



## A RARE CASE OF PLACENTA INCRETA – CASE REPORT

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**ABSTRACT** In these years with the raise in cesarean section rates, the frequency of PAS cases has risen. It has accounted for 33–50% of all emergency peripartum or obstetric hysterectomies. PAS is an obstetric emergency associated with a high maternal morbidity and mortality rate, presenting unique challenges in its diagnosis and management. We present a 24-year-old third gravida with previous 2 LSCS, who presented with PV bleeding, being unaware of pregnancy. This 22week pregnancy with previous 2 LSCS with placenta previa with active PV bleed, was managed surgically with obstetric hysterectomy as per intraoperative evidence and unstable vitals with severe hemorrhagic shock. Post operative recovery and follow-up was uneventful.

**KEYWORDS :** LSCS, placenta accreta spectrum, Placenta increta, Obstetric hysterectomy, Placenta previa, postpartum hemorrhage.

### INTRODUCTION

Placenta increta is a condition where complete placenta or a part of it invades myometrium in abnormal way. Reason for this pathological condition is defective decidualization at the time of implantation. Invasion of placental villi into myometrium only is termed as increta. The estimated rate of placenta accreta spectrum (PAS) devastating condition leading to complication is increased by 0.2 to 0.6 childbirths. Vigilance during antenatal period in cases of prior scarred uterus is must as there is dramatic increase in PAS incidence in last few decades, leading to maternal mortality and rescue hysterectomies leading psychological impact due to early fertility loss (1). This is why there is a tendency to opt for a conservative treatment whenever possible. Otherwise, hysterectomy is considered as the ultimate life-saving procedure if conservative approaches fail or if required by the workup of the lesion.

### Case Report

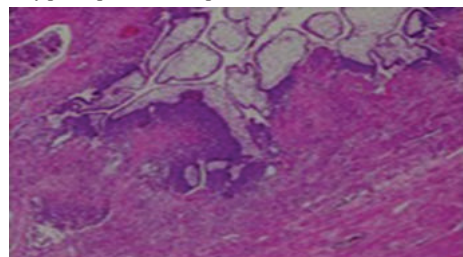
A 24 years old G3P2L2 with previous 2 LSCS was brought to labour room with vaginal bleeding since morning. Bleeding is fresh and associated with pain in abdomen, with history of change of 8 pads. Gives history of 4 months of amenorrhea. There was no history of trauma, fall or passage of clots or products. No history of previous abortions, suction evacuation or uterine surgeries. Patient was unaware of LMP. Last child birth was 3 years back with history of 2 prior LSCS with AB Rh negative pregnancy. UPT on kit was positive.

On examination her general condition was moderate, pulse rate of 120/min, regular and all peripheral pulses felt. BP- 100/60 MMHG in supine position, saturation of 99% in room air. Pallor was significant and peripheries were cold. No cyanosis, icterus, edema, lymphadenopathy. On abdominal examination, uterus size corresponding to 22-24 weeks, mild contractions +, external ballotment +, previous LSCS scar+ with no scar site tenderness. On per speculum examination cervix and vagina seemed healthy and there was evidence of active bleeding+. Per vaginal examination was not done. Patient catheterized and blood sample was sent for cross matching and rest of the investigations.



**Fig. 1** Showing abnormal vasculature on LUS

Emergency ultrasound was suggestive of 21 weeks live intrauterine pregnancy with placenta previa completely covering OS. Patient was taken up for emergency hysterotomy in view of previous 2 LSCS with placenta previa with active PV bleeding. Intraoperatively adhesions were present and scar appeared thinned out with minimal visible vasculature over lower uterine segment [Fig1]. Female abortus weighing 400 gms extracted by an incision at upper part of lower uterine segment. LUS appeared thinned out and attempt to separate placenta lead to torrential bleed with atonicity which was uncontrollable with oxytocics, continuous uterine massaging done. Due to the inability to obtain AB negative blood from nearby banks, the patient was transfused with 2 pint O RH negative PCV and fresh 4 frozen plasma. Due to torrential bleeding, unstable vitals, and intraoperative findings, the placenta accreta spectrum was suspected. A written informed consent decision was made for an obstetric hysterectomy as a life-saving procedure. During the procedure of obstetrics hysterectomy as there was dense adhesion between bladder and lower uterine segment, there was injury to the anterior wall of bladder, which was repaired in layers followed by placing IP drain, abdomen was closed in layers. Intraoperatively 3 pint PCV (O RH negative), 5 crystalloids, 2 colloids, 4 FFP were transfused. Intraoperatively due to severe hemorrhagic shock with unstable vitals (pulseless) patient revived with 3 cycles of CPR. With highest dose of inotropic support patient was shifted to ICU for postoperative management. Post operative patients hemoglobin was 3 gms, 3 AB negative PCV with 3 FFP and 3 RDP were transfused post operatively over a period of time with adequate interval. On post operative day 2 patient was extubated and inotropic support gradually tapered, on post operative day 14 patient was vitally stable without any inotropic support with hemoglobin of 9.3gms, shifted to ward. Foleys catheter was kept for 21days, on post operative day 25 patient discharged without any post operative complication.



**Fig. 2** Histopathology slide showing placental invasion into myometrium

Histopathological report was suggestive of placenta increta [Fig2], with myometrium lined by placental tissue composed of chorionic villi and decidua, in areas chorionic villi are seen infiltrating into myometrium. Post operative recovery and follow-up was uneventful.

**DISCUSSION**

Over the past 50 years, PAS-associated abnormalities have increased 10 times due to rising cesarean rates. Previous uterine surgery such as cesarean section, hysteroscopic removal of intrauterine adhesions, cornual resection of ectopic pregnancy is most frequently associated with PAS, with a 3% risk for previous cesarean sections and 40-77% for multiple cesarean sections (1-2).

The diagnosis of placenta previa is often made due to abnormal resistance and difficulty in delivering the placenta. Sonographic evaluation is used to suspect placenta adhesion abnormalities, which may include sonolucent areas in the placenta, a condition of the lower segment, loss of hypoechoic areas between the placenta and myometrium, hypervascularization on the surface between serosa and bladder, and vascular stasis with turbulent flow. MRI is a more precise imaging procedure for identifying the condition (3).

Uterine preserving methods, such as uterine conservation and resection of the adherent placenta and underlying myometrium, can be considered for women who desire future fertility. These methods involve leaving the placenta in situ after trimming the umbilical cord, stopping bleeding, and resorbing the placenta within 1-12 months. However, complications like sepsis, pulmonary embolism, and arteriovenous malformations can occur. Methotrexate treatment for resorption is not proven effective. Some women may undergo a subsequent hysterectomy after days to weeks postpartum, if blood loss is less. Conservative management is considered only in cases where expected blood loss is minimal and the woman desires future fertility (4).

Our patient was unaware of conception and unbooked, missed an antenatal diagnosis of PAS, experienced torrential bleeding for which pregnancy was terminated. Due to unstable vitals decision of hysterectomy was made as a lifesaving procedure followed by histopathological confirmation

**CONCLUSION**

Abnormal placental invasion in a pregnancy implanted in a cicatricial uterus has risen in last few decades due to the increase in obstetric scars. This abnormal invasion of placenta into uterine musculature leads to weakening and thinning of isthmic region leading to abnormally adherent placenta. This placental abnormality may lead to complications like PROM, abortions, PPH and retained placenta.

Uterine preserving conservative management can be considered if women desire future fertility and vitally stable. Ultimately, the hysterectomy remains as the life-saving procedure if conservative methods fail or if required by the workup of the lesion.

Ultrasound criteria for PAS spectrum should be systematically sought during second trimester ultrasound as its risk is increasing, there should be detailed evaluation in patients with previous scarred uterus during antenatal period. Proper antenatal counselling of patients and relatives should be done in diagnosed case for planned cesarean delivery followed by hysterectomy.

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