

CONSERVATIVE MANAGEMENT OF PLACENTA PERCRETA

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ABSTRACT

Placenta percreta is a very rare condition. The incidence varies from 1:540 deliveries to 1:93,000. It is becoming more common in view of the increasing Caesarean Section rates all over the world. In this case report, clinical features, risk factors and management have been discussed. The Obstetrician therefore has to be very wary in cases of repeat Caesarean Section. Most cases of placenta percreta will end in a hysterectomy, but this case was managed conservatively.

KEY WORDS: Placenta Percreta, Conservative Management.

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INTRODUCTION

Placenta percreta is a form of morbidly adherent placenta where the chorionic villi invade the serosa and may even attach itself to surrounding organs such as the bladder and the bowels.^{1,2} It constitutes about 5% of all cases of adherent placenta. Other forms include accreta where the villi grow into the basal decidua and may be in contact with the myometrium (80%) and placenta increta where the villi invade into the myometrium (15%).

This condition, may lead to antepartum haemorrhage (APH) and post partum haemorrhage (PPH), and may be life threatening. It is usually diagnosed when usual placental separation is discovered absent.

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CASE REPORT

A 32-year old woman, G₂P₁ was admitted at 38 weeks gestation for elective caesarean section. The indication was cephalo – pelvic disproportion. Her first pregnancy ended in emergency caesarean section after prolonged labour, and the baby died three days later. She had a very stormy postoperative recovery due to severe sepsis.

The present pregnancy progressed uneventfully after booking at 10 weeks. Abdominal palpation at 37 weeks revealed a big baby lying longitudinally with cephalic presentation and the head very high. The pelvis was considered contracted on clinical evaluation and delivery by repeat caesarean section was decided.

The operation was performed under general anaesthesia. More than a quarter of the anterior surface of the lower segment was invaded by placental tissue. The bladder was spared. A lower segment caesarean section was performed which involved cutting through the placenta. A live male baby was delivered which, had open spina bifida. The placenta was removed piecemeal which resulted in severe haemorrhage and tattered anterior wall of lower segment. Haemostasis was achieved with considerable difficulty and the uterus

repaired with catgut. Her immediate postoperative condition was stable. A total of 4 units of blood were transfused. She made good progress and was discharged a week later. She was reviewed during her postnatal visit, and there were no problems.

DISCUSSION

As at present, most cases present during caesarean section without any previous warning.³ Risk factors include previous caesarean section and other uterine operations such as dilation and curettage (D & C), uterine malformation, septic endometritis, submucous myoma, and previous manual removal of placenta.⁴ The incidence of prior caesarean section in patients with praevia / percreta varies from 43 – 60% and the risk rises proportionately with the number of Caesarean Section.

Women with risk factors should be screened by ultrasound and colour flow Doppler studies. Magnetic resonance imaging (MRI), where available may also be helpful by delineating the placenta interface.^{1,2,5} Another diagnostic criterion may be an elevated maternal alpha foeto protein (AFP) level in the second trimester in the absence of fetal anomaly, and where the placenta is low lying.¹

Optimal management includes recognizing the risk factors and antenatal diagnosis, whenever possible. This enables adequate preparations made for blood transfusion and assembling the requisite personnel.^{6,7} Most cases will end in a hysterectomy. Conservative management has a role where there are focal defects, moderate blood loss, and where fertility is to be preserved, as in our case. These procedures include localized resection with uterine repair, over sewing of the uterine defect, blunt dissection followed by curetting of the uterine cavity. A non-surgical conservative method is to leave the placenta in situ to resorb and treatment with methotrexate. Other procedures

include uterine or internal iliac artery ligation and embolization¹ to control haemorrhage. Complications include bowel and urological injuries haemorrhage, sepsis, and surgical morbidity.

In view of the increasing Caesarean Section rate, more cases of placenta percreta are bound to occur.⁵ In order to reduce the associated maternal mortality and morbidity, it will be of tremendous help if the condition is diagnosed antenatally so that appropriate management will be instituted. A high index of clinical suspicion especially in high-risk patients backed by directed scans or special imaging techniques are a key to early diagnosis.

Conservative management in highly selected cases should always be considered in women where fertility is needed to be preserved.

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