

## CASE REPORT

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### A RARE CASE OF PLACENTA PERCRETA AND ITS OBSTETRIC OUTCOME

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#### HOW TO CITE THIS ARTICLE:

Shobha Dhananjaya, Bandamma. N, Umasree G, Srushti D. S “A Rare Case of Placenta Percreta and its Obstetric Outcome”. Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 30, July 28; Page: 8414-8417, DOI: 10.14260/jemds/2014/3063

**ABSTRACT:** A 24-year-old woman G2P1L1 with previous caesarean section presented at 39 weeks of gestation to CG Hospital attached to JJM medical college, Davangere. Ultrasound showed features suggestive of placenta accrete. The patient was taken for elective cesarean delivery with blood in hand. On table, there was massive hemorrhage with atonic Post-partum hemorrhage. The obstetricians immediately proceeded with an emergency hysterectomy, during which time the lower uterine segment was found to be densely adherent to the bladder wall and the placental tissue invading into the bladder wall. The adherent part of placenta was left behind. She developed reactionary hemorrhage after 9 hrs. Relaparotomy was done and bleeding was found from the placental tissue adherent to bladder. Ligation of the internal iliac artery was done. She was discharged home on postoperative day 9 after removal of the abdominal drain. Her USG after one month shows non vascular placental tissue of 17 ml and her beta HCG values were less than 1

**KEYWORDS:** percreta, myometrium, invasion, emergency-hysterectomy, beta HCG.

**INTRODUCTION:** Placenta accreta is classified according to its degree of invasion into the myometrium. Placenta accreta vera, placenta increta, and placenta percreta. Placenta accreta vera is a term used to denote a placenta with villi that adhere to the superficial myometrium. Placenta increta occurs when the villi adhere to the body of the myometrium, but not through its full thickness. Placenta percreta occurs when the villi penetrate the full thickness of the myometrium and may invade neighboring organs such as the bladder or the rectum.

Although the exact cause of placenta accreta is unknown, it is associated with several clinical situations such as previous cesarean delivery, placenta previa, grand multiparity, previous uterine curettage, and previously treated Asherman syndrome, which is a condition characterized by the presence of scars within the uterine cavity.<sup>1</sup>

**INCIDENCE:** Incidence of placenta has increased from 1 in 4027 pregnancies in 1970 s to 1 in 2510 pregnancies in 1980 s and it was found to be 1 in 553 pregnancies in 1982-2002. This can be attributed to increase in the caesarean delivery rates.<sup>2</sup>

**CASE REPORT:** A 24-year-old woman G2P1L1 with previous caesarean section presented at 39 weeks of gestation to CG Hospital attached to JJM medical college, Davangere. Prenatal ultrasound was noted as normal. Ultrasound at the time of presentation, however, revealed features suggestive of placenta accrete. The patient's obstetric history was significant for 1 prior pregnancy delivered by cesarean. The patient was taken for elective cesarean delivery with blood in hand. A healthy, 35000-g female was delivered. However, there was massive hemorrhage with atonic Post-partum hemorrhage. The obstetricians immediately proceeded with an emergency hysterectomy, during which time the lower uterine segment was found to be densely adherent to the bladder wall and the

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placental tissue invading into the bladder wall. The patient was then admitted to the intensive care unit with drain insitu. She developed reactionary hemorrhage after 9 hrs. Relaparotomy was done and bleeding was found from the placental tissue adherent to bladder. Ligation of the bleeding points and resection of all the stumps with internal iliac artery ligation was done. After 48 hours, transferred to the ward, and discharged home on postoperative day 9 after removal of the abdominal drain. Her USG after one month shows non vascular placental tissue of 17 ml and her beta HCG values were less than 1.

She remained well till today without any further complication.

**DISCUSSION:** Placenta accreta occurs in approximately 1 in 2500 pregnancies. Of these, approximately 75% to 80% are placenta accreta vera, about 17% are placenta increta and the remaining 5% or so are placenta percreta. Although the overall incidence of placenta percreta is extremely low, the appearance of this rare disorder seems to be increasing due to the performance of more cesarean deliveries in the past few years.<sup>3</sup> About 75% of placenta percreta cases are associated with placenta previa.<sup>4</sup>

Bladder invasion by the placenta (placenta percreta) is a potentially life-threatening obstetric complication, albeit a rare one. The diagnosis is usually established when attempts are made to separate the adherent placenta from the bladder. This maneuver causes massive hemorrhage that is often quite challenging to control. A firm preoperative diagnosis allows adequate preparation and organization of multidisciplinary help for what may be a difficult surgical procedure requiring massive blood transfusion.

**Diagnosis:** Transvaginal ultrasound is safe for patients with placenta previa and allows a more complete examination of the lower uterine segment. The ultrasonographic features suggestive of placenta accreta include irregularly shaped placental lacunae (vascular spaces) within the placenta, thinning of the myometrium overlying the placenta, loss of the retroplacental “clear space,” protrusion of the placenta into the bladder, increased vascularity of the uterine serosa–bladder interface, and turbulent blood flow through the lacunae on Doppler ultrasonography.<sup>5,6</sup> The presence and increasing number of lacunae within the placenta at 15–20 weeks of gestation have been shown to be the most predictive ultrasonographic signs of placenta accreta, with a sensitivity of 79% and a positive predictive value of 92%.<sup>7</sup> These lacunae may result in the placenta having a “moth-eaten” or “Swiss cheese” appearance.

**Magnetic Resonance Imaging:** Magnetic resonance imaging is more costly than ultrasonography and requires both experience and expertise in the evaluation of abnormal placental invasion. Although most studies have suggested comparable diagnostic accuracy of MRI and ultrasonography for placenta accreta, MRI is considered an adjunctive modality and adds little to the diagnostic accuracy of ultrasonography. However, when there are ambiguous ultrasound findings or a suspicion of a posterior placenta accreta, with or without placenta previa, ultrasonography may be insufficient.

**CONCLUSION:** Placenta percreta, which can affect any neighboring uterine structure, is a life-threatening condition. Skill full surgery, timely management and constant vigilance is the key to

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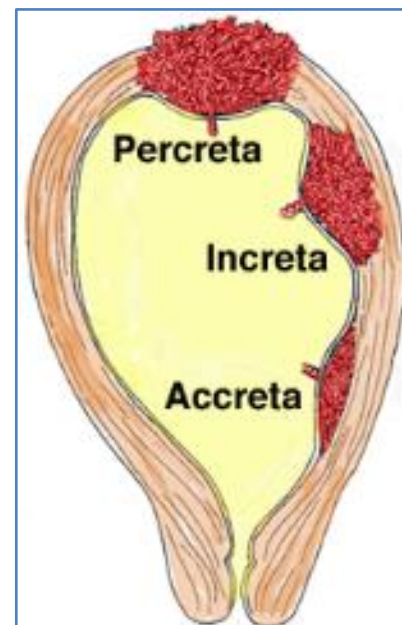
successful management. Every attempt should be made to achieve the diagnosis antenatally, to minimize blood loss, and to preserve the bladder.

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**Fig. 1: Placenta adherent to uterus hysterectomy was done**



**Fig. 2: Types of adherent placenta**

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Date of Submission: 23/06/2014.

Date of Peer Review: 24/06/2014.

Date of Acceptance: 07/07/2014.

Date of Publishing: 24/07/2014.