ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 10, Issue, 10, pp.74663-74664, October, 2018
DOI: https://doi.org/10.24941/ijcr.32657.10.2018

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

CASE STUDY

ADHERENT PLACENTA AT UNSCARRED SITE OF UTERUS IN PREVIOUS CAESAREAN SECTION

[1,*]Naghma Shahrukh, [2]Zehra Mohsin and [2]Dr. Enas mushtaq

[1]Department of Gynecology and Obstetrics, JNMCH, AMU, Aligarh, India
[2]Department of OBGY, JNMCH, Aligarh, India

ARTICLE INFO

Article History:
Received 06th July, 2018
Received in revised form
17th August, 2018
Accepted 24th September, 2018
Published online 31st October, 2018

Key Words:
Caesarean, Placenta accrete,
Maternal morbidity and mortality

ABSTRACT

Adherent placenta is not a rare association with previous caesarean it usually presents with vaginal bleeding during difficult placental removal in 3rd stage of labour. Increasing incidence is due to increasing caesarean rates. Pathogenesis of placenta accreta in cases of women with previous caesarean section is believed as defective decidualization, abnormal maternal vascular remodelling, excessive trophoblastic invasion or a combination occurring at uterine scar site .Placenta accreta is an obstetrical complication associated with significant maternal morbidity and mortality .Adherent placenta at unscarred area is a rare presentation. Antenatal diagnosis of morbidly adherent placenta is key to save the women's life.

Citation: ***Naghma Shahrukh, Zehra Mohsin and Dr. Enas mushtaq*, 2018.** "Adherent placenta at unscarred site of uterus in previous caesarean section", *International Journal of Current Research*, 10, (10), 74663-74664.

INTRODUCTION

Adherent placenta is a potentially life threatening obstetric condition that require multidisciplinary approach for management (Nahark *et al.,* 2016). Adherant placenta is characterized by complete or partial absence of decidua basalis and imperfect development of fibrinoid layer (Nitabuch layer) leading to chorionic villi to invade the myometrium abnormally (Dankar *et al.,* 2017). Placenta accreta is a general term used to describe the clinical condition when part of placenta or entire placenta invades and is inseparable from the uterine wall and it is increta when chorionic villi invade only myometrium &percreta when invasion through myometrium and serosa occasionally into adjacent organs, such as bladder (Mittal *et al.,* 2017). Clinically placenta accreta becomes problematic during delivery when placenta does not separate completely and is followed by massive obstetric haemorrhage leading to DIC, need for hysterectomy (Divyaa *et al.,* 2016). Average blood loss for a female with placenta accreta is 1500-3000ml (Hudon *et al.,* 1998). Maternal mortality with placenta accrete has been reported to be as high as 7% to 10% (Rajkumar *et al.,* 2014). Diagnosis of placenta accreta before delivery allows us to minimize potential maternal and neonatal morbidity and mortality by proper counselling and referral. Diagnosis is done usually by USG which has sensitivity of 93% and specificity of 71% but may be occasionally supplemented by MRI especially in posterior placentation (Dwyer *et al.,* 2009).

Corresponding author: **Naghma Shahrukh,**
Department of Gynecology and obstetrics, JNMCH, AMU, Aligarh, India.

CASE REPORT

Pt 'X' 30 yrs old female presented to JNMCH as unbookedcase with G_3P_2+L_2with9 months amenorrhoea with previous caesarean section with palpitations and dizziness for 6 hrs. First and second trimester was uneventful, quickening at 5th month, during third trimester, there was no H/o of headache, blurring of vision, epigastric pain, breathlessness, syncope, vaginal bleeding. LMP was not known. Her previous FTND 11 yrs back was unevent full followed by one caesarean section 5 yrs back indication was not known.

On examination

She was conscious and oriented, PR:92/min, regular, normovolumic. BP: 140/88 mm Hg, Temp: 98.6`F, R/R: 18/min and urine albumin: 1 plus and chest was bilateral clear. CVS: WNL .P/A: fundal height 36 wks, cephalic, FHS+R 134bpm uterus relaxed .P/V:OS 1.5cms dilated, 20% effaced, soft, anterior, vertex at-2 station .Bishop score=6.With Hb 10%,BCT 5.5min, platelet: 2.5lac/dl, LFT and RFT were normal. Within 1hr of admission she developed convulsion, at that time her BP was 160/110 mmHg and urine albumin: 1+. Injection $MgS0_4$ loading followed by infusion was given along with injection labetalol 20 mg, that controlled her BP then after one hour she developed leaking per vaginum and syntocinondrip was started .She delivered after 8 hrs as VBAC delivery of a live male baby by vertex baby cried and handed over to paediatricians. Placental delivery could not be done, it was found adhered to uterine fundus then patient shifted to OT

for manual removal of placenta (MRP). MRP tried under general anaesthesia but failed& the patient was bleeding and her vitals began to deteriote. So, decision for subtotal hysterectomy taken. Hystrectomy was done,3 units of PRBCs were transfused intraoperatively, her post-operative period was uneventful and she was discharged from hospital at post-operative day 8 with healthy stitch line.

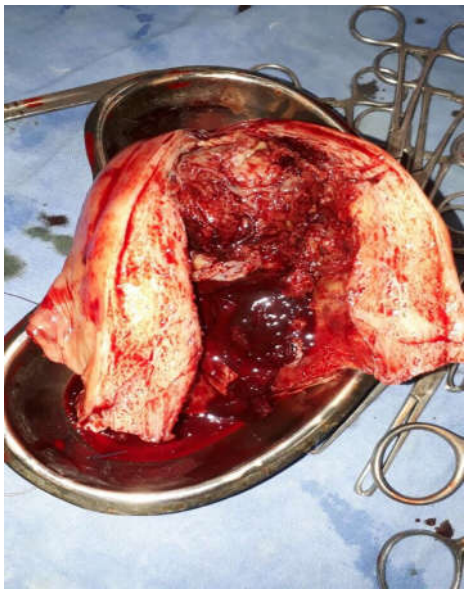

Fig. 1.

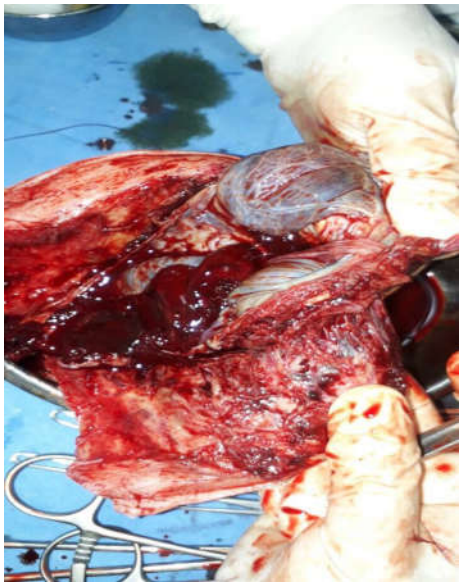

Fig. 2.

Figure 1 and 2. Cut section of subtotal hysterectomy specimen showing adherent placenta at fundal region

DISCUSSION

Morbidly adherent placenta is one of the most serious obstetric emergency (Nahark *et al.,* 2016). Incidence of abnormal placentation including placenta accreta on an average is 1 in 7000. Now a day's increase in incidence of placenta accrete may be due to increase rate of caesarean deliveries (Mittal *et al.,* 2017) predisposing factors include: advanced maternal age, multiparity (>6), co-existing placenta previa., raised serum AFP level, any condition followed by myometrial tissue damage like myomectomy, endometrial defect following curettage resulting in asherman syndrome and submucousleiomyomas, (Garmi and Salim, 2012). For managing placenta accreta patient, multidisplinary approach is needed, including gynaecologist, anaesthesiologists, Radiologists, haematologist (Khandaker, 2014).

For diagnosis- we use USG and colour Doppler& MRI (when sonography is equivocal or placenta cannot be clearly visualized)

USG diagnostic criteria are:

- Obliteration of reteroplacentalecholucent zone
- Abnormally prominent placental lacunae
- Thinning or disruption of hyper echoic uterine serosa-bladder interface.

Sensitivity and specificity of usg in diagnosing placenta accreta is 93% and71% respectively (Khandaker, 2014). There are many consideration of management depending on severity of haemorrhage conservative management may be an option in order to prevent peripartumhystrectomy and to preserve fertility as long as bleeding remains minimal. Leaving placenta in-situ undisturbed with administration of prophylactic antibiotic and prophylactic postpartum oxytocics. During follow-up, USG examination and serial BHCG estimation is required. Bilateral uterine artery embolization can be done in case of abnormal placentation.

Conclusion

For evaluating high risk patient multidisciplinary team approach is required. Diagnosis and delivery should be done in specialized tertiary centre with adequate resources including massive transfusion anticipating need for hysterectomy. Antenatal diagnosis of morbidly adherent placenta is key to save the women's life.

REFERENCES

Dankar, S., Bachani, S., Patel, P.B. and Shivhare S. 2017. Placenta increta at Unscarred Area in a Previous Caesarean women: A Case Report of an unusual pathogenesis of usual etiology,7:6.

Divyaa, R., Saraswathi, K. and Chellamal, K. 2016. Rare Case Report On Placenta Accreta In Unscarred Uterus,1:11-14.

Dwyer, B.K., Belogovkin, V. and Chitkara, U. 2009. Prenatal Diagnosis of Placenta Accreta: Sonography or Resonance Imaging?. 27(9):1275-1281.

Garmi, G. and Salim, R. 2012. Epidemiology, etiology, diagnosis, and management of placenta accreta. *Obstet Gynecol Int.,* J 1-7.

Hudon, L., Belfort, M.A. and Broome, D.R. 1998. Diagnosis and management of placenta accretareview. Obstetrics – gynecologic survey, 53:509-17(pubmed).

Khandaker, S. 2014. An undiagnosed case of placenta Percreta presenting as a massive haemoperitoneum in obstetric emergency, 4(1):3.

Mittal, N., Pineda, M., Lim, B. and Carey, E. 2017. Placenta previaincreta in an unscarred uterus with marked thinning of myometrium in the entire uterus in a patient with systemic lupus erythromatosus, *International journal of gynaecological pathology,* 00:1-6.

Nahark, Farhad, Q., Apsara, S. and Afsana, J. 2016. Morbidly Adherent Placenta in Midtrimester Abortion, 31(1):50-53.

Rajkumar, B., Kumar, N., Sirinivasan, S. 2014. Placenta percreta in primigravida,an unsuspected situation. *Int J Reprod Contracept Obstet Gynecol.,* 3:239-241.

****