CASE REPORT: MANAGEMENT OPTIONS OF MORBIDLY ADHERENT PLACENTA

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ABSTRACT

In the currentstudy, two cases of abnormally adherent placenta were reported and presented. The first case was treated by the conservative method, oxytocic drugs and methotrexate medication helped to separate the placenta and preserve the uterus. In the second case, hysterectomy was done to save the patient's life.

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Keywords: adherent placenta; oxytocic; methotrexate; hysterectomy.

Placenta accreta, increta, and percreta aretypes of morbidly adherent placenta which are usually associated with postpartum hemorrhage and high maternal morbidity and mortality. The goal of management is to control the excessive bleeding and to avoid hysterectomy with abnormal placental adherence by leaving the placenta in situ. This conservative treatment has been addressed as a difficult approach because of the risk of severe hemorrhage according to the American College of Obstetricians and Gynecologists (ACOG), but it maybe adopted to preservefertility, especially in young and low parity patient.

The aim is to emphasize the importance of antenatal diagnosis of abnormally adherent placenta, which helps todecrease blood loss at delivery and to prepare the optimal facilities to reduce the risk of postpartum hemorrhage.

CASE ONE

A 27 years old primigravidawas noted at 40 weeks + 2daysgestation. She conceived two months after her marriage and had regular antenatal visits during her pregnancy period. Everything was normal until her last visit; she had a phobia from vaginal delivery as in the family history her mother died of uncontrolled postpartum hemorrhage 12 years ago. On examination, she looked well, her weight was78kg, and her vital signs were normal. The ultrasound reportshowed a healthy full term fetus with no obvious abnormalities. The patient was advised to have an induction and a short trial of labor, but she insisted on having a Caesarean section due to her phobia. She was admitted 0n 7th of October 2017 for elective caesarean section. During operation and after the delivery of the baby, the placenta failed to separate, and there was a localized swelling on the right side of the uterine fundus. The placenta was bulgingout through the whole uterine

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wall as shown in **Figure 1**. Intra operative 40 unit oxytocin infusion with gentle uterine massage along with cord traction was done,but it was difficult to separate the placenta. Although there was no bleeding from the site of the placenta, only a slightamount of blood loss was seen.

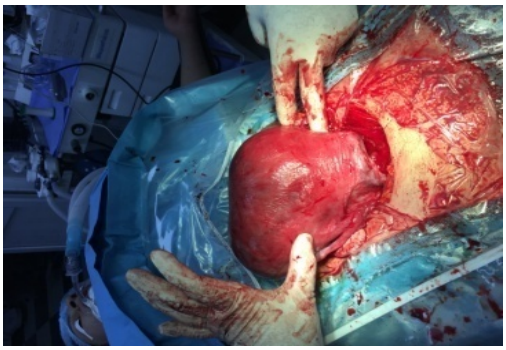


Figure 1: The Placenta was Bulging Out through the Whole Uterine

The umbilical cord was passed down to the vagina, as shown in **Figure 2**, the uterus was sutured, and the abdominal wall was closed in layers. The condition was diagnosed intra-operatively as an abnormal adherent placenta (that is placenta increta).

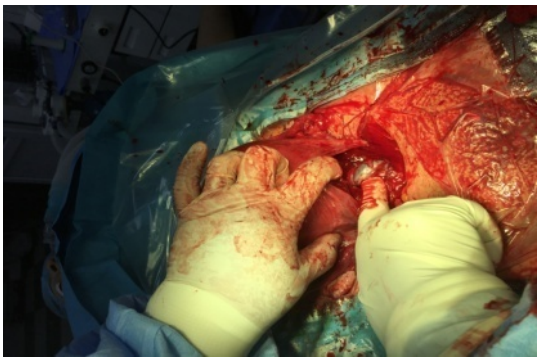


Figure 2: The Umbilical Cord Delivered through the Vagina

Postoperatively the patient was given 100 IU of oxytocin in drip, 800microgramsof prostaglandinrectally, and 50 mg of methotrexate was injected. The patient was kept under strict observation and monitored for blood loss and vital signs. She did not need a blood transfusion. Sixteen hours later, the placenta was expelled spontaneously and completely with minimal blood loss as shown in **Figure 3.**

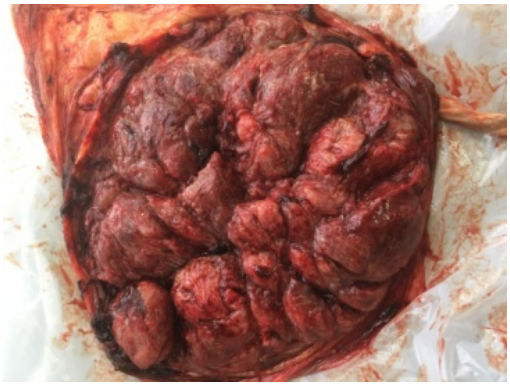


Figure 3: The Placenta after Separation

The patient began to feel well. Her baby was healthy and weighed in 3100 grams. Both were discharged in good condition on thethird postnatal day. Ten days later, she visited the clinic to remove the stitches.

CASE TWO

A 31-year-old lady from Erbil, Para 4 Gravida 5,had four previous cesareansections,was noted at 38 weeks gestation and had occasional antenatal care visits. In the last visit, she was diagnosed by ultrasound as a case of low lying placentapercreta with dilated sinuses involving the entire myometrium reaching the serosa covering the urinary bladder and the left side of the broad ligament. The condition was diagnosed antenatally as placenta percreta. She was givena terrible prognosis and very high risk of mortality. She looked puffy, with chloasmaonherface,she had normal vital signs, weighed 90kg,andnormal preoperative investigations. She was admitted for elective Caesarean Section

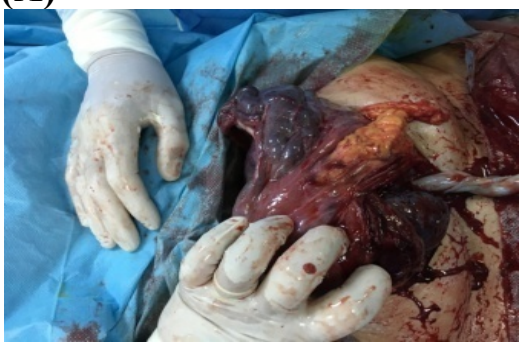
and hysterectomy on the 10th of September 2016.

Preoperative preparation

Ten pints of blood were prepared to control expected postpartum hemorrhage

The patient was operated on; the abdomen was opened in layers by lower midline incision, adhesion with the bladder was found and gently separated to free the lower segment. A lower segment cesarean section was done, alive full-term female baby was delivered weighing 3300grams.The placenta was penetrating anteriorly the left lower wall of the uterus reaching the broad ligament and the peritoneal bladder cover ,confirming the preoperative ultrasound diagnosis of placenta percretaas shown in **Figure 4A and 4B.**

(A)



(B)

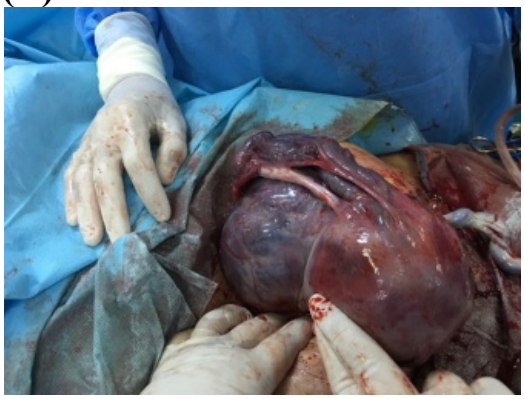


Figure 4(A) and (B): Uterus and Placenta Invading the Myometrium Reaching the Left Broad Ligament.

Then immediate ligations of the uterine, ovarian and internal iliac arteries were done before the separation of the sinuses, and then total abdominal hysterectomy was done as shown in **Figure 5**.

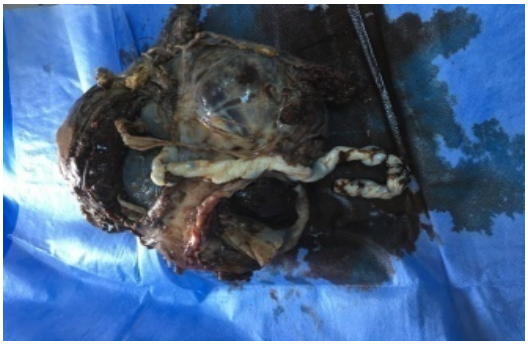


Figure 5: Uterus after Hysterectomy with the placenta Protruding through the Broad Ligament

Intra peritoneal drain was left inside.The bladder wall was intact, Folly's catheter was left for further two days. The patient needed only two pints of blood transfusion, and she was kept under strict observation and hourly chart. Post operatively prophylactic two doses of 4000 IU Low Molecular Heparin (Clexan) was given subcutaneously to prevent the risk of Deep Venous Thrombosis. She did well the next two days and was discharged with her breastfeeding baby in good condition.

RESULTS

Case one: On the next day, sixteen hours after Cesarean Section, the placenta was expelled spontaneously and completely by conservative medical treatment, the uterus was preserved, the patient was discharged in good condition.

Case two: intraoperative total abdominal hysterectomy was done to save the life of the patient.

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DISCUSSION

Abnormal placental adherence (APA),is the definition of the following placenta accreta, increata, transcreta, and percreta.It has been estimated to complicate approximately 1 in 2500 deliveriesand resulted in significant morbidity and mortality[1]. Over the last 50 years, the incidence of placenta accreta is estimated to have increased 10-fold[2]. APA represented 8 per 1000 C/S and associated with obstetric complications (severe bleeding, multiple transfusions, hysterectomy, and maternal death)[3], its also reported to involve the wall of the urinary bladder[4].Control of bleeding in case of APA usually necessitates hysterectomy[5]. A conservative management leaving the placenta in place, using Argon beam coagulation[1]. Uterine artery embolisation, with secondary uterine revascularization, local placental site excision and multidisciplinary approach to preserve the uterus[3]. During cesarean section classical or trans- fundal longitudinal uterine incisions to leave the placenta in situ, and postoperative methotrexate injection or uterine artery embolization can be performed[6]. In one study, the B-lynch suture was used to prevent uterine relaxation due to the retained placenta, while the tamponade balloon was used to control bleeding from the lower segment[7].

In the first case the diagnosis was doneintraoperatively there was a complete failure of separation of the placenta within more than 30 minutes and there was regular blood loss, the placenta was left in-situ, with intra-operative/postoperative Oxytocin and Prostaglandin with single dose of Methotrexate 50mg IM injection postoperatively, no blood transfusion was needed. This approach was beneficial for the first patient to preserve her fertility, but under strict follow-up. On the other hand, the second case was presented with the antenatal diagnosis of placenta percreata pre-operatively. The best operative procedure which was used to control bleeding is to perform total hysterectomy and to save the life of the patient with only two pints of blood transfused.

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DECLARATION OF INTEREST

Nothing declared.

REFERENCES

1. Scarantino SE, Reilly JG, Moretti ML, Pillari VT. Argon beam coagulation in the management of placenta accreta. Obstet Gynecol. 1999;94(5Pt2):825–827.
2. ACOG committee on obstetric practice. ACOG committee opinion No.266: January (2002) placenta accrete. Obstet Gyneco2002; 99(1):169-170.
3. Berthelot-Ricou A, Villota BJ, Eggermont-Gavage J, Birsan-Francesca A, Von Theobald P. New Multidisciplinary Approach of Conservative Surgical Management of Placenta Percreta Antenatally Diagnosed. Surgery Curr Res. 2014; 4:195.
4. Swaminarayan DG, Nanda SS, Desai MR. A Case Report on Placenta Percreta involving Urinary Bladder. J

South Asian Feder Menopause Soc 2004; 2(1):38-9.

5. Nishijima K, Shukunami K, Arikura S , Kotsuji F.. An operative technique for conservative management of placenta accreta. Obstet Gynecol. 2005;105(5 Pt2): 1201–1203.
6. Caliskan E, Vural B, Turkoz E, Tan O.Conservative surgical management of placenta percreta: two cases with an emphasis on tubal patency Gynecol SurgeryEndoscopy, Imaging, and Allied Techniques2005;2(1):29-31.
7. Mechery J, Burch D.Alternative management of placenta accreta. *Gynecolo* 2005;3(1): 143-154.

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ثوختة

بذاردةيين ضارةسةركرنا مندالدانا ثيَظةطر ب نةخوَشيىَ

دوو حالةتيَن مندالدانا ثيَظةطر ب نةخوَشيىَ هاتنة راطةهاندن، حالةتا ئيَكىَ هاتة ضارةسةركرن ب ريَكا ثاراستنىَ بكارئينانا دةرمانيَن طرذبوونا زةظلَةكا مالبضويكى و دةرمانيَن هاريكار بو جودابوونا مندالدانىَ وةك ميسوتركسيت و مالبضويك وةكى خوما. لىَ نشتةرطةريا راكرنا مالبضويكىَ نةخوَشا دووىَ هاتةكرن بو رزطاركرنا ذيانا وىَ.

الخلاصة

خيارات معالجة المشيمة الملتصقة مرضياً

تم الابلاغ عن حالتين من المشيمة الملتصقة مرضياً، الحالة الأولى عولجت بطريقة التحفظ باستعمال ادوية لتقلص عضلة الرحم والادوية المساعدة على انفصال المشيمة مثل الميثوتركسيت وتم الإبقاء على الرحم ، بينما اجريت عملية استئصال الرحم للمريضة الثانية لانقاذ حياتها.

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