

Unexpected Accreta: A case report

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Introduction

Placenta accreta spectrum (PAS) is relatively an uncommon condition in pregnancy which can be explained as abnormal trophoblast invasion into the myometrium.¹ While caesarean hysterectomy remains commonest approach, however, there have been other measures to preserve uterus such as extirpative technique, leaving the placenta in situ, one – step conservative procedure (OSCP), triple-P procedure, embolization, uterine balloon tamponade and methotrexate. In this case report, we describe a new uterus conservative technique which was used to manage undiagnosed focal placenta accreta during caesarean section.

Case Presentation

31 years old, Gravida 3 Para 0 with 2 previous missed miscarriage which were managed surgically, presented to induction suite for induction at 38 weeks and 6 days for gestational diabetes mellitus (GDM) which was managed with insulin. In her 19 weeks ultrasound, placenta positioned at left lateral uterine wall and it’s inferior margin was clear from internal os by 24mm.

Following her induction process, she required emergency caesarean section for suspected foetal distress. Intraoperatively, there weren’t signs of placenta accreta prior to uterine incision. Routine lower section caesarean section followed by controlled cord traction applied to deliver placenta. Placenta was delivered with ease however approximately 4cm focal placental piece noted to be adherent to uterine wall with myometrial deficiency raised possibility of PAS. Given ongoing bleeding, decision made to surgically excise the focal adherent placental piece and sutured placental bed in 2 layers with size 1 Polysorb. Uterine serosal layer was not breached during this procedure. Concurrently, she was given intramuscular injection of ergometrine 250mcg followed by syntocinon infusion to improve the tone. Intravenous tranexamic acid 1gm was also given.

Uterine incision was closed in 2 layers followed by routine closure of rectus sheath, fat layer and skin. Bakri balloon was inserted and inflated with. 150mls saline. Total estimated blood loss was 1500mls. Bakri was removed after 6hours, and no further vaginal bleeding noted.

Patient was discharged home on 3rd day following her caesarean section. Histopathology confirmed placenta accreta. Pelvis ultrasound with Hysterosalpingo-Contrast Sonography (HyCoSy) was organised after 3 months to check for myometrial deficiency at the area where focal placental excision was performed. HyCoSy demonstrated normal cavity shape and myometrial thickness

Result

Mainstream treatment option is caesarean hysterectomy.²Alternatively, uterus conserving procedures such as extirpative technique, leaving the placenta in situ, one – step conservative procedure (OSCP) ,triple-P procedure , embolization, uterine balloon tamponade and methotrexate can be considered after discussion with patient.³⁻⁵ Extirpative technique and leaving the placenta in situ can cause increase blood loss and possibility of hysterectomy.⁹ Whereas OSCP , triple-P and uterine artery embolization require interventional radiologist input with experienced surgeon.⁴ Uterine balloon tamponade with methotrexate are associated with infection and prolong follow up.⁴ Other important drawback of these procedures is difficulty to apply them in undiagnosed PAS during caesarean section especially by junior clinician who are practising in rural or resource limiting settings.

Most of the time clinicians would fall back on caesarean hysterectomy which has been mainstream treatment for decades. Without appropriate skill sets and resources, performing emergency caesarean hysterectomy can be challenging. Schwikert et al (2021) study has shown that unplanned emergency hysterectomy is associated with increased blood loss compared to planned hysterectomy.² Interestingly, there is no difference in estimated blood loss between planned hysterectomy and uterine conservative procedures.² Apart from surgical risk, unplanned hysterectomy can leave psychological trauma on women especially on those who planned to have more children in future.

Hence, we strongly believe that focal excision of adherent placenta should be considered in cases with focal adherent placenta as this technique sets itself apart from caesarean hysterectomy and other mentioned uterus conserving procedures for the following reasons:

1. Cost effective as it requires only routine caesarean set up
2. Fertility sparing
3. Relatively lesser blood loss compared to emergency hysterectomy
4. Doesn’t require advance surgical skill sets

Conclusion

Inconclusion, it is paramount to consider partial myometrial resection in managing focal adherent placenta.

References

1. Hecht, J.L., Baergen, R., Ernst, L.M., Katzman, P.J., Jacques, S.M., Jauniaux, E., Khong, T.Y., Metlay, L.A., Poder, L., Qureshi, F., Rabban, J.T., Roberts, D.J., Shainker, S. and Heller, D.S. (2020). Classification and reporting guidelines for the pathology diagnosis of placenta accreta spectrum (PAS) disorders: recommendations from an expert panel. *Modern Pathology*, [online] 33(12), pp.2382–2396. doi:https://doi.org/10.1038/s41379-020-0569-1.
2. Sentilhes, L., Kayem, G., Chandraharan, E., Palacios-Jaraquemada, J. and Jauniaux, E. (2018). FIGO consensus guidelines on placenta accreta spectrum disorders: Conservative management., *International Journal of Gynecology & Obstetrics*, 140(3), pp.291–298. doi:https://doi.org/10.1002/ijgo.12410
3. Schwickert, A., Beekhuizen, van, Bertholdt, C., Fox, K.A., Gilles Kayem, Morel, O., Rijken, M., Stefanovic, V., Strindfors, G., Weichert, A., Weizsaecker, K. and Braun, T. (2021). Association of peripartum management and high maternal blood loss at cesarean delivery for placenta accreta spectrum (PAS): A multinational database study. *Acta Obstetricia et Gynecologica Scandinavica*, 100(S1), pp.29–40. doi:https://doi.org/10.1111/aogs.14103.
4. SENTILHES, L., KAYEM, G. and SILVER, R.M. (2018). Conservative Management of Placenta Accreta Spectrum. *Clinical Obstetrics & Gynecology*, 61(4), pp.783–794. doi:https://doi.org/10.1097/grf.0000000000000395
5. Sompolinsky, Y., Yagel, S., Hochner-Celniker, D. and Tal, Z. (2020). [UTERINE PRESERVING METHODS FOR TREATING PLACENTA ACCRETA SPECTRUM: A PROPOSAL FOR A SURGICAL PROTOCOL]. *Harefuah*, [online] 159(3), pp.186–190. Available at: https://pubmed.ncbi.nlm.nih.gov/32186789/ [Accessed 14 May 2023].