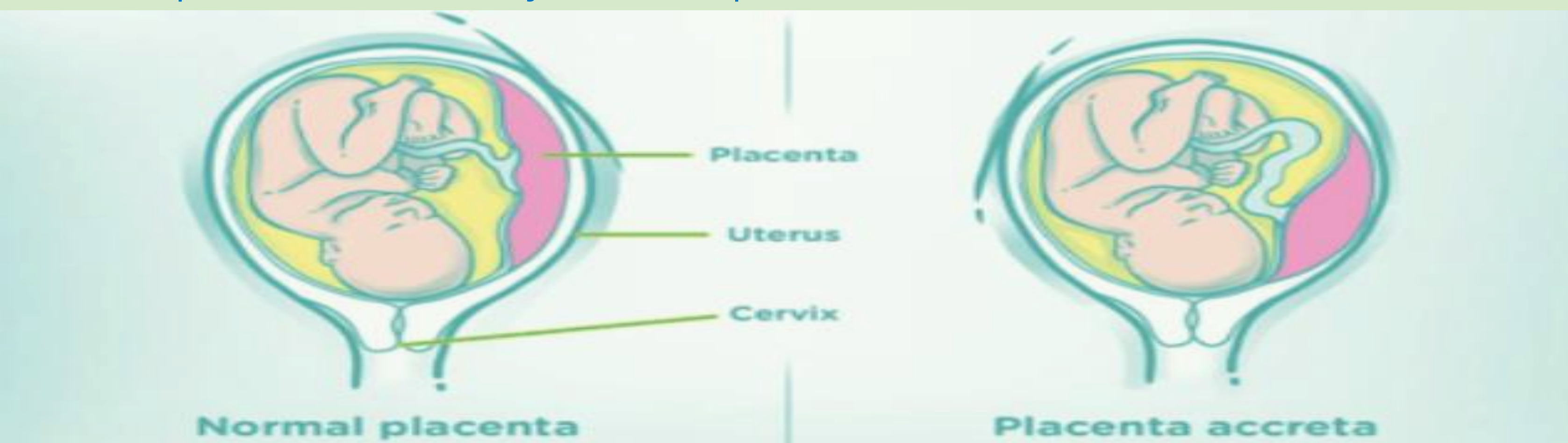


Unexplained placenta accreta in Primigravida: Two rare case scenarios, a learning experience!!

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Introduction

Placenta accreta spectrum is a complication of pregnancy which has a very rare occurrence varying from 1 in 300 to 1 in 2000. For its diagnosis in antenatal period ultrasound evaluation is important, but the absence of ultrasound findings does not rule out the diagnosis of placenta accreta spectrum & therefore clinical risk factors remain essential as predictors of PAS. It's very rare to find placenta accreta in women who do not have any clinical risk factors or the ultrasound findings, two such clinical scenarios of placenta accreta in primigravidae women (diagnosed at the time of LSCS) are discussed below , which were managed in our secondary care NHS hospital. As SOP, the care of all the antenatally diagnosed /suspected placenta accreta cases are transferred to designated tertiary care units from their respective secondary care hospitals.



Case Discussion

CASE 1

19-year-old primigravida, overall, a low-risk pregnancy. No previous history of uterine surgery, pelvic infection, miscarriages & medical or surgery history relevant to placenta accreta. First trimester was clinically uneventful, her ultrasound at 12 weeks showed an echo poor area between placenta & anterior wall of the uterus. Her anomaly scan was normal . At 21 weeks she presented with a brownish PV discharge that was managed conservatively & she remained asymptomatic apart from this one episode . She presented at 36+4 weeks of gestation with an episode of PV bleeding following which she was admitted .She presented at 36+4 weeks of gestation with an episode of PV bleeding following which she was admitted .Per speculum showed some dark blood in vagina, no active bleeding from cervix & no local cause(tear/trauma/ectropion) of bleeding .She was discharged after 24 hours of observation . At 41+3 weeks of gestation, she had a Category 2 Caesarean section following failed induction of labour, the baby was born healthy with no requirement for special care. Placenta was found to be adherent at the time of caesarean section ,

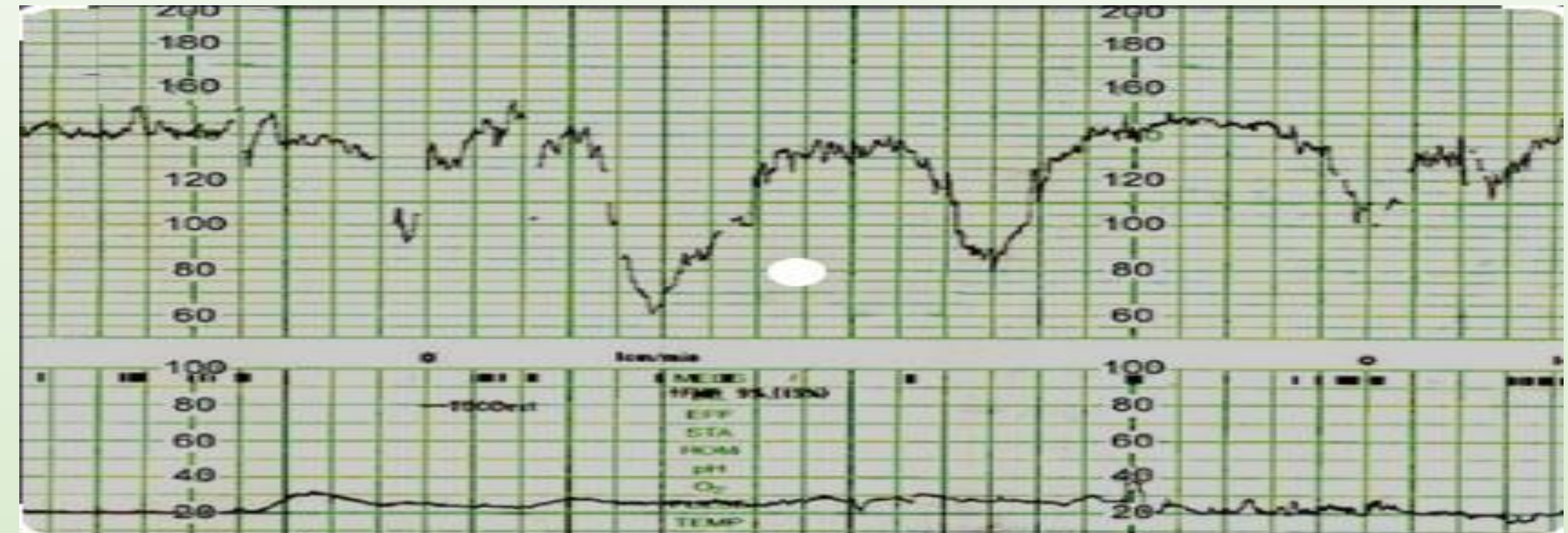
Senior gynaecology consultant was also called in (apart from on call obstetric consultant) once suspicion of placenta accreta was made. The placenta was removed piecemeal along with a segment of myometrium , the tissues retrieved were sent for histology . She received all oxytocic medications intraoperatively as per guidelines for PPH & later she had an intrauterine balloon tamponade for uterine atony refractory to medical management. She was transfused 10-unit PRCs with 8 units of FFP in total of which 7 units PRC was transfused intraoperatively & 3 units were transfused in recovery ,decision making was done with involvement of anaesthetic team & haematology team. Total measured intraoperative blood loss was 6000ml . Patient was admitted to ITU for strict monitoring for 48hrs where intrauterine balloon was removed after first 24hrs . Preop Hb was 130g/L & post op Hb (after blood transfusion) was 96g/L . She was shifted to post-natal ward once stable. Recovery in postnatal ward was uneventful. Histology confirmed placenta accreta -due to presence of adherent placenta tissue (lack of decidua) to myometrium tissue segments

Case 2

29-year-old Primigravida. First trimester was uneventful. At 20-week scan, the placenta was found to be low-lying which was followed up at a 32-week scan & was not found to be low lying anymore. She had one episode of PV bleeding at 32+4 weeks of gestation(approximately 50mls). Her speculum showed some blood in vagina but no active bleeding from cervix & no local cause(tear/trauma/ectropion) of bleeding .This APH was managed conservatively, & patient was discharged home on second day.

At 34+5 weeks of gestation, patient had spontaneous rupture of membranes, following which she had 150ml of APH along with passage of small clots. Uterus was relaxed & foetus was cephalic in position.

P/S showed frank leaking PV. She was given first dose of steroid & was started on antibiotics for PPROM as per GTG.Her NST showed variable decelerations within 6hrs of admission(as shown) & she had an emergency LSCS with EBL 800ml. Baby's at birth APGAR was 8,9 & was kept in NICU for observation. Placenta was found to be adherent which was removed in piecemeal. The severely adherent segment of placenta was not removed completely & approximately 3x4cm segment was left in situ, after weighing the risk of major intraoperative hemorrhage, surrounding organ damage & potential of obstetric hysterectomy & patient's desire of future fertility. Removed placental tissue was sent for histology. She had an uneventful postnatal recovery. A post natal plan was made for follow up at 6-week & at 3-month with an MRI pelvis (with gadolinium contrast). MRI for placenta accreta shows heterogeneous signal intensity within the placenta, dark placental band on T2 & focal interruptions in the myometrial wall .



MRI in follow up period showed a 1x1 cm avascular region in myometrial bed suggestive retained necrosed placental tissue. Patient remained asymptomatic. In view of clinical & imaging findings patient needed no further intervention .

Discussion

Deciding factors to opt for either conservative or radical surgical approach for management of placenta accreta include patient choice, severity of placental adherence as well as clinical requirement of the situation. There has been no RCT to back either kind of approach. With cases like the ones discussed above of young primigravida women present with placenta accreta, where the management approaches were different , its is imperative to understand that individualized approach is essential along with MDT input for making sure that patient receives best care. There is no definitive follow up protocol defined for PAS but BHCG trend doesn't not accurately predict the placental resorption & using BHCG remains controversial. Placental size on follow-up ultrasound is used after conservative management is not evidence based.

Conclusion

It is safe to recommend that for PAS in primigravida management should preferably be in tertiary care centre with facilities like pelvic devascularization/ Interventional radiology which can prevent hysterectomies. Conservative approach has lower morbidity & higher fertility potential as compared to Hysterectomy ,but a future RCT comparing both will pave the way for a more well-defined & structured plan for future management of PAS. There is vast scope for future research on causes other than the ones known to be associated with PAS, this is because as discussed in this case series placenta accreta is seen in women who do not have any of the risk factors historically known to cause PAS .