideration of the risk of haemorrhagic shock and the length of operation time. Furthermore, team approach and preoperative management to prevent the uncontrolled haemorrage are helpful in difficult cases.

References

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