

CASE REPORT

Challenges in Diagnosis and Management in Placenta Accreta Spectrum: A Case Report

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ABSTRACT

Background: Placenta accreta describes aberrant placentation characterized by abnormally implanted, invasive or adhered placenta. Myometrial fibers attached to the basal plate in an antecedent pregnancy are predictive for a subsequent placenta accreta spectrum. Placenta accreta spectrum is a leading cause of haemorrhage and emergency peripartum hysterectomy. Risk Factors are placenta previa in present pregnancy, prior surgery like caesarean section, hysterotomy, myomectomy, metroplasty, curettage, endometrial ablation. There are many challenges in diagnosing placenta accreta spectrum because of limitations in imaging modality in emergency situations. Most of the times, placenta accreta spectrum is an intraoperative diagnosis leading to catastrophe.

Case: 25-Y/O G3P1L1A1 with 19-weeks of gestation with previous Lower Segment Cesarean Section (LSCS) with intrauterine fetal demise came to casualty with c/o profuse pv-bleeding for one hour. On examination her shock index was 1.3. USG S/O IUFD 18 weeks of gestation with grade 4 placenta previa suspicious placenta accreta. Emergency hysterotomy done for complete Placenta previa. Intraoperative finding of placenta accreta spectrum with patient's shock index of 1.3, emergency obstetric hysterectomy was done. Uterus with placenta sent for histopathology examination. Pt was given 7 PCV, 4 FFP, 4 RDP. Histopathology report s/o placenta percreta. Patient was discharged on post operative day 10.

Conclusion: Maternal morbidity and mortality are significantly correlated with placenta accreta spectrum. Group 5 accounts for the highest percentage of caesarean sections (34.97%) in accordance with Robinson's classification. Prenatal screening is crucial in light of this frequency. In patients who have had one previous caesarean procedure, the frequency of placenta accreta spectrum rises to 25%, and in patients who have had two previous caesarean sections, it rises to 40%. Early diagnosis of placenta accreta spectrum can be aided by clinical evaluation of risk factors and the use of the proper imaging modalities. Reducing morbidity and mortality and enhancing maternal and foetal outcomes depend on antenatal diagnosis. The most qualified and experienced surgeons and interventional radiologists should handle placenta accreta spectrum conservatively in a facility with a multidisciplinary team, intensive care unit capabilities, and sufficient blood and blood products.

Keywords: Placenta Accreta spectrum, Obstetric Hysterectomy, Lower Segment Cesarean Section (LSCS), Obstetric Hysterectomy, Placenta Accreta spectrum.

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INTRODUCTION

Placenta accreta describes aberrant placentation characterized by abnormally implanted, invasive or adhered placenta. Myometrial fibers attached to the basal plate in an antecedent pregnancy are predictive for a subsequent placenta accreta spectrum. Placenta accreta spectrum is a leading cause of haemorrhage and emergency hysterectomy. Risk Factors are placenta previa in present pregnancy, prior surgery like caesarean section, hysterotomy, myomectomy, metroplasty, curettage, endometrial ablation. There are many challenges in diagnosing placenta accreta spectrum because of limitations in imaging modality in emergency situations. Most of the times placenta accreta spectrum is an intraoperative diagnosis leading to catastrophe.

CASE REPORT

A 25-year-old G3 P1 L1 A1 with 5-months of amenorrhea with previous Lower Segment Cesarean Section (LSCS), k/c/o placenta previa came to casualty with complaints of bleeding PV since 1 hour.

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MH- LMP 1 June, 2023

OH- MS 2-years

G1- Abortion, 3-months of amenorrhea, Dilatation and curettage done I/v/o incomplete abortion (16-months back).
G2- 10-months, male child, LSCS done i/v/o CPD with fetal distress.

G3- present pregnancy.

Her BP was 80/ 60 mmhg, pulse was 16 /minute with mild pallor, shock index was 1.3.

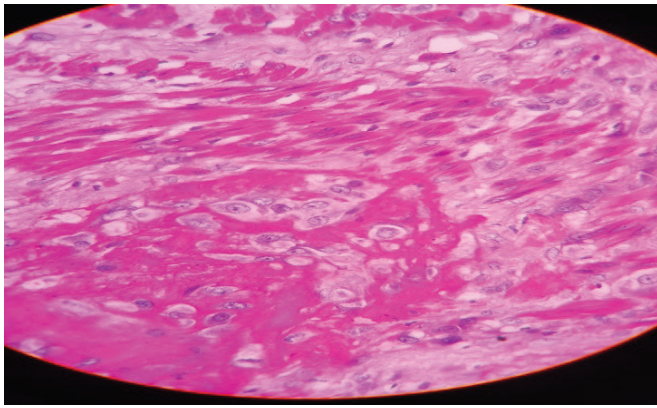


Figure 1: Histopathology report

Her P/A examination revealed relaxed, 18-week sized uterus, FHS not localized by hand Doppler, previous LSCS scar present.

Her P/S examination revealed bleeding ++.

Gentle PV was done, cervix-os closed, boggy was felt along with bleeding ++.

Her medical history was not significant but surgical history showed history of dilatation and curettage 16-months back and also history of emergency LSCS for CPD with fetal distress 10-months back.

Due to Rapid deterioration in patient condition, emergency ultrasound Doppler was done after stabilizing the patient haemodynamically. Ultrasound revealed single intrauterine pregnancy of 18-weeks with no cardiac activity s/o intrauterine fetal distress. There was suspicion of placenta accreta with grade 4 Placenta previa and oligohydramnios. Emergency investigation showed decrease HB 6.8, PT 13.5, and INR 0.91.

After written informed valid consent, patient was induced under general anaesthesia. Emergency LSCS was done, 190 gm male abortus extracted. After difficult placental separation finding of placenta accreta spectrum confirmed and decision for obstetric hysterectomy was taken. With sharp and blunt dissection, adherent bladder was separated from lower segment and specimen (uterus,

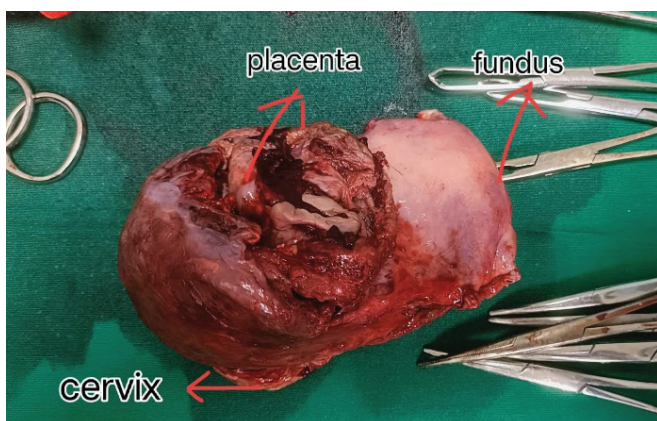


Figure 2: Specimen after 12 hours, about 7 PCV.

cervix with placenta) sent for HPE. Intra abdominal drain and subcutaneous drain inserted. There was approximately 1.5 lit. of blood loss, Central IV line inserted. Intraoperative 3 PCV 4FFP, 4RDP given. Patient was shifted to ICU and extubated 4 FFP, 4 RDP were given in the total. On post of day 10, complete sutures were removed.

Histopathological examination report suggestive of placenta percreta, therefore patient was advised to follow-up after 15-days, during follow-up patient was stable.

DISCUSSION

PAS is recognised, as a major cause of maternal morbidity and mortality and is more common nowadays. Previous caesarean section in combination with Placenta previa are the main risk factors. Worldwide, increase in number of Cesarean Section performed is due to increased incidence of PAS.¹

Hysterectomy has been the treatment of choice traditionally due to massive PPH which is associated with complication such as massive blood transfusion by mortality rate, injury to the bladder, bowel, uterus, ovarian damage and infection.^{2,3} Long term psychological sequelae may also occur due to fertility and loss of fertility.⁴

A cautious strategy with the placenta, in order to maintain fertility and prevent the catastrophic consequence of a salvage hysterectomy following an effort to remove a morbidly attached placenta, in situ was devised.^{5,6} The side effects of fertility preservation surgery include morbidity and subfertility, which necessitate expensive, sophisticated treatments and increase the chance of a high-risk pregnancy. It has a psychological impact as well. Numerous women who had conservative therapy for PAS have reported experiencing unexpected vaginal bleeding during the postpartum phase. Due to aberrant uterine bleeding, these women also needed a lot more postpartum surgical treatments, such as hysteroscopy or "dilation and curettage."⁷

CONCLUSION

Maternal morbidity and mortality are significantly correlated with placenta accreta spectrum. Group-5 accounts for 34.97% of the overall caesarean section rate, using Robson's Classification. In patients who have had one previous caesarean procedure, the frequency of placenta accreta spectrum rises to 25%, and in patients who have had two previous caesarean sections, it rises to 40%. Early diagnosis of placenta accreta spectrum can be aided by clinical evaluation of risk factors and the use of the proper imaging modalities. The secret to bettering maternal and foetal outcomes and lowering morbidity and mortality is antenatal diagnosis. A favourable fetomaternal result can be achieved by selecting the best treatment strategy for PAS, based on the infrastructure that is available. The most qualified and experienced surgeons should handle placenta accreta spectrum conservatively.

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