

- Objective: Uterine body PAS (placenta accreta spectrum) or non-previa can be defined as the occurrence of PAS in all locations of the uterus other than the lower segment. This entity of PAS disorders is seldomly diagnosed prenatally. The increased incidence of cesarean deliveries (CD) and uterine surgeries often requires careful screening during prenatal visits. Most case reports in literature diagnose non-previa PAS after subsequent hysterectomies and pathological examination. In the current case, we present successful conservative management of morbidly adherent fundal-anterior placenta that was incidentally found intraoperatively during cesarean delivery.
- Case report: Our patient is 41-year-old, G5P2+2, with two prior CDs with a history of one D&C. Presented at 18th-week gestation to OPD, at 32nd week diagnosed with GDM and delivered by CS at 37 week+3 days due to tender scar. A transverse incision was done, delivery of the fetus, and upon trial to deliver the placenta, separation was not spontaneous with gentle traction. Exteriorization of the uterus was done to find anterior uterine wall placental invasion far from the site of the previous CS scar and 3 cm from the uterine fundus. An elliptical incision was done to remove the adherent part with the penetrated endometrium and the placenta. Suturing and approximation of the remaining anterior uterine wall and the very thin LUS was attempted in 2 separate layers. The removed part 8.5*4 cm was sent to pathology and found to be placenta incerta. At the 6-week follow-up appointment, the patient fully recovered and TVS revealed a normal-sized uterus and no lining defects with a normal endometrial line.
- Discussion: the clinical suspicion to diagnose PAS if anterior or fundal located placenta is low especially if, with the antenatal US, there was no classical signs of adherence or low-lying placenta. In our case patient had advanced maternal age, prior CDs, and history of D&C but with a less common placental location to be adherent. Most cases with non-previa PAS are histologically diagnosed from hysterectomy specimens post-operatively and thus adding to the adverse maternal outcomes and morbidity. In a non-severe life-threatening setting with uterine invasion, surgical uterine repair might be feasible for those patients who tend to remain fertile.
- Conclusion: Proper identification of patients with risk factors and early referral for proper US examination or further imaging as MRI can dramatically decrease the number of unexpected intraoperatively diagnosed cases and reduce perinatal as well as maternal morbidity.