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Placenta Percreta : A Life Threatening Situation

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Introduction

Incidence of placenta percresta is increasing. The persistent bleeding after delivery creates an emergency. Conservative management has its limitations and hysterectomy, even in a patient wishing to have more children, has to be resorted to on occassions.

Case Report

Mrs. XYZ, a 32 year old married housewife was referred from a private hospital on 27th October, 2000 as G3P2L1 with previous LSCS with preterm premature rupture of membrane since 12 hours. There was no history of any foul smelling discharge, fever, pain in abdomen or vaginal bleeding; LMP was on 8th May 2000. Her first pregnancy resulted in a normal delivery of a female baby 12 years back who is well. Second pregnancy ended in a LSCS done for low lying placenta at 7 months amenorrhea; male child died on first day due to prematurity.

On admission, her pulse was 100/min; BP 100/70 mm Hg. Uterus was 18-20 weeks in size. Vertical scar of LSCS was present. There was no scar tenderness. Uterine activity 1-2/10/20. Vaginal examination showed a 2.5 cms dilated, poorly effaced cervix and absent membranes. She aborted spontaneously on 27th October, 2000 at 8.30 PM a male abortus of 200gms. Placenta got expelled incompletely in bits that were followed by profuse bleeding; bleeding was controlled with prostodin and oxytocin. All emergency investigations were sent for. In view of patient's poor vital condition, she was managed conservatively. Blood transfusion was given and higher antibiotics started. USG of the pelvis showed retained products of conception. She was taken for emergency check curretage. She started bleeding profusely as soon as the curretage was attempted and developed tachycardia of 140/min.. B P was 100/70mm Hg. Again prostaglandin and oxytocics were given and once she was stabilized, she was advised USG of the pelvis with color Doppler, but she went away against medical advise for some personal reason on 30th October, 2000.

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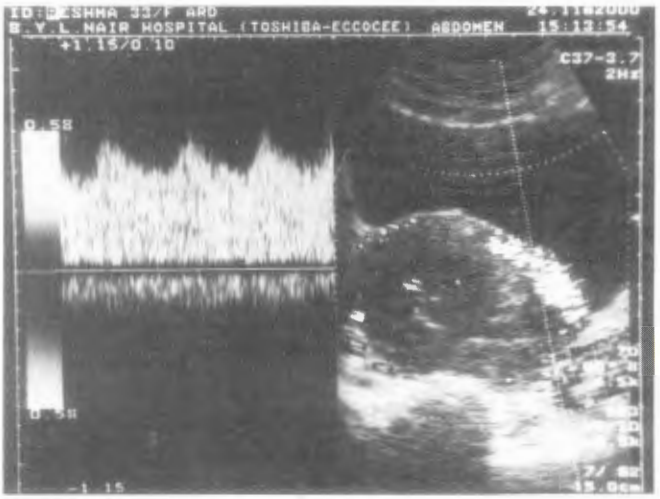
She came after three weeks on 23rd November, 2000 with a history of bleeding per vaginum since 10 days. She was anemic clinically. All her investigations were sent for, and blood transfusion was given to correct the anemia. She was sent for USG of the pelvis with color Doppler, which revealed a bulky uterus with anterior lower region showing iso - to hypoechoic lesion measuring 3.7x5 cms with hypervascularity in the form of low resistance high velocity flow (Photograph –1). Findings were suggestive of retained products of conception. Beta HCG=220 IU and value repeat after 24 hours was also 220 IU.

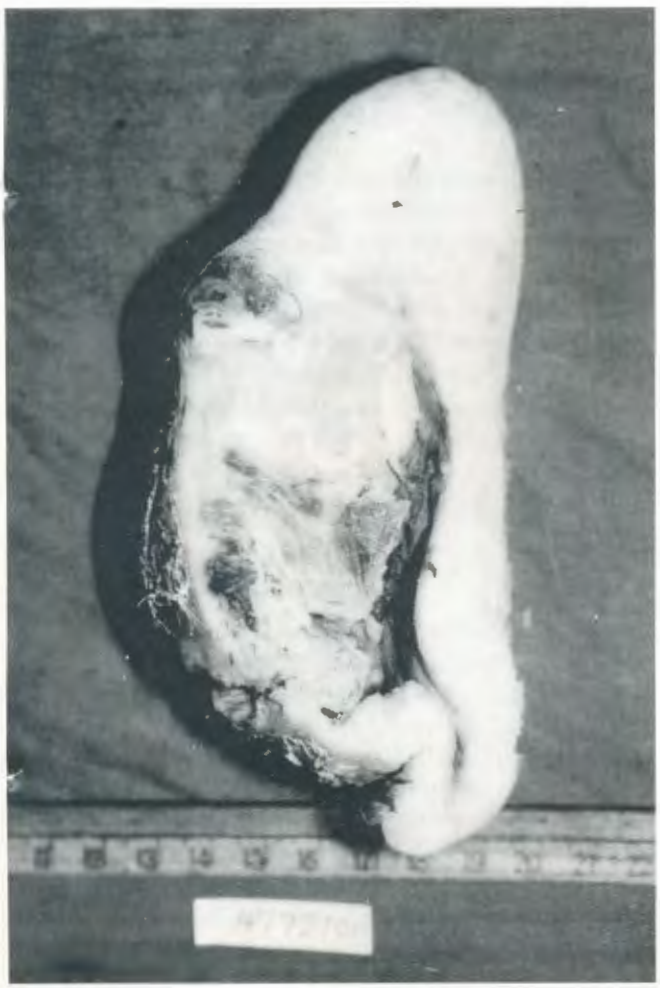


Photograph 1 : USG Pelvis with colour doppler. Uterus bulky, anterior and lower region showing iso - to hypoechoic lesion measuring 3.7x5 cms with hypervascularuty in the form of low resistance high velocity. Flow findings suggestive of retained products of conception.

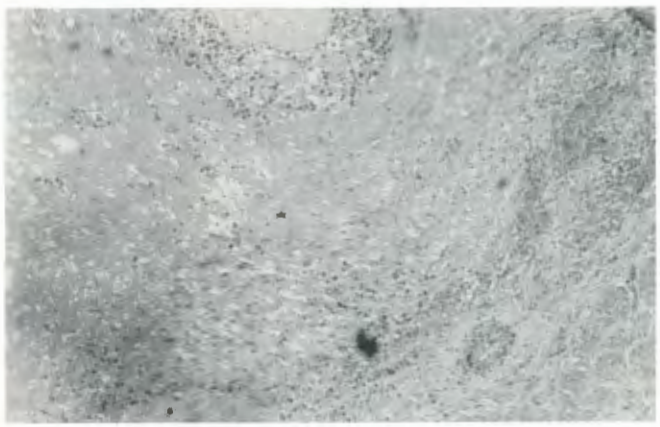
An MRI was advised but she could not afford it. Discussions with the patient and relatives regarding option of conservative versus surgical line of management resulted in the patient opting for hysterectomy. Total abdominal hysterectomy was done on 28th November, 2000.

Operative Findings – The uterus was bulky. A small mass of 2.5x5 cms size and bluish in colour and in midline on the lower uterine segment going beyond the serosa at one place was noted. Cervix and lower uterine segment appeared swollen/ballooned up, soft in consistency and vascular with dilated vessels running over the mass. Both

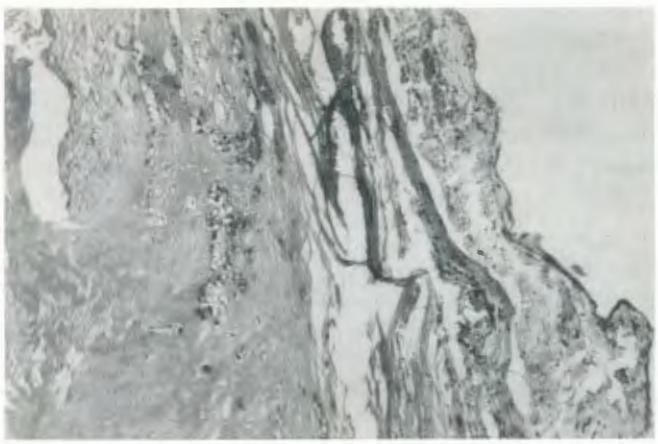
paramateria were normal and bladder was not adherent. (Photograph 2,3 and 4) The patient was discharged on 8th December, 12.2000.



Photograph 2 : Cut section of the specimen: Placental tissue seen in the lower segment replacing the myometrium and reaching upto serosa at few places.



Photograph 3 : Histopathlogical slide (H&E 100x) : single chorionic villus (center, top) with trophoblastic tissue infilterating into the uterine myometrium (right, below).



Photograph 4 : Histopathological slide (H&E100X): serosal aspect of uterine myometrium wall showing single chorionic villus (left, top) and trophoblastic tissue reaching the serosa and going beyond at one place

Histopatholgy impression :Uterus with placenta percreta.

Discussion

The incidence of placenta percreta has increased from 1:30739 (1930-50) to 1:4000 (1990-2000). On sonography there is loss of normal retroplacental hypoechoic zone, thinning or disruption of the hyperehoic serosa and focal projections beyond uterine margin[1]. Two strategies for management of percreta have been described, namely surgical removal of the uterus or the involved portion, and conservative management with the placenta in situ[2,3]. However, prompt hysterectomy still remains the gold standard of management for the treatment of placenta percreta as a life saving procedure especially in emergency.

References

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