



## Placenta - Increta: A Rare Case Report

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### ABSTRACT

Placenta increta is a serious complication of pregnancy, characterized by entire or partial absence of the decidua basalis, it has a prevalence of approximately 1 in 2500 [ACOG 2002]. It is associated with life threatening complications. Here we present a case of placenta increta which was managed conservatively, as she was diagnosed preoperatively. A 35-year-old, G4P2L2MTP1 Hindu woman was admitted during the 36th week of her fourth pregnancy electively for LSCS. After admission in Doppler study she was diagnosed to have placenta increta. At 37 weeks of pregnancy she started having abdominal pain and bleeding per vaginum so an emergency LSCS was performed. Placenta could not be separated completely due to increta component, she had atonic PPH; bilateral uterines were ligated and Blynch compression sutures were applied. She was discharged on 9th post op day. Recovery was uneventful.

### KEYWORDS

Placenta increta, Atonic PPH, Elective LSCS

### Introduction

Placenta increta is a serious complication of pregnancy. It is characterized by entire or partial absence of the decidua basalis, and by the incomplete development of the fibrinoid (Nita-buch's) layer. Although it is considered a rare occurrence with a prevalence of approximately 1 in 2500 [ACOG 2002], it is associated with high morbidity and sometimes with a lethal outcome, mainly as a result of severe bleeding, uterine rupture and infections [1]. Complications can include massive obstetric haemorrhage resulting in DIC, premature and/or incomplete placental separation, neonatal death, spontaneous uterine rupture in 2<sup>nd</sup> or 3<sup>rd</sup> trimester, intra-peritoneal haemorrhage, hysterectomy, surgical injury to ureter, bladder and other adjacent organs, renal failure and even death. Associated risk factors include advanced maternal age, multiparity (six or more pregnancies), placenta previa, previous uterine curettage and previous cesarean sections [2]. Here we are presenting a case of placenta increta, which was managed effectively.

### Case Report

A 35-year-old Hindu woman was admitted during the 36th week of her fourth pregnancy electively for elective LSCS, as she had 2 previous LSCS 6 and 3 years back and one MTP a year back.

On admission, her hemoglobin was 11.6 g/dL and other laboratory investigations were normal. In obstetric Doppler study she was diagnosed to have placenta increta. At 37 weeks of pregnancy she started having abdominal pain and bleeding per vaginum so an emergency LSCS was performed, baby was delivered by vertex and was healthy but placenta was adherent to uterus and was not separated completely. Part of placenta was left in situ due to increta component. She had atonic PPH which was managed by bilateral uterine artery ligation and B-lynch suture compression. Her post-op period was uneventful and patient was discharged on her 9<sup>th</sup> post op

day. Uterus involuted normally and USG at 6 wks postpartum showed normal findings and no placental tissue left in situ.

### Discussion

The risk of placenta accreta is common in women with 2 previous LSCS and one MTP. Under these circumstances, the more conservative treatment can be achieved only in cases of a partial placenta accreta/ increta, when bleeding is minimal. The increased morbidity associated with cesarean hysterectomy has prompted an increase in conservative management approaches.

In 1972, Fox<sup>3</sup> suggested a hysterectomy in women with placenta accreta to avoid serious complications, but since then there have been several reports of conservative management. The benefits are the avoidance of major surgery with the consequent morbidity and the preservation of future fertility. Arukumaran et al.<sup>4</sup> first reported the successful treatment of placenta accrete with methotrexate. There was no ultrasonographic diagnosis of the extent of myometrial invasion and no placenta was found on ultrasound two weeks after completion of treatment.

Variations in treatment protocols have included hypogastric artery ligation, uterine artery embolization (UAE), B-Lynch compression sutures, recombinant activated factor VII, and chemotherapy with methotrexate.<sup>5, 6</sup>

Conservative management is not without risks. Conservative management is often dependent on factors such as maternal age, desire to preserve fertility, extent of placental invasion, and likelihood of immediate surgical complications. Extensive blood loss can be associated with consumption of clotting factors that leads to disseminated intravascular coagulation and subsequent morbidity and death.

The key to successful conservative treatment and decreasing morbidity and mortality rates is the early identification of placenta percreta/accreta and the development of a delivery plan. The preoperative identification of AVMs and their locations, which based on our experience most often involve the ovarian veins, may provide useful information.<sup>7</sup>

#### Ultrasound/Magnetic Resonance Imaging

The Ultrasound characteristics of placenta accreta include the loss of decidual hypoechoic zones, the invasion of placenta in the myometrium and, in cases of low anterior placenta percreta, the disruption of the hypoechoic uterine serosa-bladder interface. If an abnormal placentation is suspected, Doppler ultrasound diagnose accurately the extent of myometrial invasion or even the presence of placenta percreta in the majority of cases. However, magnetic resonance imaging appears to provide a more accurate diagnosis in cases of posterior high placentation. In the case of a placenta praevia, Doppler ultra-

sound appears very sensitive in accurately showing the extent of the placental abnormality.<sup>8</sup>

#### Conclusion

Based on the few reported cases, we conclude that the diagnosis of abnormal placentation and its extent can be made accurately with the use of Doppler ultrasound in the majority of cases. In the rest, the magnetic resonance imaging can also be used to provide a definite diagnosis. In women considered to be high risk (i.e. those with placenta praevia or repeated caesarean sections), it is feasible to make an accurate diagnosis of placenta accreta and to define the extent of myometrial invasion antenatally. This will help to reduce the associated morbidity and mortality, although, it can occur with no major predisposing factors. Unless a life threatening haemorrhage occurs, a conservative approach is recommended even in women who do not want to preserve their fertility, considering the morbidity associated with a caesarean hysterectomy.

#### REFERENCES

- Berchuck A, Sokol RJ: Previous cesarean section, placenta increta, and uterine rupture in second-trimester abortion. *Am J Obstet Gynecol* 1983, 145:766-767.
- Miller DA, Chollet JA, Goodwin TM: Clinical risk factors for placenta previa-placenta accreta. *Am J Obstet Gynecol* 1997, 177:210-214.
- Fox H. Placenta accreta 1945-1969. *Obstet Gynecol Surv* 1972; 27:475-479.
- Arulkumaran S, Ng CS, Ingemasson I, Ratnam SS. Medical treatment of placenta accreta with methotrexate. *Acta Obstet Gynecol Scand* 1986; 65: 285-286.
- Shih J-C, Liu K-L, Shyu M-K. Temporary balloon occlusion of the common iliac artery: new approach to bleeding control during caesarean hysterectomy for placenta percreta. *Am J Obstet Gynecol* 2005;193:1756-8.
- Mechsner S, Baessler K, Brunne B, Albrecht T, Hopp H, Dudenhausen JW. Using recombinant activated factor VII, B-lymph compression and reversible embolization of the uterine arteries for treatment of severe conservatively intractable postpartum hemorrhage: new method for management of massive hemorrhage in cases of placenta increta. *Fertil Steril* 2008;90:2012.e1-5.
- James T. Barber Jr, DO; Terry B. Tressler, DO; Gregory S. Willis, DO; Francis J. Martinez, DO; David B. Peisner, MD; Jay D. Goodman, MD; Claudia D. Taboada, DO: Arteriovenous malformation identification after conservative management of placenta percreta with uterine artery embolization and adjunctive therapy. *American Journal of Obstetrics & Gynecology* MAY 2011. e 4-8 | 8.
- Theodore A. Panoskaltis, TAlessandra Ascarelli, TNandita de Souza Senior, Colin D. Sims, Keith D. Edmondst: Placenta increta: evaluation of radiological investigations and therapeutic options of conservative management. *British Journal of Obstetrics and Gynaecology* June 2000, Vol107, pp. 802-806 |