

PLACENTA PERCRETA PRESENTING WITH HYPOVOLUMIC SHOCK AT EARLY GESTATION: A RARE CASE REPORTS

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INTRODUCTION:

Abnormal placental localization occurs as a defective interaction between decidual layer and placenta. The first case reported in history by Plater in 1588 in modern literature. The incidence is up to 1 in 2500. With the increase in number of cesarean section the risk increases more up to 10% at 4 or more. The placenta percreta presents with uterine rupture in late 2nd and 3rd trimester but it is very rare when presents with uterine rupture in late 1st and early 2nd trimester. When morbid adherent placenta are diagnosed at the gestation before viability, counseling of patient should be done to terminate pregnancy to avoid mortality and morbidity. Guidelines should be made for localization and sonographic examination of placental localization in early 2nd trimester. Planned hysterectomy with involvement of MDT is important to assess surrounding structures integrity to avoid post op complications including bowel and bladder.

CASE REPORT



A 32 years old G4P3+0 previous 3 scar known case of cholelithiasis at C.A. 14 weeks presented in emergency with symptoms of drowsiness, shortness of breath, pain in abdomen radiating to hypogastrium and shoulder tip pain. Her vitals were B.P. 80/40, pulse 150b/min, SpO₂ was 85 %, clinically pallor. Her bed side blood investigations were performed including complete blood count, Serum electrolytes, Serum LFTS, Serum RFTS, ABCs, serum amylase, Serum lipase. Ultrasound was performed. Her HB was 60g/L. ABCs showed metabolic acidosis. Other serum investigations were normal. Ultrasound was performed which showed massive hemoperitoneum, single intrauterine 13 weeks viable pregnancy with placental localization cannot be commented due to hemipertoneum. Gall bladder showed multiple small stones with intact wall. Laprotomy was performed with MDT involvement including anesthetist, hematologist, urologist and surgeon. 1000 ml hemoperitoneum removed, uterus was ruptured from fundal region due to placenta percreta. Hysterectomy was performed followed by cystoscopy to assess direct visualization of bladder wall integrity. Cystoscopy findings were normal. Surgeons performed cholecystectomy with intact gall bladder wall. 4 units of packed RCC and FFPs and platelets transfused with ratio 1:1:1. Patient shifted to Intensive care unit. Her post op recovery was smooth. Sample sent for histopathology confirmed that tissue was of chorionic villi breaching out of fundus of uterus.

CONCLUSION

Placenta percreta is a life threatening condition presents with hypovolumic shock and uterine rupture at early gestation. TVS with color Doppler at early gestation should be emphasized for diagnosis. And treatment of choice is hysterectomy in patients who presents with shock. Bladder and bowel involvement should be assessed in collaboration with MDT team to avoid post op complications.

REFERENCES

1. P.Sinha, M.Mishra. Caesarean scar pregnancy : a precursor of placenta percreta/ accrete, JOG,2012, Sep,4; V 32 (7:621-623)
2. M Hopker, G. Fleckenstein, W. Heyl. Placenta percreta in 10 week of pregnancy with consecutive hysterectomy: a case report. Human Reproduction. 2002, March ; VII(3):817-20
3. Parveen Haider. PLACENTA PERCRETA IN EARLY GESTATION. JPMA. 1990, Nov ; 40 (11): 274-5

DISCUSSION

Placenta percreta is the rare and life threatening condition of pregnancy due to defective placentation. Highest incidence reported from Thailand due to defective implantation of decidua (3). Monks et al reported a case of G4P3 previous 3 c- section with incomplete miscarriage at 10 weeks of gestation (11). Harer reported a case at 10 weeks with induced abortion. Hornstein et al reported invasive placenta at 15 weeks (3)(12). The above cases showed that placenta accreta spectrum not even present at late gestation but may starts during early pregnancy. Porreco et al showed half of uterine rupture occurs in an unscarred uterus. By doing early ultrasound we can prevent adherent placental complications so ultrasound should be emphasized and part of guidelines in early 2nd and late 1st trimester to avoid mortality and morbidity of such patient presenting with uterine rupture at early gestation. In our case we reported a case at 14 weeks with viable pregnancy which is very rare. Although patient had previous 3 c-section but the uterine rupture was not from the scarred site but from fundal region. Conservative management including methotrexate treatment, uterine artery embolization, internal iliac artery ligation can be used. Cox et al 1988 tried conservative management by covering a uterine rupture. Mussalli 2000 reported cases to conserve uterus after methotrexate but in cases of emergency hysterectomy is the treatment of choice.