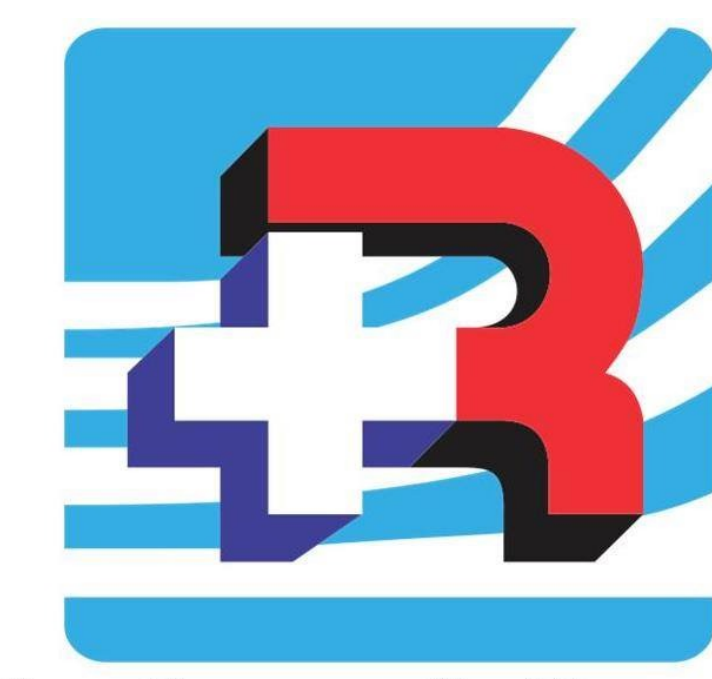




TYPE I CS SCAR PREGNANCY WITH PLACENTA PREVIA AND PLACENTAL ACCRETE SYNDROME



Objective:

To present a case of Type I CS scar pregnancy with concomitant Placenta Previa and Placental Accrete Syndrome.

Case Report:

A case of a 44 years old G6P3 (3023) who was admitted due to vaginal bleeding. She had a total of six pregnancies with 3 live births, 1 abortion and 1 ectopic pregnancy. Of the 3 term pregnancies, 2 were delivered via NSVD and 1 delivered via Inverted T-Incision for Fetal Malpresentation. Initial transvaginal ultrasound showed a thickened endometrium (1.8 cm) that was considered to be a decidualized endometrium.



Repeat scan at 6 4/7 weeks revealed a single, live pregnancy.



Another scan at 8 4/7 weeks showed a low lying gestational sac near the cesarean section scar site. Growth of the fetus was towards the endometrial cavity suggesting a type 1 cs scar pregnancy.



Follow up scan at 16 5/7 weeks showed a single, live fetus within the expanded mid portion of the lower uterine segment. The placenta was anterior, totally covering the internal os.



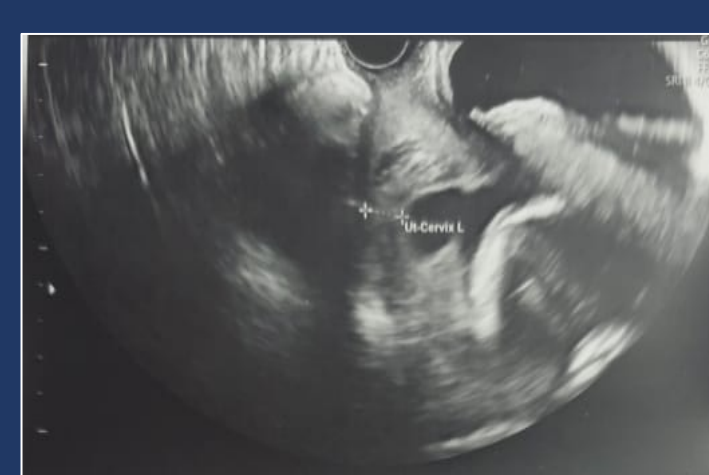
Color mapping showed vascularity. The anterior myometrial wall was 0.15 cm thin. Uterine serosal and bladder interface is intact.



Placental examination at 18 weeks showed loss of retroplacental sonoluscent space with the anterior uterine wall of the uterus markedly thinned out without normal looking myometrium between the serosa and bladder wall. CSP with placental accrete syndrome was considered.

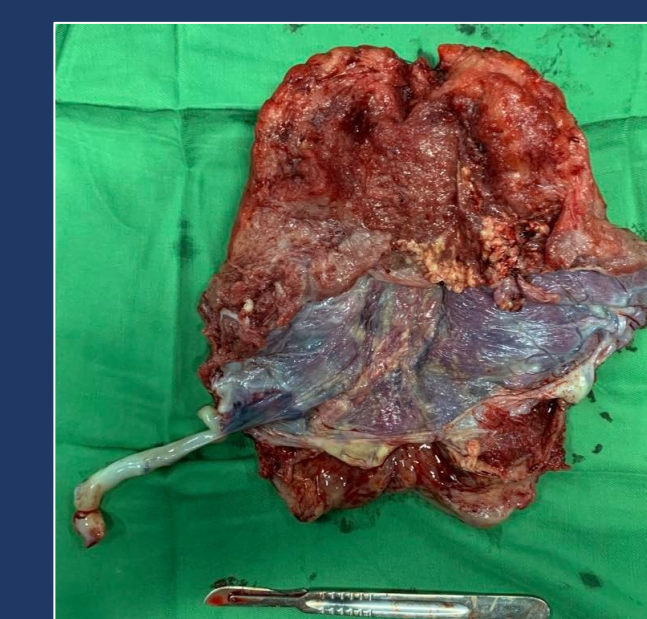
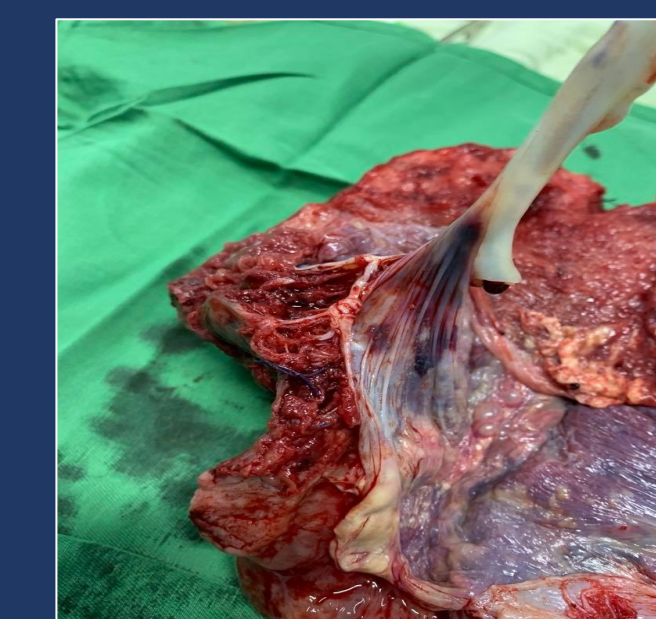


At 21 3/7 weeks, expansion of the midportion of the lower uterine segment still noted. The cervical length was 1.2cm with funneling suggestive of preterm labor.

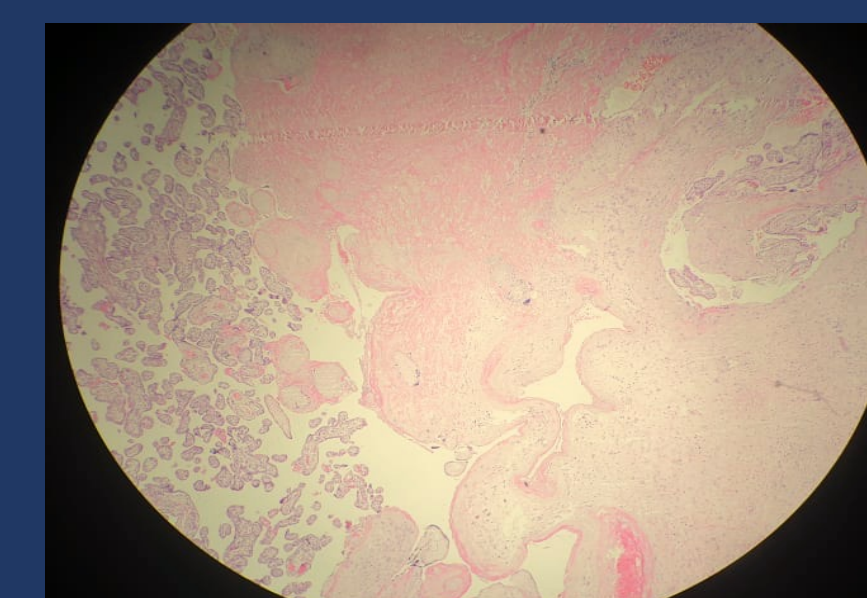
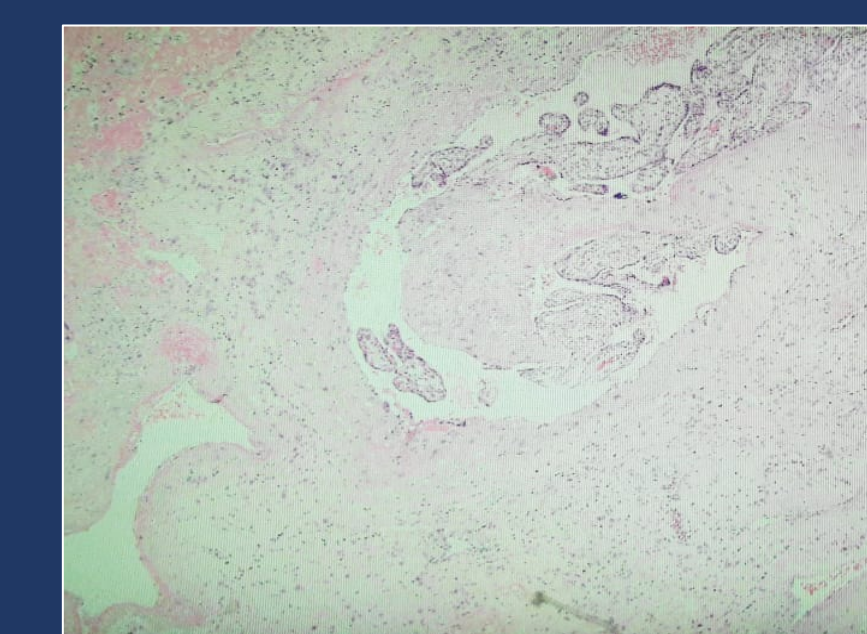


At 23 weeks, she had vaginal bleeding and was admitted. She subsequently underwent Cesarean Hysterectomy with Bilateral Salpingectomy, Bladder Cystorrhaphy under Epidural-General Anesthesia for beginning intra-amnionic infection.

Intraoperatively, cut section of the uterus revealed increta of the whole anterior wall up to the lower lateral sides of the corpus on both sides; thinned out serosa covering the lower segment attached to the posterior bladder wall.



Patient was discharged in a stable state. Surgical pathological report showed Placenta Increta. The microscopic examination showed sections thru the endometrium showing small chorionic villi with note of infiltration into the myometrium.



Discussion:

There is no universal management for CSP. Treatment options are individualized and based on the patient's age, number of living children, need for future child bearing, hemodynamic condition and viability of the pregnancy.

The dilemma lies on whether to terminate a live pregnancy or to continue the pregnancy with a possibility of delivering a live offspring.

Conclusion:

The increasing number pregnancies concluding to cesarean deliveries has been associated with an increased incidence of Cesarean Scar Pregnancies.

A high index of suspicion coupled by an accurate sonographic diagnosis must be done to provide optimal management to the patient and thereby reducing overall maternal morbidity and mortality.

Acknowledgements:

I would like to say thank you to my mentor, Dr. KKB, for pushing me beyond my limits. To my mother, for her never ending support. And to CJ for being with me, always.