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Research Article

Successful Conservative Management of Recurrent Focal Placenta Accreta, A Case Study

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ABSTRACT

Placenta accreta refers to an abnormality of placental implantation in which the anchoring placental villi attach to myometrium rather than decidua, resulting in a morbidly adherent placenta . It is a life-threatening diagnosis increasing in number due to the growing number of caesarean sections. For most patients, the method of choice is elective cesarean section followed by hysterectomy. For women who wish to preserve fertility, a conservative procedure may be considered. Almost all reported cases have known major risk factors which are previous caesarean section , current placenta previa , previous uterine surgery and known uterine anomalies .We report here an extremely rare case of recurrent focal placental accreta in 35 years old Saudi female, G3P2+0. 39 weeks pregnant, previous 1 cesarean section, breech with current focal accreta discovered late at 38wk +.Our case doesn't have known major or even controversial minor risk factors in her 1st accreta.Risk factors for the second accreta were previous focal accreta at fundus and previous 1. In addition this is a successful uterine conservation for the 2nd time with no complications apart from mild bleeding of 2 liters- (the average usual bleeding is 6100). known complications for placental accreta include:Severe vaginal bleeding: 53 %, Sepsis: 6%, Secondary hysterectomy: 19% , death: 0.3 % [1] .Cesarean-hysterectomy is the best management of placenta accreta because it has reduced mortality and morbidity as well as injuries to nearby organs and hospital stay. It is important to report this case in order to keep in mind screening for suspicious of placenta accreta during perinatal US even if the patient has no risk factors in order to have planned delivery which will improve the mother and fetal outcome including most importantly decreasing the mortality rate due to postpartum hemorrhage and will increase the likelihood of successful uterine conservation especially in low parity patient.

Keywords:

INTRODUCTION

Placenta accreta is abnormality of placental implantation in which the anchoring placental villi attach to myometrium rather than decidua, resulting in a morbidly adherent placenta[1].

The incidence is around 1 in 30,000 deliveries[1]

Major risk factors which are previous caesarean section, current placenta previa, previous uterine surgery and known uterine anomalies[1]

Minor risk factors are: maternal age, ethnicity,socio-economic group, body mass index (BMI),smoking status, gender of infant, or whether the women had a multiple pregnancy, an IVF pregnancy, pregnancy inducted hypertension or pre-eclampsia, other previous uterine surgery, or previous uterine perforation[8,9,10,11,12,13]

The recurrence risk of placental attachment disorder following uterine conservation treatments is 20%. Subsequent pregnancy is achieved in 85% [13]

Placenta accrete is usually asymptomatic, discovered usually by ultrasound. In difficult cases such as posterior placenta as in our case MRI may help in diagnosis.

-First trimester sonographic finding suggestive of placenta accreta is:[1]

a gestational sac located in the lower uterine segment (rather than the fundus), next to or lower than the hysterotomy scar.

anechoic placental areas and an irregular placental-myometrial interface may also be observed

2nd and 3rd trimester US:

Loss of placental homogeneity, which is replaced by intraplacental sonolucent spaces (venous lakes or placental lacunae)

adjacent to theinvolved myometrium. This is the most consistent ultrasound finding. Loss or thinning of the normal hypoechoic area behind the placenta (termed the 'clear space'). Loss or disruption of the normally continuous white line representing the bladder wall-uterine serosa interface (termed the 'bladder line') -Color doppler: [1]

Diffuse or focal intraparenchymal lacunar flow
Vascular lakes with turbulent flow
Hypervascularity of serosa-bladder interface
Prominent subplacental venous complex

MRI:[1]

Uterine bulging into the bladder
Heterogeneous signal intensity within the placenta

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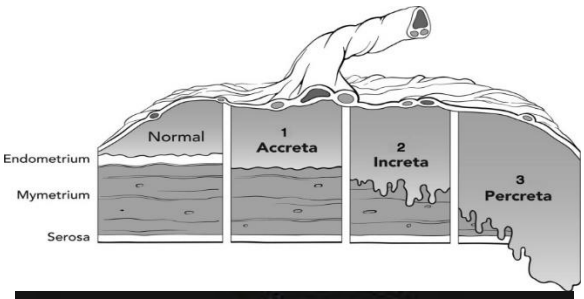
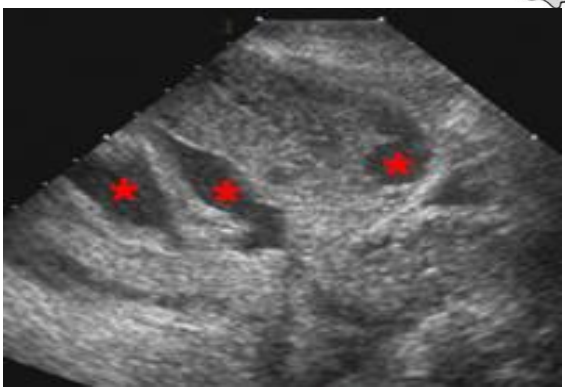
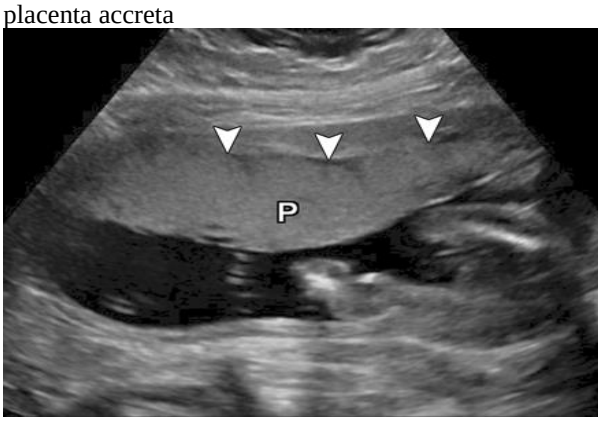
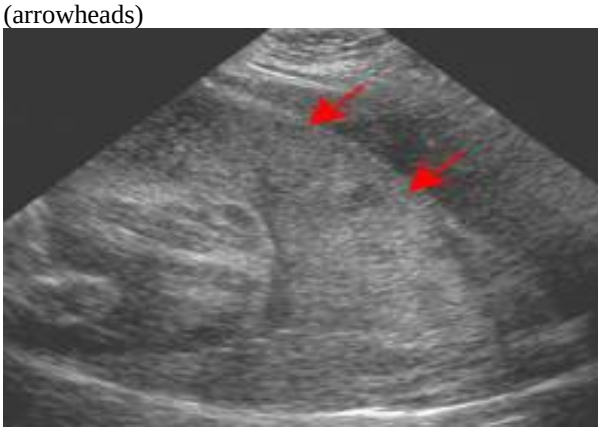




Sonogram demonstrating numerous vascular lacunae (asterisks) within the placenta in a patient with placenta accreta



US image shows normal placenta that is relatively homogeneous in echo-texture.
The retroplacental clear space is hypoechoic (arrowheads)



Sonogram demonstrating absence (arrows) of the intervening myometrium between the placenta and uterine serosa

Presence of intraplacental bands on the T2W imaging
Abnormal placental vascularity
In our case ultrasound diagnosed was late at third trimester 38wk+ only in spite of many ultrasound that were done, and MRI could not be done to role out suspicion, but still discovered on the right time and managed well with good plan.

Management of accreta[1,2,4,5,6]

It is critical to develop a plan preoperatively, Cesarean section should be planned near term around 34-37wk.Blood and fresh frozen should be prepared, and consent for cesarean hysterectomy should be taken.
Dexamethasone is given if delivery is planned at 34wk.
The optimal management of placenta accreta remains unclear. Conventional management of
this condition has long been extirpative given that mortality rates approached 25 % with conservative measures, but these rates were lowered to only 6 % with prompt hysterectomy.
However, since extirpative management inevitably leads to loss of fertility, a conservative approach is still required. Placenta can be left in place with counseling and close follow up of the patient for complications. Indications of uterine conservative surgery are: focal accreta- Fundal or posterior placenta accreta.

Risk of uterine conservation include[1,2]

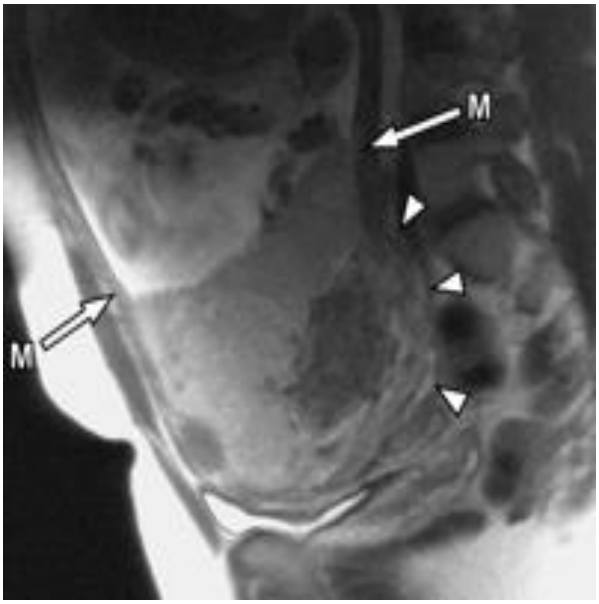
Severe vaginal bleeding: 53 percent
Sepsis: 6 percent
Secondary hysterectomy: 19 percent (range 6 to 31 percent)
Death: 0.3 percent (range 0 to 4 percent)
Subsequent pregnancy: 67 percent (range 15 to 73 percent)
Our case was ideal for uterine conservation in both pregnancies complicated by placenta accreta.Regarding the first delivery:she was primigravida and the placenta was focal accreta ,one cotylydon was left in uterus with no active bleeding and removed later . The second placenta accreta is complicating the current pregnancy.It is also focal fundoposterior. Uterus was managed successfully with planned cesarean attendanded by senior staff.Blood and FFP were ready for the patient.The uterus contracted well on accreta site with uterotonic medications and there were no active continuous bleeding.

MATERIAL, METHOD AND RESULTS

Not applicable for case study

DISCUSSION AND CONCLUSION

It is important to keep in mind screening of placenta accreta during perinatal US even if the patient has no risk factors in order to have planned delivery which will improve the mother and fetal outcome and will increase the likelihood of successful uterine conservation especially in low parity patient.
Since most pregnancies are followed up by family physicians in primary health care centers, we need to train the family physicians to screen for placenta accreta also.
This success is due to screening during pregnancy , planned C.S with consultant attendance, type and site of acceta in addition to the absence of acute emergency.



Sagittal MRI shows obliteration
of the normal dark myometrium (M)posteriorly, with placental
tissue of heterogeneous signal
intensity (arrowheads) penetrating
the full thickness of the uterine
wall. This appearance is indicative
of placenta percreta.

Antenatal diagnosis was associated with reduced levels of haemorrhage (median estimated blood loss 2750 versus 6100 ml, P = 0.008) and a reduced need for blood transfusion (59 versus 94%, P = 0.014)[2]
In our case bleeding was about 2000 ml required transfusion, there were no maternal or fetal complications due to prenatal diagnosis and planned delivery.

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