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A case of placenta accreta left in situ

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Objective

Placenta accreta is characterized by abnormal invasion of the placenta into the myometrium. It is a potentially life-threatening obstetric condition associated with massive hemorrhage and emergency hysteroctomy. Its incidence has increased parallely to the increasing cesarean section delivery rate. The diagnosis before delivery allows multidisciplinary planning in an attempt to minimize potential maternal or neonatal morbidity and mortality. Ultrasonography is sensitive (77%) and specific (95%) enough for the diagnosis, but magnetic resonance imaging may be helpful in ambiguous cases. In general, the recommended managment of suspected placenta accreta is planned preterm cesarean hysterectomy, however, some studies suggests that leaving placenta in situ lowers the risk for subsequent hysterectomy and may hence be an option for women who have a strong desire for future fertility.

Methods

We present a case of a 38-year-old woman, Gravida 3, Para 2, with a history of 2 previous cesarean deliveries which had a neonatal death in Pakistan. She suffers from chronic hypertension treated with Labetalol 5mg/12 h. Her second screening ultrasound at 22 weeks of gestation showed normal fetal anatomy and placenta previa. The first suspicion of placenta accreta based on pathological 'storm flow' on Doppler ultrasound was raised at 25 gestational weeks (Image 1). Placenta accreta was confirmed at 35 gestational weeks by transabdominal and transvaginal sonography that showed a placenta with a “Swiss cheese” appearance. The placental vessels appeared to invade through the thin myometrium anteriorly to the wall of the urinary bladder but not bladder wall. Multiple placental lakes were noted throughout the entire placental tissue and the upper part of the cervix (Image 2). After informed consent, including risks, benefits, and alternatives; the patient opted against hysterectomy, because she desired to have more children.

Results

Delivery was attempted by an elective Caesarean section performed at 36. 6 weeks of gestation. The weight of the newborn girl was 2980 g, APGAR score was 9/10/10. A medium-high transverse uterine incision was used to extract the fetus in order to avoid the adherent low placenta. The placenta was partially removed (>90%), leaving only a fragment of a previous cotiledon in situ. The patient received the 4 units of packed red blood cell transfusion. A cystoscopy was done to confirm bladder integrity. The recovery was uneventful, and the patient was discharged on the third day post-operatively. She received prophylactic Amoxicillin Clavulanic-Acid and Bemiparina 2500 UI for ten days. The patient was followed for six months. Two weeks after the surgery, her C-reactive protein (CRP) concentration was 1, 2 g/L and chorionic gonadotropin (hCG) concentration was 110 U. A pelvic examination showed no significant findings. Serial periodic serum hCG levels decreased from 74 U to 3 U over the next six weeks. Her intra-uterine placental volume was measured by repeat ultrasound examinations: The placenta shrunk from 18 x 19 mm on the first examination to 15 x 19 mm and then to 7 x 10 mm over six weeks (Image 3 y 4). Ultrasound examination at six months showed total resolution.

Conclusion

Because conservative management of placenta previa accreta to preserve future fertility is a relatively new concept, extensive patient counseling and discussion regarding risks, benefits, and alternatives are required. We think that this innovative management of placenta previa accreta left in situ could benefit women requesting conservative management for potential future fertility.