

PRENATAL DIAGNOSIS OF PLACENTA ACCRETA TREATED BY POST-PARTUM HYSTERECTOMY

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OBJECTIVE

Placenta accreta (PA) is characterized by abnormal invasion of the placenta into the myometrium (0.3% of pregnancies). PA is a potentially life-threatening obstetric condition that requires a multidisciplinary approach to management. The incidence of PA has increased and seems to parallel the increasing cesarean delivery rate. Women at greatest risk of PA are those who have myometrial damage caused by a previous cesarean delivery with either an anterior or posterior placenta previa (PV) overlying the uterine scar.

METHODS

A 40 years-old gravida 3 para 2 (2 cesarean sections), with no other significant family or personal history, attended in our high risk obstetrics unit for pregnancy monitoring with a normal singleton pregnancy first-trimester scan. Second trimester ultrasound scan at 20+6 weeks showed an occlusive placenta previa with sonographic findings of placental accretism overlying the uterine scar. Several control ultrasound scan were done, the last of them at 37+2 weeks of pregnancy which showed a fetus in transverse situation and a thinning of the myometrium up to 9mm at the lower uterine segment. Magnetic resonance imaging was performed at 30+6 weeks of pregnancy with findings of placenta previa accreta.



Fig. 1,2,3: Ultrasonographic images of placenta previa with signs of accretism overlying the uterine scar.

At 37+3 weeks of gestation an elective cesarean section was performed and a 3742g male newborn was delivered with an Apgar score of 9/10/10. Subsequently, the patient initiated severe bleeding that did not respond to pharmacological measures with hemodynamic instability which required the use of vasoactive drugs so abdominal hysterectomy was performed. The patient was discharged in good condition on the 5th postoperative day. Pathological study of the placenta and the uterus showed mature chorionic villi with areas of infarction, lack of integrity of cotyledons and focus of placental accretism (invasion of myometrium).



Fig. 4: post cesarean section hysterectomy.

RESULTS

Grayscale ultrasonography is sensitive and specific enough for the diagnosis of PA; magnetic resonance imaging may be helpful in ambiguous cases. Although recognized obstetric risk factors allow the identification of most cases during antepartum period, the diagnosis is occasionally discovered at the time of delivery. In general, the recommended management of suspected PA is planned cesarean hysterectomy with the placenta left in situ because attempts at removal of the placenta are associated with significant hemorrhagic morbidity. However, this approach might not be considered first line treatment for women who have a strong desire for future fertility. Therefore, surgical management of PA may be individualized and in some cases conservative treatment should be considered. Different methods of conservative management have been described such as leaving the placenta in situ, one-step conservative surgery (removal of the accreta area), triple-P procedure (suturing around the accreta area after resection), other include the use of interventional radiology for embolization or vessel ligation.

CONCLUSION

Diagnosis of PA before delivery allows multidisciplinary planning in an attempt to minimize potential maternal or neonatal morbidity. Women with PV or "low-lying placenta" overlying a uterine scar early in pregnancy should undergo follow-up imaging in the 3rd trimester with attention to the potential presence of PA. Apart from hysterectomy, conservative management should be considered.