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Case Study

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CONSERVATIVE SURGICAL TREATMENT OF PLACENTA ACCRETA IN A PATIENT WITH TOTALLY OVERLYING PLACENTA PREVIA AND A HISTORY OF CURETTAGE.

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ABSTRACT

Placenta accreta can be managed with preservation of the uterus, especially when further fertility is intended. We report a case of placenta accreta diagnosed intraoperatively and treated conservatively in a patient with a history of curetted abortion, caesareanized for a hemorrhagic totally overlying placenta previa.

KEYWORDS: placenta accreta; conservative surgical treatment; caesarean section; curettage; hemorrhagic totally overlying placenta previa; preservation of fertility.

INTRODUCTION

Placenta accreta is defined as abnormally firm adherence of placenta to the uterine wall.[1] The placenta may extend into the myometrium (placenta increta) or through the myometrium to the uterine serosa or adjacent organs (placenta percreta). An abnormally adherent placenta is associated with considerable maternal morbidity such as severe hemorrhage, uterine perforation and infection, and even mortality.

The history of curettage and the presence of a totally overlying placenta previa in our case are most likely the cause of placenta accreta.

The standard treatment for placenta accreta is hysterectomy. To preserve fertility, conservative surgical treatment has been used in selected cases.

CASE REPORT

Patient 27 years old, history of curettage, gravida 2, para 1, the first pregnancy ended with an abortion at two months cured one year ago, the second pregnancy is the current with gestational age estimated at 38 weeks of amenorrhea according to the date of the last menstrual period. The patient is hospitalized for hemorrhagic totally overlying placenta previa.

The clinical examination on admission found a normotensive patient with a heart rate of 89 beats per minute, apyretic, the infectious anamnesis was negative, there was no edema of the lower limbs, the search for proteinuria in the urine was negative.

The obstetrical examination finds a uterine height of 29 cm, presence of uterine contractions, fetal heart sounds are present with the stethoscope of pinard, minimal reddish bleeding of genital origin. The vaginal touch is not done, the membranes are intact.

Obstetrical ultrasound showed a monofetal pregnancy with positive cardiac activity, cephalic presentation, totally overlying placenta previa with no obvious signs of accretion, amniotic fluid was normal in quantity; fetal measurements were at term with an estimated fetal weight of 3100 grams.

The patient underwent a complete biological workup, which was normal except for an anemia of 10.8 g/dl.

An emergency cesarean section was indicated for totally overlying hemorrhagic placenta previa in labor that allowed cephalic extraction of a live female newborn, birth weight 2900 grams, apgar 10/10/10, amniotic fluid clear.

The delivery of the placenta is incomplete with a piece of remaining placenta measuring 3 cm / 2 cm, there is a hemorrhage of great abundance and uterine inertia.

We decided to perform a conservative surgical treatment to preserve the patient's fertility, we packed the lower segment of the uterus with a sterile field opposite the accreted area, which was then removed, we performed a triple ligation of the uterine arteries, arteries of the round ligaments and utero-ovarian arteries, we did the hysterography, and then we performed a b-lynch and padding of the lower segment in frames.

We administered 40 UI of synthocinon (oxytocin) and 4 tablets of cytotec (misoprostol) intra-rectally, exacyl (tranexamic acid), transfusion of three red blood cells. After this management, there was no active bleeding, hemostasis was ensured with a very good uterine security globe, and there was no bleeding of endo-uterine origin.

A drain was placed. At the end of the operation, the patient was hemodynamically stable with a blood pressure of 11/6, a heart rate of 74 beats per minute, a diuresis of 100 cc with clear urine, there was no blood in the drain, the dressing opposite the laparotomy scar was clean.

A sandbag was placed on the patient's belly, and then the patient was transferred to the maternal resuscitation ward for armed monitoring with very good hemodynamic status where she stayed for two days and was then discharged.

The postoperative period is without particularities for the mother and the newborn. The placenta is sent to anatomopathological study for histological confirmation.

Anatomoathology confirms the accretion of the placenta. It indicates that the placenta at term showing retroplacental hematoma associated with lesions of fetal vascular malperfusion and maternal vascular malperfusion evidencing placenta accreta.

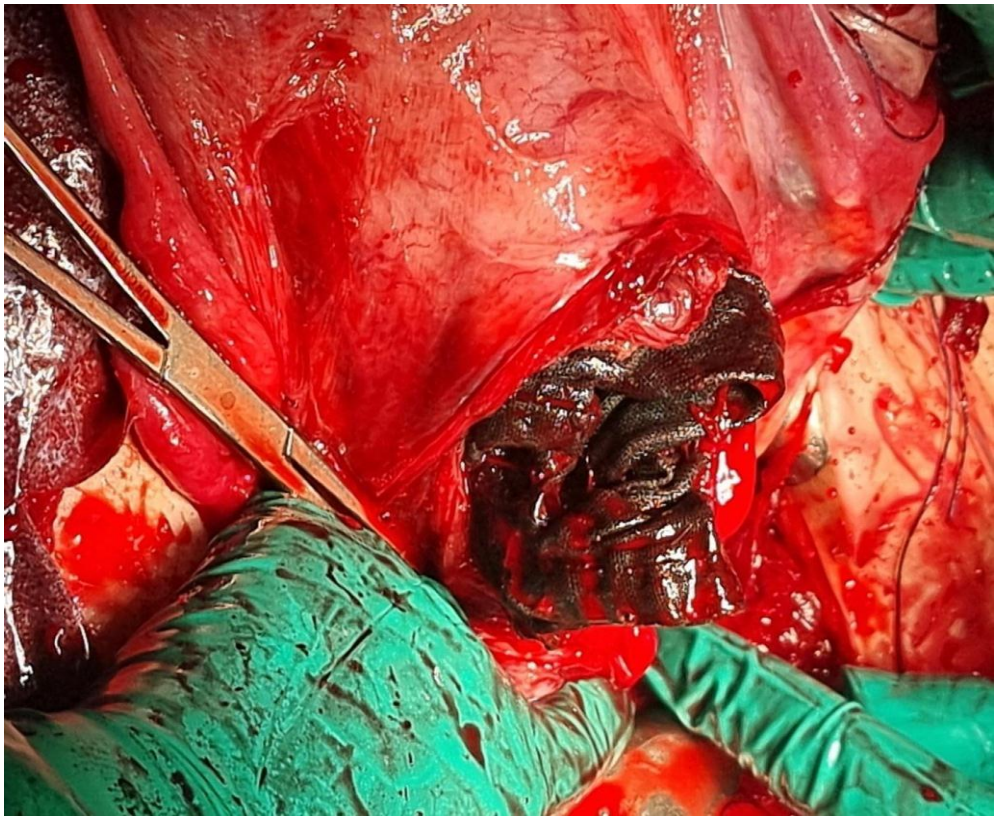

Figure 1: Packing with a sterile field in front of the placenta accretion area.

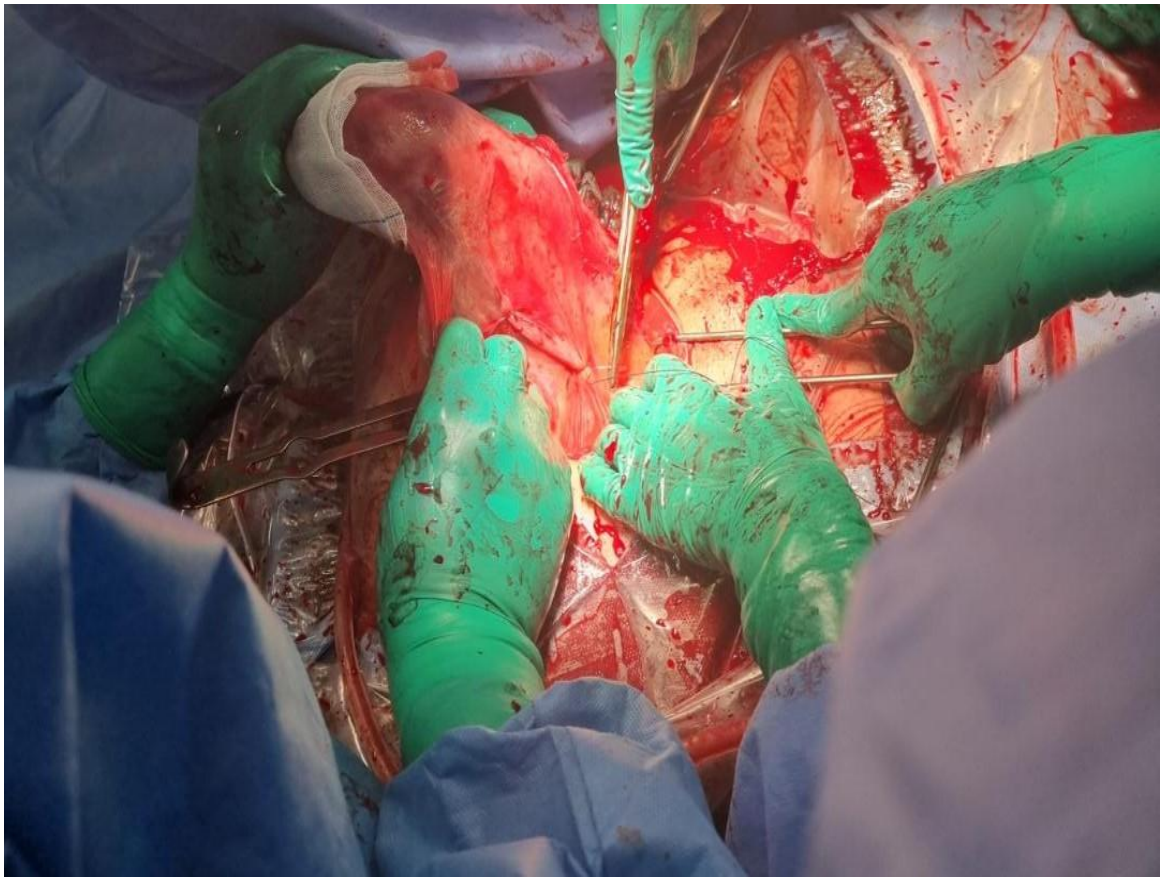

Figure 2: Uterine inertia and beginning of triple ligation.

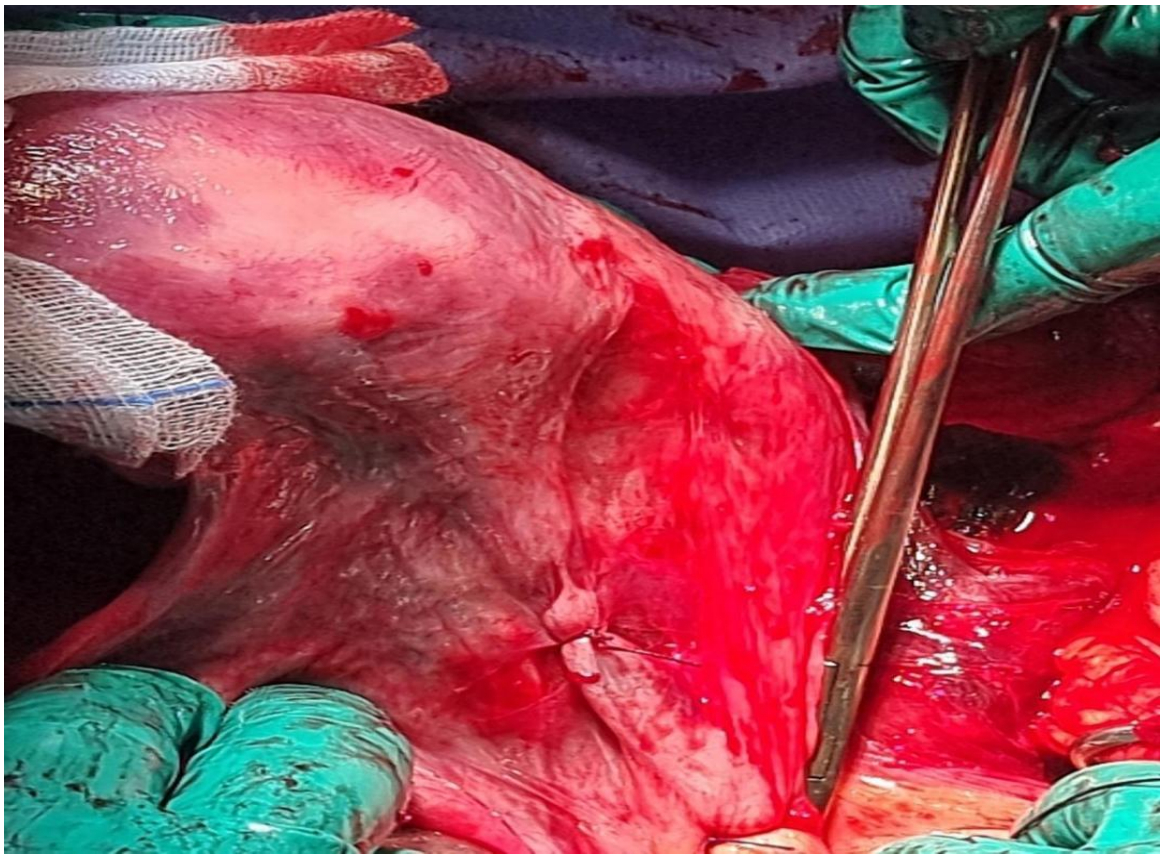

Figure 3: Ligation of the arteries of the round ligaments.

Figure 4: Ligation of the utero-ovarian arteries.

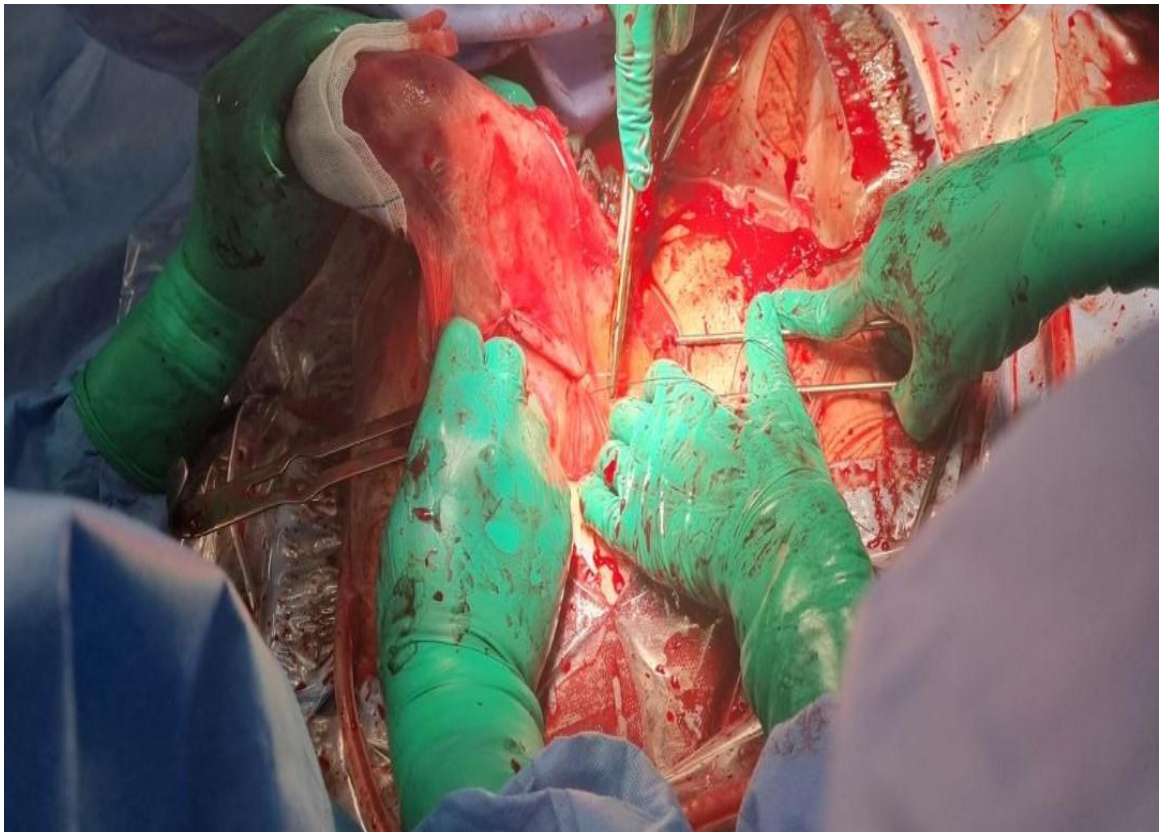

Figure 5: Packing with triple ligature.

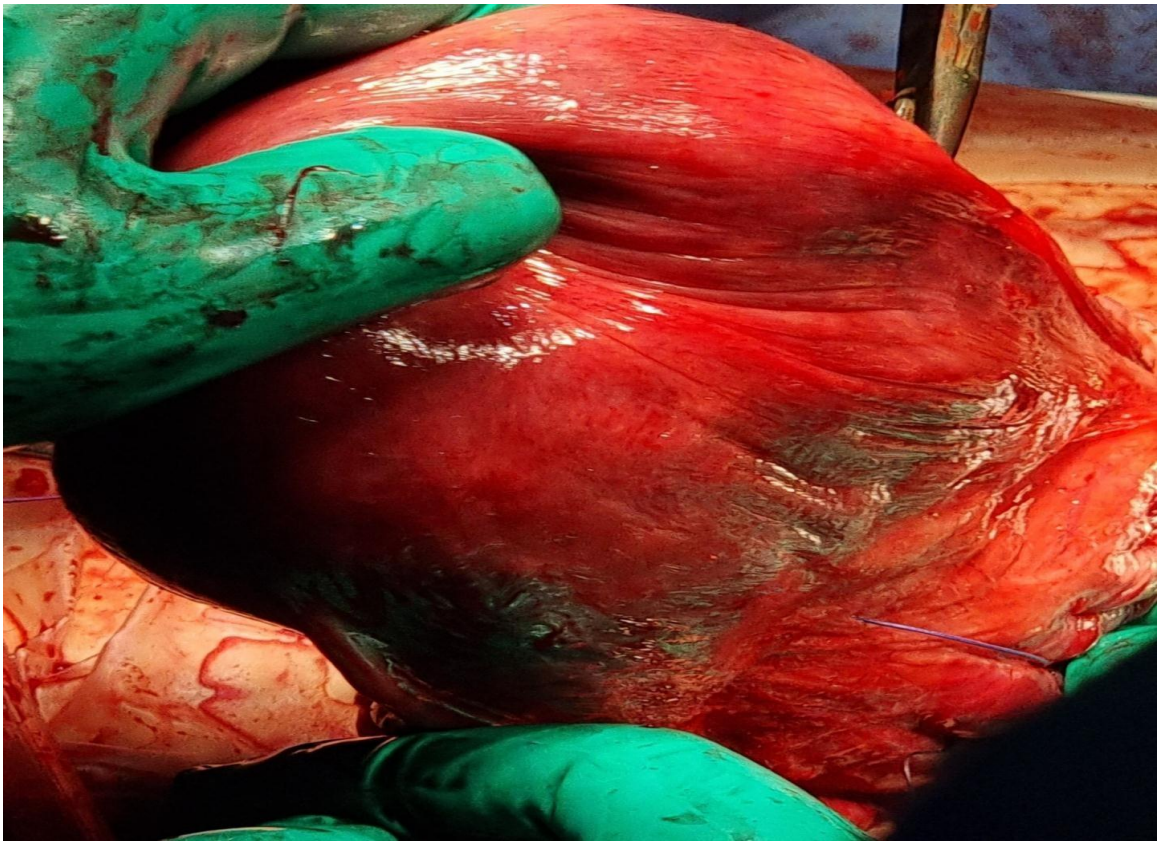

Figure 6: Hysterorraphy after triple ligation.

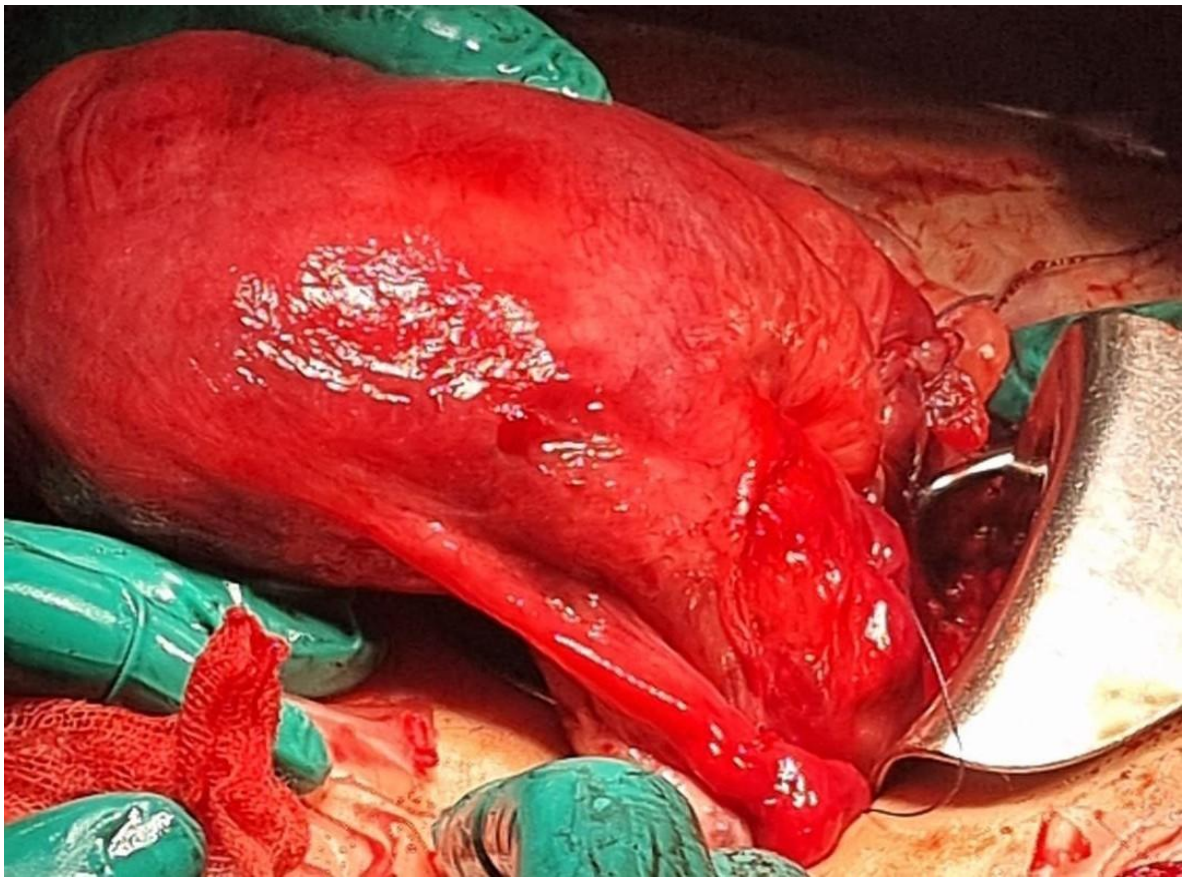

Figure 7: Uterine inertia persists even after packing, triple ligation and hysterorraphy.

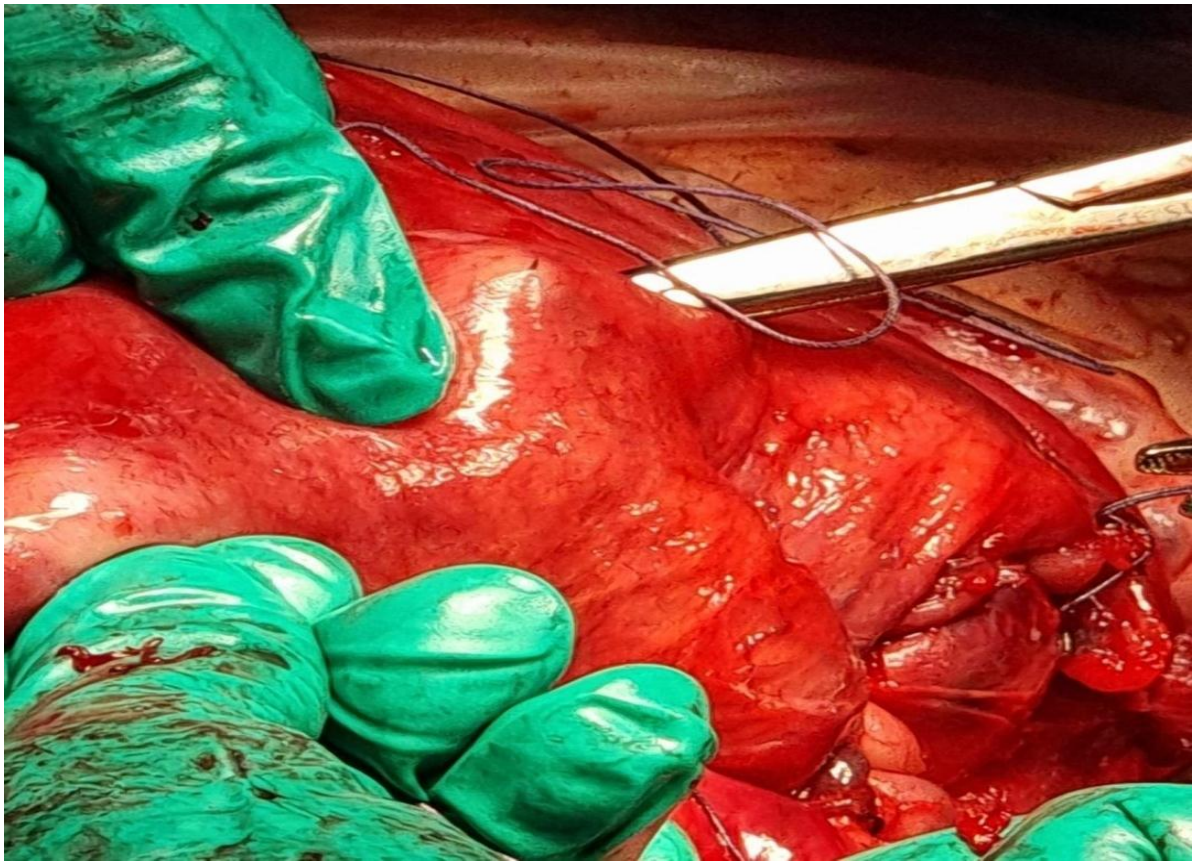

Figure 8: Start of the bi-lynch.

Figure 9: Bi-lynch.

Figure 10: End of the bi-lynch.

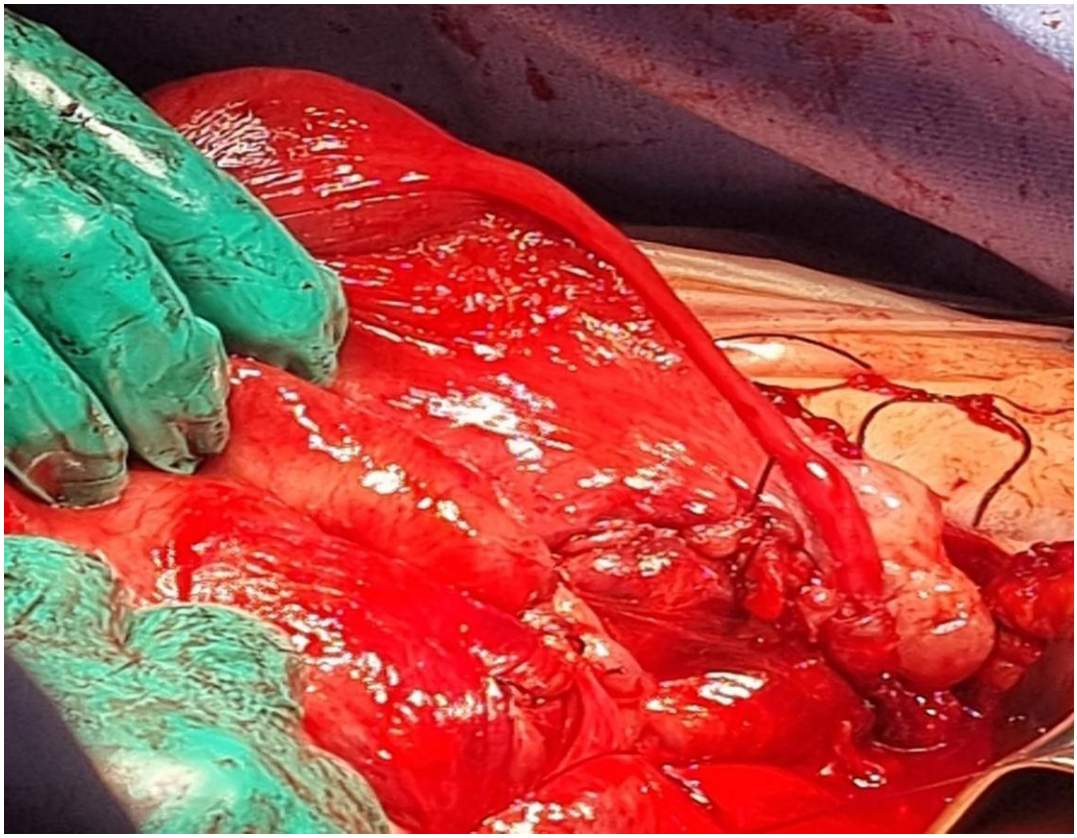

Figure 11: Beginning of padding in frames of the lower segment after triple ligation and bi-lynch.

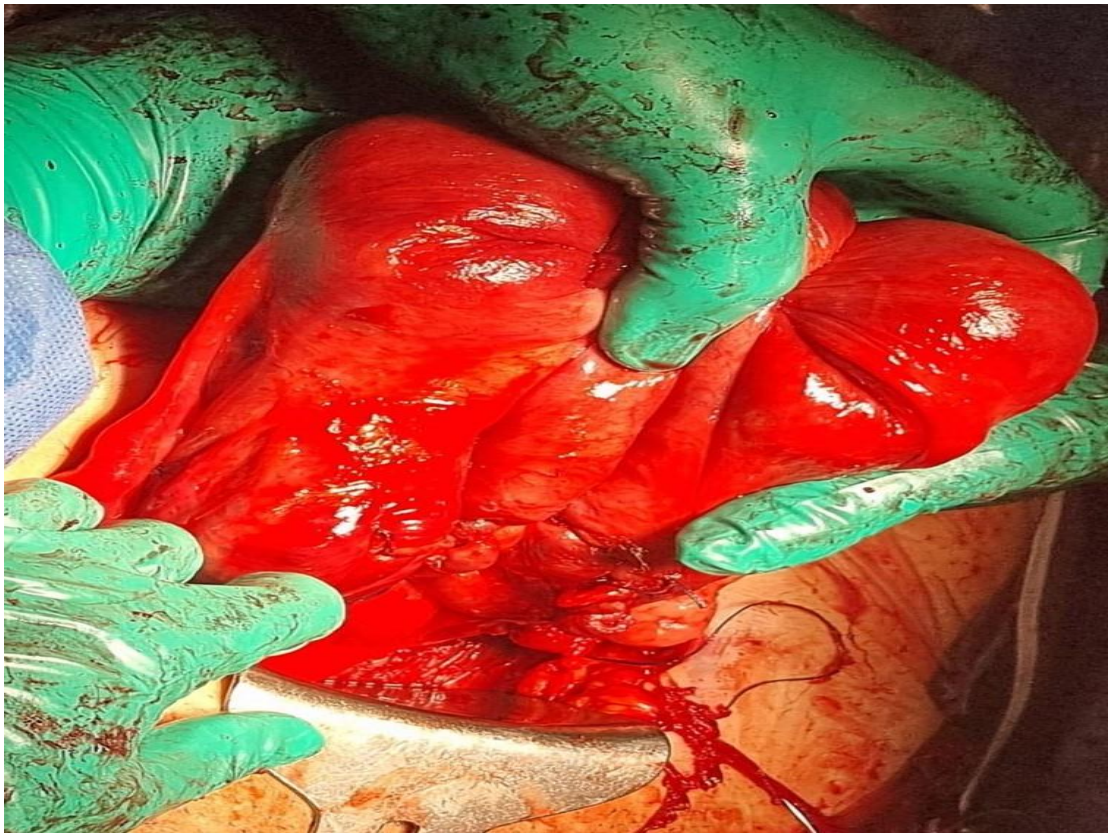

Figure 12: Padding in frames of the lower segment after bi-lynch.

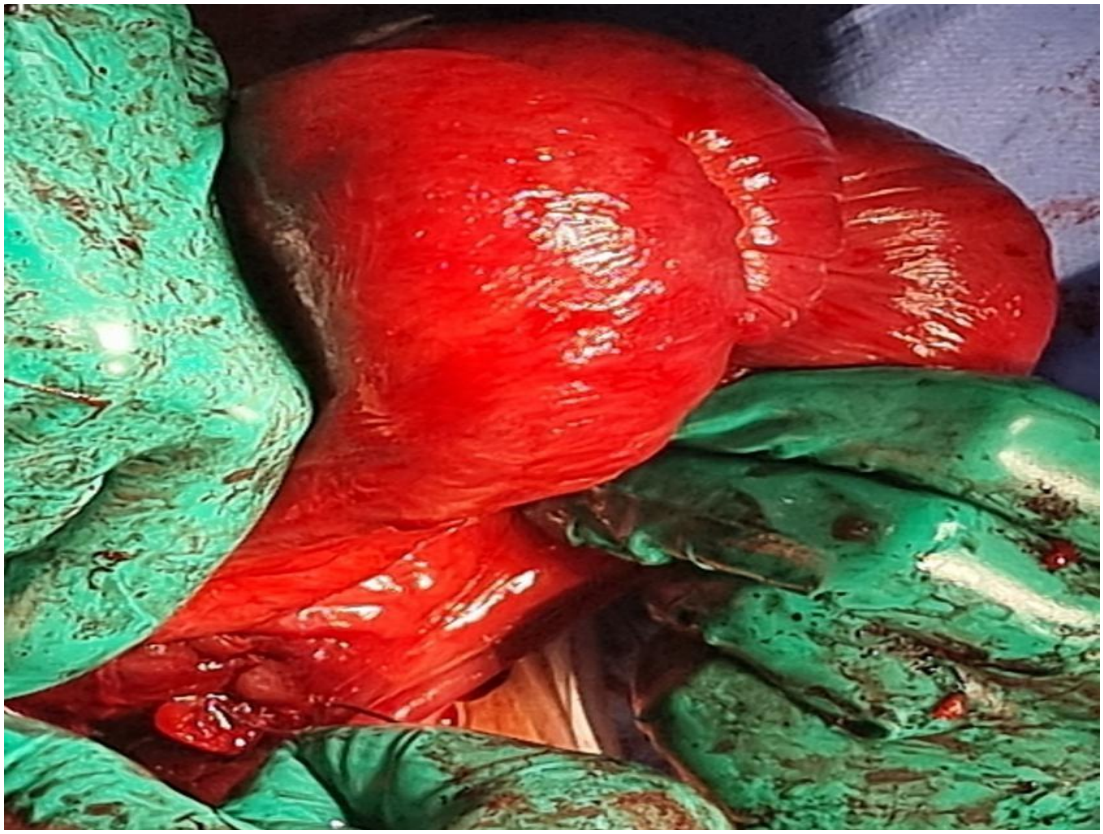

Figure 13: Hemostasis assured after conservative surgical treatment.

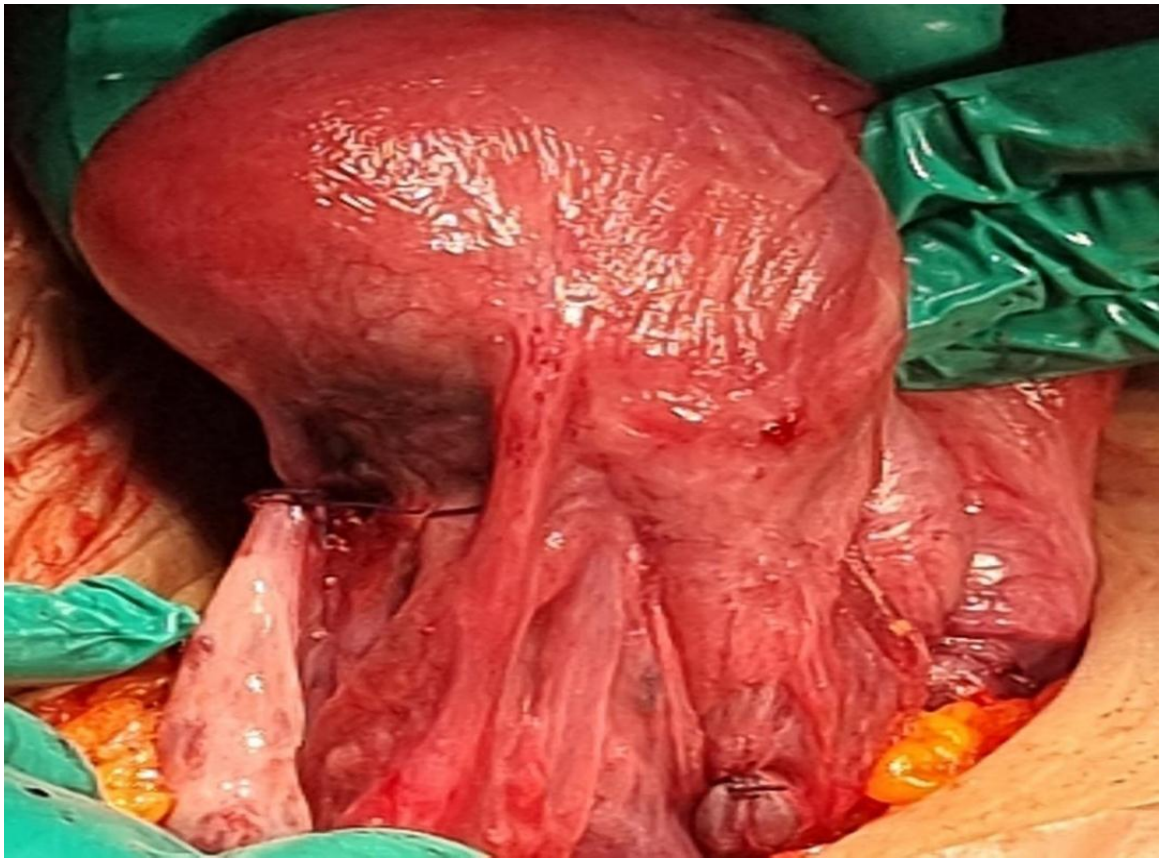

Figure 14: Very good security globe after conservative surgical treatment.

Figure 15: Reintegration of the uterus into the pelvis and decision to close the abdominal wall after checking the hemostasis and placing a drain.

Figure 16: Incomplete delivery of the placenta which is shredded, it is referred to anatomopathological study for histological confirmation of placenta accreta.

DISCUSSION

Placenta accreta is defined as abnormal placentation such that the villi attach directly to the myometrium, without an intervening decidua. A definitive diagnosis can only be made from histologic findings, but assumptive diagnosis should be made if there is difficulty inseparating the placenta.

Obstetrician Frederick C. irving and pathologist Arthur T.hertig of boston lying-in hospital are credited with publishing the first case series of placenta accreta in 1937.[2]

The incidence of placenta accreta in a recent large-scale study was 1 in 111 deliveries.[3] It is believed that the rising incidence may be attributed to the rising number of pregnancies with risk factors, including previous cesarean delivery, advanced maternal age, high gravidity, multiparity, and previous curettage and placenta previa.[3]

A 2016 study using the national patient sample found that the overall rate of placenta accreta in the United States was 1 in 272 deliveries for women who had a discharge diagnosis, which is very high.[4]

This progression appears to directly correlate with the increase in alterations of the uterine lining during the patient's genital life and more particularly with the increased rate of caesarean sections during the period of the last five decades.

Maternal age is correlated with an increased risk of developing the disease. Miller et al. found an increase in incidence of 14.6% in patients over 35 years, these women represented 45% of his study.

Multiparity is also one of the risk factors, either by facilitating trophoblastic invasion due to sensitization of the uterine immune system to paternal genes, or by occult infectious sequelae of a first childbirth.[5]

The history of curettage and placenta previa in our case are most probably risk factors for placenta accreta.

Antenatal diagnoses of placenta accreta can be made by color Doppler ultrasonography[6], magnetic resonance imaging[7], and elevated serum- fetoprotein levels.[8] Color Doppler ultrasound gives the most specific diagnostic criteria such as diffuse or focal intraparenchymal placental lacunar flow, bladder–uterine serosa interphase hypervascularity, prominent subplacental venous complex, and loss of subplacental Doppler vascular signals.[6] However, the ultrasonographic findings at first admission in this case were unremarkable except for a low-lying placenta.

Cesarean hysterectomy remains the gold standard treatment for placenta accreta. Conservation is considered only when the patient's bleeding is not excessive, hemodynamics are stable, and further fertility is desired. Once conservative treatment has been chosen,

refractory hemorrhage during and after delivery and intrauterine infection should be considered. Various surgical and medical methods for hemostasis such as direct packing, oversewing the uterine defect, wedge resection of the implantation site, bilateral hypogastric arterial occlusion, methotrexate injection, and subendometrial vasopressin infiltration have been used for conservative treatment.[9,10] Advances in antenatal diagnosis, improvements in antibiotics, and the multiple intraoperative hemostasis options make preservation of the uterus more and more feasible.

Management techniques for uterine preservation include leaving the placenta in situ, partial myometrial resection of the accreta area with myometrial repair and various suturing methods around the accreta area.[11] These methods have been used either alone or in combination with additional procedures such as uterine artery devascularisation techniques with either surgery or interventional radiology.

When the extent of the placenta accreta area is limited in depth and can be entirely visualised and is accessible, a conservative uterus-preserving surgery may be appropriate. Partial myometrial resection can be attempted to allow a conservative management of the uterus.[11,12] However, this should only be attempted by teams with experience and appropriate expertise in complex pelvic surgery and prepare for emergency hysterectomy if required.[11]

Conservative treatment may increase the risk of secondary infertility, recurrent placenta accreta, and probably ectopic pregnancy.

CONCLUSION

The placenta accreta is a potentially life-threatening condition. Its incidence will predictably increase further over time, because of multiple risk factors and if modern obstetric caesarean delivery trends continue. Total hemostasis hysterectomy is the standard treatment. But in some cases, when the indications are present as in our patient, conservative surgical treatment is possible, allowing fertility to be preserved.

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