

SUCCESSFUL CONSERVATIVE TREATMENT PLACENTA PERCRETA BY UTERINE EMBOLIZATION. A CASE REPORT

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ABSTRACT

Conservative management was recently adopted as an option with an aim to reduce surgical complication and improve maternal outcome. Morbidly adherent placenta is a rare complication of pregnancy associated with high maternal morbidity. It may cause massive haemorrhage thereby requiring emergency hysterectomy. We present a case of placenta percreta which was managed successfully by conservative management. The work has been reported in line with the SCARE criteria (Agha et al., 2018,^[1]).

1 INTRODUCTION

Morbidly adherent placenta is a rare condition,^[2] Morbidly adherent placenta occurs when there is a defect of the decidua basalis, resulting in abnormally invasive implantation of the placenta. Rising caesarean section rates have resulted in an increase in the incidence of placenta accreta/increta/percreta that presents a risk of massive intraoperative haemorrhage.

Maternal complications have been reported, including adjacent organ injuries, excessive blood loss with transfusion of blood products, infection, disseminated intravascular coagulation, and even death.^[3] To decrease maternal morbidity in such cases, conservative management was recently adopted as an option.^[4]

Here we report a case of placenta percreta diagnosed intrapartum and managed conservatively, thereby, preserving fertility.

2. Clinical presentation

A 36-year-old woman presented with gravida 3, para 3, and 2 living children. She had previously had 1 caesarean sections. She was 36 weeks pregnant as confirmed by an ultrasound at 11 weeks.

She was referred to our centre with a diagnosis of placenta praevia with a high suspicion of placenta percreta.

Ultrasound and MRI repeated at our centre confirmed the diagnosis of placenta percreta with invasion to the rectum/sigmoid colon, urinary bladder (Fig. 1).

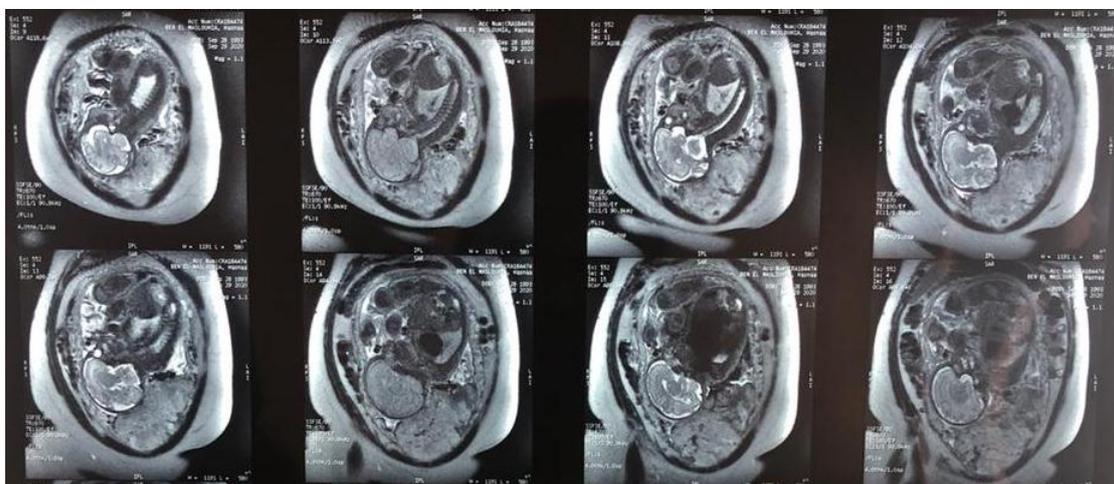


Fig. 1: Magnetic resonance imaging showing placenta percreta with invasion of the urinary bladder fundus. There was also suspicion of invasion to the anterior wall of the rectum and lower sigmoid colon.

3. Past obstetric history

The first pregnancy delivered by cesarean section in 2012. the second pregnancy spontaneous abortion cured after 4 months one year ago.

The patient was counselled regarding all treatment options,^[4,5] including conservative management. She was informed that it was newly adapted with no clear guidelines. The surgical plan and all steps were explained, and she agreed with conservative management.

Consent was obtained for high-risk treatment including bilateral tubal ligation to prevent any complications that may occur during future pregnancies.

Before surgery, the patient was cleared by an anaesthesiologist. Urology, surgery, and neonatology were consulted in case of possible interventions during surgery.

The blood bank prepared as severe bleeding was anticipated.

The obstetrics team (including senior consultant) made a vertical midline skin incision. The placenta was observed anteriorly infiltrating the bladder wall. Posteriorly it was not possible to reach the lower part of the pouch of Douglas as it was obscured, giving the impression of bowel invasion.

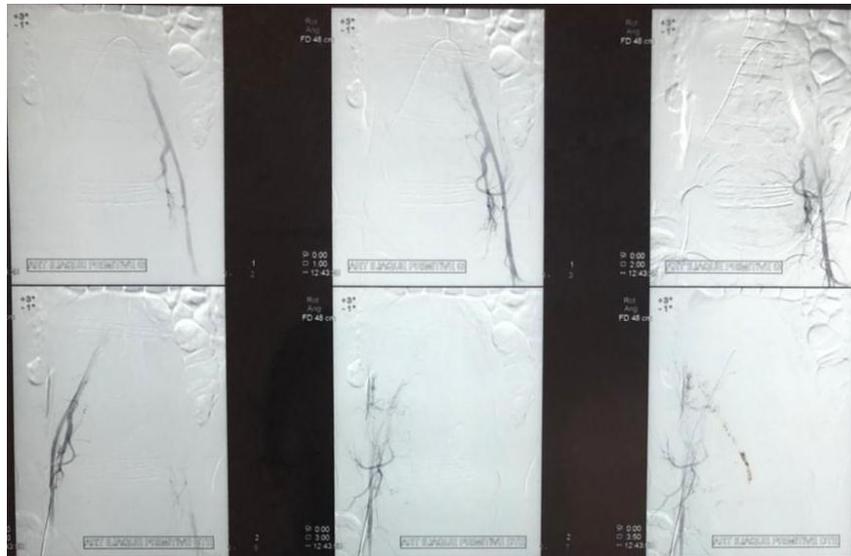
A baby boy weighing 3.420 kg with an Apgar score 10 was delivered through an upper segment vertical incision via breech extraction. The placenta was found mainly posteriorly starting from near the fundus and descending to cover the cervix and then traversing up to the anterior uterine wall with bladder invasion. Fig.2.FIG 3



No attempt was made to separate the placenta, which was left in situ. The cord was ligated proximal to the placental cord insertion. A tubal ligation was performed. The patient's estimated blood loss was 650 ml, mainly from the uterine incision.

Then patient was transferred to the intensive care unit in stable condition for very close observation for bleeding.

On postoperative day 1, the patient underwent uterine artery embolisation (UAE) that was only partially successful due to significant vascularity. A second UAE was performed on postoperative day 7. FIG 4



The patient's Foley catheter and ureteric catheters were removed on postoperative day 2 without complications.

On postoperative day 5, she was discharged from the ICU to the ward in stable condition. LOVENOX prophylaxis was initiated on postoperative day 7.

The patient remained stable. No PV, PR, or haematuria noticed on IV antibiotics + enoxaparin. She was discharged on postoperative day 26 on oral antibiotics.

During her outpatient clinic follow-up, she experienced brownish vaginal discharge with the passage of tiny pieces of tissue. She resumed her menstrual cycle 6 months after surgery.

3. DISCUSSION

The incidence of abnormal placentation reported in literature varies, but averages 1:1000.^[6,7] Known risk factors are previous uterine scars, including caesarean sections and prior uterine curettage.^[6] Other risk factors associated with placenta accreta are multiparity (>6 pregnancies); placenta previa; prior intrauterine infections; elevated maternal serum alpha-fetoprotein; and maternal age over 35 years.^[6,7]

The most important complication of invasive placentation is massive hemorrhage. This is often a result of attempted manual placental separation from its poorly formed decidua, which opens up large-caliber spiral vessels and sinuses.^[8] Hence, Manual removal of densely

adherent placental areas should not be tried because forceful separation may result in severe bleeding.

Imaging modalities during antenatal evaluation may detect the presence of morbidly adherent placentae. Comparisons between ultrasound and Magnetic resonance imaging (MRI) have shown a sensitivity and specificity for ultrasound 77% and 96% and for MRI 88% and 100% respectively, highlighting the complementary role of the two imaging modalities.^[9]

The approach most often recommended in situations of significantly abnormal placentation is hysterectomy. However, hysterectomy is not always safe, especially in cases of a placenta percreta. There is an increased risk of significant hemorrhage and damage to the urinary and gastrointestinal tract and necessarily leads to loss of fertility.^[10,11]

In a lady who desires fertility, hysterectomy should be avoided and conservative management is the choice. Where the placenta has been left in situ, there is no consensus as to whether the placenta should be removed in the postpartum period or left to resorb or to be expelled spontaneously.^[9]

4. CONCLUSION

This case has been reported for the rarity of conservative management of placenta percreta by leaving placenta in situ.

Conservative approach has always risk of complications. Hence, patient selection,. Nonetheless, experience in the literature suggests that conservative management of placenta percreta can help women avoid hysterectomy in selected patients where fertility preservation is of concern.

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