

Emergency Hysterectomy For Abnormally Adherent Placenta Praevia – Case Report

Dr Pragya Verma, Mr. Thamer Albadry, Mr. Benjamin Ayensah

Northampton General Hospital, United Kingdom (UK)

Objective

- Highlight challenges of managing placenta praevia and abnormally adhered placenta

Case Report

The patient presented at 35+5 gestation with severe abdominal pain but no initial vaginal bleeding. Vaginal bleeding began shortly after, raising suspicion of placental abruption. After necessary clinical measures, the patient was consented for emergency CS using language line. The baby was delivered in good condition; however, the CS was challenging due to extensive abdominal adhesions. At the time of CS, the posterior placenta was firmly adhered, requiring significant effort for removal, causing approximately 3L of blood loss. However, bleeding was controlled, and surgeons judged that hysterectomy could be avoided, opting to insert a tamponade balloon. The patient was kept in theatre for further observation while receiving blood products where the language line was used to explain the situation to the patient and consent her for hysterectomy if bleeding continued. Further bleeding followed with signs of hypovolaemia and the patient’s condition deteriorating to the point of potential cardiac arrest. With extensive multidisciplinary effort, hysterectomy was performed alongside resuscitation, and she gradually recovered in ITU after losing 7L.

Discussion

The patient’s presented during a high-activity period, i.e. handover, which may have introduced delays or fragmented communication. Her limited English necessitated reliance on the language line, complicating informed consent and real-time communication during a rapidly evolving situation. The posterior placenta, typically less associated with accreta, was unexpectedly firmly adhered to the uterine wall, causing significant haemorrhage. A key question was whether this was undiagnosed placenta accreta, which would require a hysterectomy during CS rather than attempting uterine preservation. Histology later confirmed no myometrial invasion but showed significant placental adherence to the uterine wall. This supported the decision to preserve the uterus when bleeding appeared to settle, and the use of a tamponade balloon demonstrated this measured approach. When bleeding resumed and the patient’s condition worsened, the team swiftly escalated care, addressing coagulopathy and performing life-saving hysterectomy.

Conclusion

This case highlights the complexity of managing obstetric emergencies, where multiple factors and changing clinical picture require careful consideration and appropriate actions. It offers a learning opportunity to discuss abnormal placental adherence without myometrial invasion, emergency haemorrhage management, and the critical decision-making between preserving the uterus or performing a hysterectomy. Coordination among the MDT (obstetricians, anaesthetists, haematologists) ensured effective management of haemorrhage, hypovolemia, and coagulopathy.