RARE CASE REPORT ON PLACENTA ACCRETA IN UNSCARRED UTERUS

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ABSTRACT
Placenta Accreta in an unscarred uterus without risk factor is a rare event in pregnancy and may cause life-threatening hemorrhage which requires a multidisciplinary approach. Incidence of Placenta Accreta without previous uterine surgery is associated with 1-5% risk. 30yrs old second gravida who was found to have central Placenta Previa on 2ND Trimester USG while patient was taken for Emergency LSCS at Gestational Age 37 weeks +2 days. On Intraoperatively was found as Placenta Accreta, and patient had profuse bleeding for which medical management and uterine artery ligation, Internal Iliac artery ligation was done and failed, so we proceeded with Emergency Peripartum Hysterectomy. The predominant indication for Emergency Peripartum Hysterectomy was abnormal placentation like Placenta Previa/Accreta which was noted in 45-73.3%.

KEYWORDS: PLACENTA PREVIA/ ACCRETA, Emergency Peripartum Hysterectomy, Multigravida, No Risk Factors, Sub Acute Intestinal Obstruction

INTRODUCTION

Placenta Accreta is defined as when placenta is abnormally adherent to the myometrium of the uterus. [1]. Incidence of Placenta Previa without previous uterine surgery is associated with 1-5% risk of Placenta Accreta. Placenta Accreta is one of the most serious complications of Placenta Previa and is frequently associated with severe obstetric hemorrhage can leading to Disseminated intravascular coagulation, increase in hysterectomy rates; surgical injury to the ureters, bladder, bowel, or neurovascular structure, Acute Respiratory Distress Syndrome, acute transfusion reaction, electrolyte imbalance, renal failure. Placenta Accreta women has estimated blood loss is 1500-3000ml (2). ¾.th of Placenta Accreta women requires blood transfusion due to profuse hemorrhage. Maternal mortality rate is increased with placenta accreta is about 7% (3). The Incidence of Placenta Accreta has increased from approximately 0.8/1000 deliveries in the 1980s to 3/1000 deliveries in the past decade due to rise in LSCS rates. Researchers have reported the incidence of placenta accreta as in 1 in 533 pregnancies for the period of 1982-2002(4). The predominant indication for emergency peripartum hysterectomy was abnormal placentation like placenta previa/ accreta which was noted in 45-73.3%, Emergency peripartum hysterectomy (EPH) is the most dramatic operation in modern obstetrics and is generally performed when all the conservative measures have failed to achieve homeostasis in the setting of life threatening hemorrhage. Complication of sub acute intestinal obstruction.
obstruction is rare and its managed by conservative measures.(5)

**CASE REPORT:**

30 Years old female, second gravida (G2P1LI) married since 10 yrs ,Non consanguineous marriage Last Child Birth is 9 YRS with previous normal vaginal delivery9 years back, who had regular menstrual cycles. First visit to SBMCH HOSPITAL in antenatal OPD at G.A of 37 weeks+2 days, booked and immunized outside. Her second trimester screening ultrasound at 21 weeks of gestation showed normal fetal anatomy and central placenta previa. Patient was advised for MRI, patient was not willing .Next day patient came with complaints of bleeding per vaginum. First pregnancy is spontaneous conception, all the 3 trimesters uneventful delivered male baby of about 3 kg alive and healthy, baby was diagnosed as staphylococcal scalded skin syndrome which was delivered by vaginal delivery Her present obstetric history: 1st trimester uneventful, 2nd trimester, uneventful, except she was diagnosed as placenta previa grade 3, 3rd trimester she had bleeding per vaginum for which emergency LSCS Done in view of central Placenta Previa.

Intra operatively: Placenta was found to be central. Placenta was cut through an ALIVE term male baby delivered which cried immediately after birth we have allowed for normal expulsion of placenta for about 5minutes, due to profuse blood loss and patient vitals was falling, so manual removal placenta was done. Only part of the placenta has separated and major portion of placenta was found to adherent to the uterus. There was profuse bleeding from the placental bed. Medical management, uterine artery ligation. Internal iliac artery ligation done all failed. In view Of Placenta Accreta and there is profuse bleeding and patients vitals has been falling, it is proceeded by caesarean subtotal hysterectomy with left salphingo oophorectomy On Postoperative day 3 patient develops abdominal distension diagnosed in USG ABDOMEN shows, sub acute intestinal obstruction, for which we managed conservatively. On pod 4 patient is fine and there is no abdominal distension. On pod 6 complete suture removal done and then patient discharged without any complaint. Post operative IV Antibiotics: Ceftrioxime, Piptaz and Oflox.

![Figure 1: Placenta and its Hysterectomy Specimen](image-url)
CONCLUSIONS

Placenta Accreta is more common in women with risk factors. One of the study shows incidence of placenta accreta in 1995, risk were about is 0.002% in unscarred uterus, 0.1% after one prior caesarean, 0.3% after 2 or 3 prior caesarean. So all Placenta Previa women with / without risk factor women should be subjected to MRI screening to rule out Placenta Accreta and its complication. Multidisciplinary approach, so that we can reduce the rate of caesarean hysterectomy and its complications, maternal mortality, and morbidity.

REFERENCES


Author Details

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CONFLICTS OF INTEREST

THE AUTHORS declare that there is no conflict of interest.