17th World Congress in Fetal Medicine

A case of conservative surgery as treatment option for placenta percreta

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Objective

To highlight the plausibility of early conservative (uterine saving) surgery for placenta percreta.

Methods

Case report: A 28 years old G5P4 previous c/s x 4, presented for the first time at 17 weeks of gestation with a sonographic diagnosis of fetal omphalocele containing liver and bowel and a narrow fetal chest. Placenta previa was evident, covering the internal OS with high vascular flow, placental lacunae and loss of hypo-echoic uterine /placental zone. These findings are highly suggestive of invasive placentation. MRI confirmed the diagnosis of placenta accreta with possible focal increta/percreta areas adherent to the posterior wall of the bladder. Due to major fatal anomalies, poor neonatal outcome and the maternal risk at a uterine preserving operation at term, that might mandate massive blood transfusion, possible need for hysterectomy and admission to ICU, the patient opted for termination of pregnancy. However, the patient was determine to make all efforts to preserve her uterus. TOP was undertaken and was followed by 3 doses of methotrexate. BHCG dropped from 30150 IU to 1520 IU in 2 weeks. conservative surgery (hysterotomy) was preformed to deliver the fetus and to extract the separable part of the placenta. A 2*2 cm adherent part of placenta on the surface of the anterior uterine wall with no serosa lining was retained. Modified B lynch was preformed to help contracting the uterus and to reduce bleeding and Redivac drain was left. Estimated blood loss was 1000 ml. Post-operative period was un-eventual. The patient's vital signs were stable, Hb levels were 9. 7gm/dl and only a minimal blood loss per vagina and in the drain bag were noted. On post-operative day 7 the patient received another dose of methotrexate and was discharged home in stable condition. Five weeks after surgery patient was seen in the outpatient clinic and found to be asymptomatic with minimal vaginal bleeding. Placental tissues significantly decreasing in size and BHCG dropped to a level of 110 IU.

Results

Patient tolerated hysterotomy procedure well. Placentas size minimised and BHCG levels continue to normalize.

Conclusion

Second trimester uterine-saving surgery appears to be a plausible management option for patient who are willing to preserved fertility.