

## PLACENTA PREVIA ACCRETA

Giri A<sup>1</sup>, Gurung G<sup>1</sup>  
Pradhan N<sup>1</sup>, Manandhar B<sup>1</sup>, Rana A<sup>1</sup>

### ABSTRACT

**Placenta accreta is defined as any placental implantation in which the placenta is abnormally and firmly adherent to the underlying uterine wall in part or in total. The probable cause is defective decidual formation as shown by its occurrence in area where the endometrium is deficient or damaged.**

**The commonest condition associated with it are placenta previa and previous caesarean section. A case of placenta previa accreta is described herewith in a 2nd gravida who eventually needed emergency caesarean hysterectomy (total) due to profuse bleeding.**

***Key Words: Placenta accreta, placenta, caesarean hysterectomy.***

### INTRODUCTION

Placenta accreta is defined as the condition where placenta is firmly adherent to the underlying uterine wall in part or in total. The commonest condition associated with it are placenta previa and previous caesarean section. It is said that with placenta previa, the incidence approaches 10% but in the presence of previous caesarean section and placenta previa, the incidence goes up to 25%.

Placenta accreta is one of the most dreaded complication of pregnancy with significant maternal morbidity and mortality due to severe haemorrhage, uterine perforation and infection. The incidence varies from 1:2500 to 1:7000 deliveries in recent years. According to Clark et al.,<sup>1</sup> 25% of patient with placenta previa and one previous C.S. and at least 50% of patients with two or more C. Section developed placenta accreta

1. Dept. of Obstetrics & Gynaecology, Tribhuvan University Teaching Hospital, Institute of Medicine, Maharajgunj.

**Address for correspondence :** Dr. A. Giri, Dept. of Obstetrics & Gynaecology  
Tribhuvan University Teaching Hospital  
Institute of Medicine, Maharajgunj, Nepal.

and 82% required caesarean hysterectomy. For this reason, one must be very careful while managing cases complicated by placenta previa in previous C. Section right from making the diagnosis so as to make best possible pre-op. arrangement.

## CASE REPORT

A 29 years old second gravida with one live baby who was delivered by caesarean section for CPD was admitted at 26+6 weeks pregnancy with profuse vaginal bleeding for 4 hours. The bleeding was fresh and painless. Her previous USG done at 23 wks. showed normal placental localisation.

At admission, she was quite pale, tachycardic with pulse rate of 120/min, weak volume and BP of 80/40 mmHg.

Her abdomen was non tender and the height of uterus was corresponding to the period of gestation. The FHR was 160/min and regular. She was immediately resuscitated with fluids and blood was transfused. When her general condition improved urgent USG was done which showed complete placenta previa (Fig. 1) with viable fetus corresponding to same gestational age.

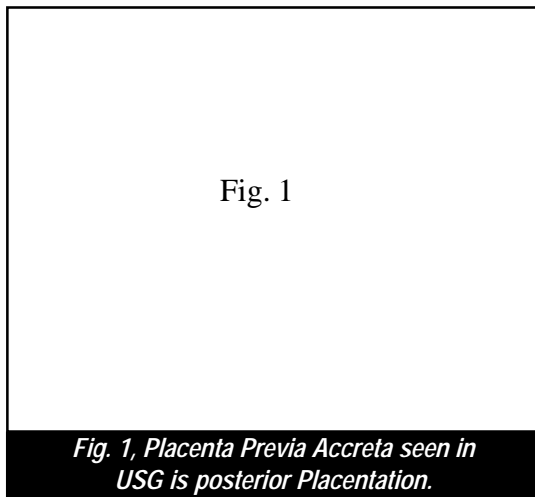


Fig. 1

*Fig. 1, Placenta Previa Accreta seen in USG is posterior Placentation.*

There were 2 other episodes of bleeding at 28 and 32 wks while she was on rest but fetal condition was satisfactory.

At 36 completed week, elective CS was done under G.A. As placenta was implanted in lower segment (Fig. 1), baby was delivered cutting through the placenta. At the attempt to remove the placenta manually, it was found to be densely adherent to the lower uterine segment in the previous caesarean scar. It was very difficult to separate the placenta. In view of profuse bleeding that occurred at the attempt to separate the placenta emergency caesarean (total) hysterectomy (Fig. 2) was

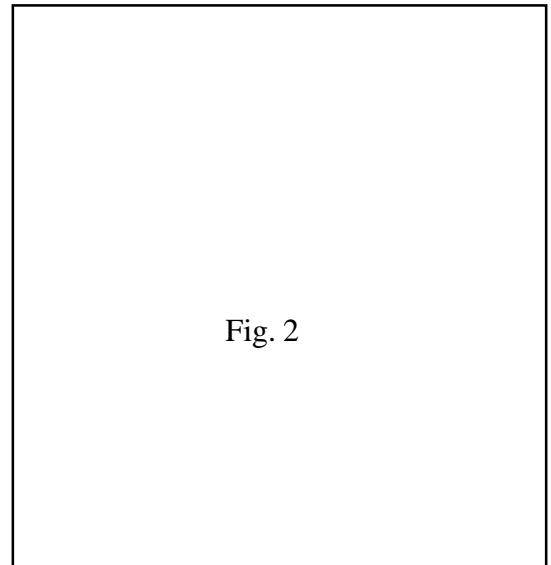


Fig. 2

*Fig. 2, Hysterectomy specimen. Placental membrane is shown to be adherent.*

proceeded with the diagnosis of placenta accreta in mind.

Intraoperatively patient went into shock due to massive bleeding (3-3.5 litres) for which she was transfused 6 units of blood. In immediate post operative period her condition did not improve and she went into respiratory arrest. She was intubated immediately and Inj. adrenaline 0.1mg was given to raise her BP which was unrecordable at that time.

She was shifted to ICU where she was kept on oxygen, inotropic support with dopamine, antibiotics (cephazoline 500mg 6 hrly & metronidazole 500mg 8hrly) and fresh blood was transfused to compensate for her loss. She was persistently tachycardic but maintaining the BP of 100-110 mm Hg systolic. In 2nd post op day, she developed abdominal distension and USG done showed intraabdominal collection which was self aspirated through the drain site. About 800ml of old blood was removed. From 3rd post op day, her condition started improving and both mother and baby were discharged 14 days after surgery in better condition.

## DISCUSSION

Planned elective cesarean hysterectomy has better outcome than emergency procedure in terms of morbidity (more blood loss, prolonged operative time, high infection rate) and mortality.<sup>2</sup> In our case as we could not envision this probable situation, the patient went in Hemorrhagic shock intra-operatively. Reprospectively, can we say that bleeding from the placenta could have been avoided ? The upper uterine caesarean delivery could have avoided the bleeding from the cut edges of the placenta that bled torrentially, needing 6 units blood per-operatively. Planned elective caesarean hysterectomy with upper uterine segment fetal delivery could have been better option.

Recent techniques like TVS with color doppler imaging has been documented to be useful in detection of placenta accreta antenatally.<sup>3</sup> One can also think of angiographic ballon occlusion & embolization<sup>4</sup> of internal iliac arteries, should the problem arise in a woman desirous of preserving the uterus.

## REFERENCES

- 1 Clark SL, Koonings PP, Phelan JP, Placenta previa/accreta and prior cesarian section. *Obstet gynecol* 1987, 66:89.
- 2 Zelop cm et al : Emergency peripartum hysterectomy *AM J Obstet gynaecol* 168:1443, 1993.
- 3 Lerner JP, Deane S, Timor-Tritsch LE. Characterisation of placenta accreta using transvaginal sonography and colour Doppler imaging. *Ultrasound obstet gynaecol* 1995, 5:198.
- 4 Dubois J, Garel L et al. Placenta percreta ballon occlusion and embolization of the internal iliac arteries to reduce intra-operative blood loss. *AM J obstet gynaecol* 1997, 176:723.

