

## Placenta Percreta And Its Successful Outcome: A Rare And Difficult Case Report And With Review Of Literature

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**Abstract:** Placenta Percreta is one of the most serious complications of placenta previa, the incidence of which has been on a rising trend and is frequently associated with severe obstetric hemorrhage usually necessitating hysterectomy. Placenta Previa complicates 0.3–0.5% of all pregnancies and is a major cause of third-trimester hemorrhage which is on the rise due to rise in incidence of cesarean sections. Significant maternal morbidity in form of increased incidence of fetal mal presentation, cesarean delivery, increased blood loss, and peripartum hysterectomy have been noted in cases of placenta previa and can lead to prolonged hospitalization in these women. Premature deliveries can occur which lead to higher admission to neonatal intensive care unit and stillbirths. (1). We present a case of placenta previapercrta in a case of previous cesarean section , managed excellently with a surgical expertise. [Katke R Natl J Integr Res Med, 2021; 12(1):91-94]

**Key Words:** placenta percreta, placenta accrete, placenta previa, caesarean, obstetric hysterectomy, rare, difficult case

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Introduction: Placenta accrete syndrome is a leading cause of antepartum hemorrhage (vaginal bleeding) affecting approximately 0.4–0.5% of all pregnancies<sup>1</sup>. Maternal complications of placenta previa are—antepartum hemorrhage, adherent placenta, postpartum hemorrhage (PPH), shock, and peripartum hysterectomy causing significant maternal morbidity which can lead to prolonged hospitalization in these women. The fetal complications are intrauterine growth restriction (IUGR) (15% incidence), premature delivery and death. Premature deliveries and IUGR lead to higher admission to neonatal intensive care unit and stillbirths<sup>1</sup>.

The secondary rise in repeat cesarean delivery has been associated with an increase in severe complications particularly the complication of placentation like placenta praevia and placenta accreta which in turn increases the maternal morbidity & even mortality<sup>2</sup>. Placenta accreta is one of the most serious complications of placenta previa and is frequently associated with severe obstetric hemorrhage, usually necessitating hysterectomy if medical therapies have failed.

**Case Report:** A 26 years old Gravida two, Parity one, Living one, with previous LSCS with 9 months of gestation Registered & Immunized at Grant Government Medical College, Mumbai,

came for antenatal checkup and got admitted in view of Complete Placenta Previa with Placenta Accreta for safe confinement. Patient was 35.1 Weeks of gestation. Patient had no history of pain in abdomen, bleeding or spotting per vaginum. Patient perceived fetal movements well. In obstetric History she was Gravida two, Parity one , Living one with a 3yr male child with previous cesarean done for breech.

Past /History - Not Significant. On Examination, General Condition – Fair, patient was afebrile, Pulse- 90 beats/ min, B.P.100/70 mm Hg. No pallor / icterus /cyanosis or clubbing. CVS, RS – No Abnormality, Per abdomen—Ut 36 weeks, Cephalic, FHS – 140 /min, regular, relaxed. Patient was admitted for safe confinement in ward. Daily fetal surveillance and vitals monitoring was done. Interventional Radiologist opined regarding the difficulties pertaining to the case in view of extensive vascularity and placentation. The patient and relatives were explained about all the high risks involved in the case.

The patient had bleeding per vaginum and hence underwent emergency LSCS followed by Obstetrical Hysterectomy Followed /By Bilateral Internal Iliac Artery ligation. The indication being G2P1L1 with 37 weeks with Placenta Previa With Placenta Accreta With Antepartum Haemorrhage.

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Intra- operatively, once the abdomen was opened up in layers, dense vascular placentation could be seen between the anterior uterine wall and the bladder, only thin serosa of the uterus was present , and just below that bluish – pinkish placenta was seen .The placenta was inseparable and no surgical plane was present between the uterine wall and the placenta, suggesting the diagnosis of placenta percreta. There were huge dilated vessels over it. A healthy male baby of weight 2.5 kg was delivered through the incision.

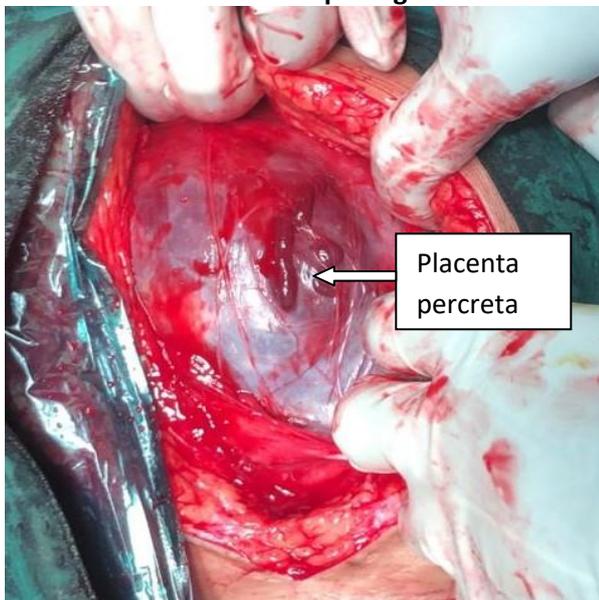
After delivery of the baby, the entire upper uterine segment was covered with placenta and the entire lower uterine segment was thinned out. From delivery of the fetus done, hemostasis achieved by ligating the vessels, taking the bilateral uterine and the internal iliac ligation.

The obstetricians immediately proceeded with an emergency obstetric hysterectomy, during which time the lower uterine segment was found to be densely adherent to the bladder wall.

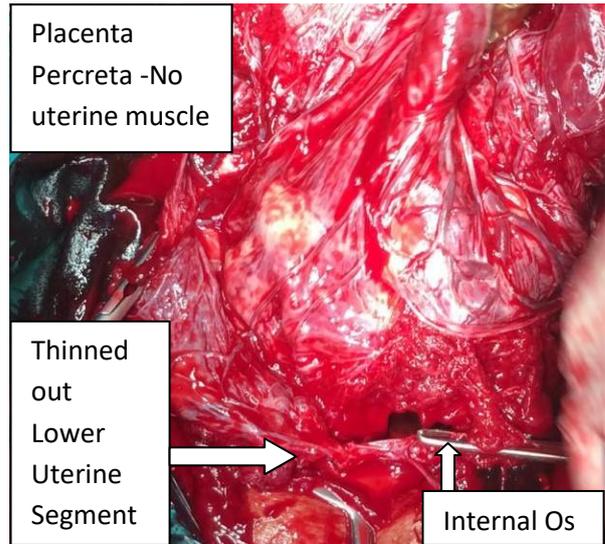
Immediate post operative, GC –fair, Pulse- 90 beats/ min,BP-100/70 mmHg, CVS , RS – NAD,P/A – soft , non- tender. Blood loss was around 1200 ml.

Post operatively, the patient was monitored vigilantly, patient shifted to CCU and four blood transfusions were given, and vitals monitored. Later the patients post operative events were uneventful and patient was discharged home with a healthy baby after suture removal.

**Figure 1: Intra Operative Dense And Vascular Placenta Percreta After Opening The Abdomen**



**Figure 2: Intra Operative Placenta Percreta With No Plane Between Uterus And Bladder**



**Figure 3: Intra Operative Photography Of Diffuse Placenta Percreta With Umbilical Cord After Delivery Of The Baby**



Post operatively, the patient was monitored vigilantly and hence discharged home with a healthy baby.

**Discussion:** Placenta accreta occurs in approximately 1 in 2500 pregnancies. Of these, approximately 75% to 80% are placenta accretavera, 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>. Adherent placenta in association with placenta previa and previous cesarean section has clinical significance because of rising cesarean section rates all over the world. Management of morbidly adherent placenta previa is challenging and requires a team approach and there are very high chances of cesarean hysterectomy<sup>1</sup>.

The incidence of caesarean section is continuously rising, giving women the title of "previous LSCS". Till now the incidence of higher order caesarians like previous 3 or 4 is low, but is Bound to increase owing to the injudicious use of caesarian sections. Morbidity in the form of increased incidence of adherent placenta, increased blood loss, increased incidence of scar dehiscence/rupture, intraoperative adhesions, injury to bladder/ureter, increased requirement of hysterectomy, postoperative complications, requirement of ICU admissions, have been noted<sup>4</sup>.

About 75% of placenta percreta cases are associated with placenta previa. Unlike the painless third trimester prepartum hemorrhage common with placenta previa, vaginal bleeding of placenta percreta is more likely to be painful due to invasion of the hemorrhaging placental tissue into the uterine wall. Some patients with placenta percreta have even described a history of dull, continuous lower abdominal pain during their pregnancy. Microscopic or gross hematuria should prompt further evaluation in the setting of other clinical signs and symptoms resulting in suspicion of placenta percreta<sup>3</sup>.

Evaluation to identify whether placenta percreta may be present includes ultrasound, magnetic resonance imaging (MRI), and cystoscopy. Grayscale ultrasonography, when performed in the first trimester, will reveal a low-lying uterine sac with a thin myometrium. Sonographic findings during the second and third trimester include placental lacunae (vascular lakes of various shapes and sizes seen within placental parenchyma),<sup>6</sup> an irregular border between the bladder and myometrium, a thin myometrium, and loss of clear space (loss of the decidual layer of the placenta). Doppler ultrasonography will often reveal turbulent blood flow extending from the placenta to surrounding tissues. MRI may reveal nonvisualization of the inner layer of the placenta-myometrium interface on half-Fourier

single-shot turbo spin-echo images<sup>5</sup>. Cystoscopy may often show posterior bladder wall abnormalities. Biopsy and/or fulguration of these abnormalities should be avoided, as this may precipitate massive hemorrhage<sup>6</sup>.

In the presence of bladder wall invasion and in the setting of uncontrolled uterine bleeding following delivery, every attempt should be made to preserve the bladder, as this has been demonstrated to be a reasonable possibility provided that the integrity of the ureters is established during and after the operation.

Reconstructive surgery, if necessary, may be postponed until after the patient is hemodynamically stabilized<sup>7</sup>. Although removal of the posterior bladder and distal ureters has been advocated if invasion is found at time of delivery, resection of the bladder base with the distal ureters can be performed, but it carries the risk of coagulopathy, transfusion reaction, sepsis, adult respiratory distress syndrome, multiorgan failure, and vesicovaginal fistula due to aggressive blood transfusion and extensive surgery<sup>3,8,9</sup>.

Regardless of the decision whether to remove the bladder, anterior bladder wall cystotomy is particularly helpful for defining dissection planes and determining whether posterior bladder wall resection is required<sup>3</sup>.

**Conclusion:** Placenta accreta is one of the difficult condition to manage, but at the same time placenta percreta is a nightmare to the obstetrician. It increases the maternal morbidity and mortality, if not managed properly.

The key of the success is anticipation of the case, diagnosing with a good imaging technology like good ultrasound with doppler effect and MRI, that gives an idea of exact invasion, extent and vascularity, that helps in management of the patient. The role of interventional radiology is very much useful in some of the cases.

In our case, as it was a diffuse percreta and dense vasculaity, so the interventional radiologist opined it to be a difficult case for embolisation with a good baby outcome. But by keeping the availability of critical care centre, making availability of the blood and blood products and with surgical expertise, we could able to manage this patient with good maternal and neonatal outcome.

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