

Anesthetic Management of Placenta Percreta: An Incidental and Alarming Finding!

Priya Shenwai; Manjusha Kuraganti; Maritza Luna Marin; Allison Kalstein-Apple; Joel Yarmush
New York Presbyterian Brooklyn Methodist Hospital, Anesthesiology, Brooklyn, NY, USA,

CASE PRESENTATION

- Patient is a 40-year-old G1P1001 with no significant past medical history and uneventful prior cesarean section, scheduled for repeat cesarean section at 39 weeks under combined spinal epidural.
- Upon performing uterine incision, it as found that placenta was anterior.
- A live baby weighing 3140 grams with APGAR of 9 was delivered.
- A massive transfusion protocol was announced when placenta percreta was incidentally noted measuring 3 cm through the myometrium and adhering to the bladder's serosa anteriorly.
- Large bore secondary IV access and arterial line placed.
- Due to hemodynamic instability, it was decided to convert to general anesthetic.
- Vasopressors, blood products, and tranexamic acid infusions were given till hemostasis and surgical repair were achieved.
- Hence, hysterectomy was avoided.
- The patient remained intubated and transferred to the ICU for hemodynamic monitoring and care.
- She was extubated the next day, recovered uneventfully, and was discharged home with an OB follow-up in 2 weeks.

INTRODUCTION\

- Placenta percreta is the most serious type of aberrant placentation, in which the placenta penetrates myometrium and attaches to surrounding organs, resulting in considerable blood loss and maternal morbidity.
- This is one of the common causes of intraoperative hysterectomy. In many circumstances, preoperative planning and a multidisciplinary approach can improve the outcome for the mother and baby.

CONCLUSION

Placenta Accreta Spectrum is abnormal placentation leading to massive life-threatening hemorrhage. Early diagnosis, multidisciplinary management approach, or transfer to higher-level care contributes to the decrease in maternal morbidity and mortality.

DISCUSSION

- The term "placenta accreta spectrum" refers to abnormal placentation.
- It is classified as accreta (connected to myometrium), increta (penetrates myometrium), and percreta (attachment to extrauterine organs such as bladder, bowel, etc).
- This can lead to life-threatening hemorrhage due to inability to remove the placenta.
- The pathophysiology of aberrant placentation is malfunction at the endometrial-myometrial interface, failure of decidualization, and a deep invasion of villi into the myometrium and surrounding pelvic organs.
- Diagnosis is made by ultrasound and MRI during the antenatal period. Placental bulging or invasion into the bladder is also a common occurrence.
- Risk factors for placenta accreta are previous cesarean delivery or uterine scar, advanced maternal age, multiparity, placenta previa, and elevated second-trimester AFP.
- Management includes early detection, scheduled cesarean delivery, and a multidisciplinary approach to improve outcomes.
- Anesthetic management includes obtaining two large bore IV access, hemodynamic monitoring with arterial line and central line if required, availability of rapid transfuser, cell saver, and blood products in the OR.
- The main goal of intraoperative management is to replace blood volume while maintaining hemodynamic stability.
- The optimal use of blood products, vigilance, ICU support, and multidisciplinary care are pivotal in successful outcomes.

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