

"Managing the unexpected: undiagnosed placenta accreta during elective caesarean delivery leading to hysterectomy"

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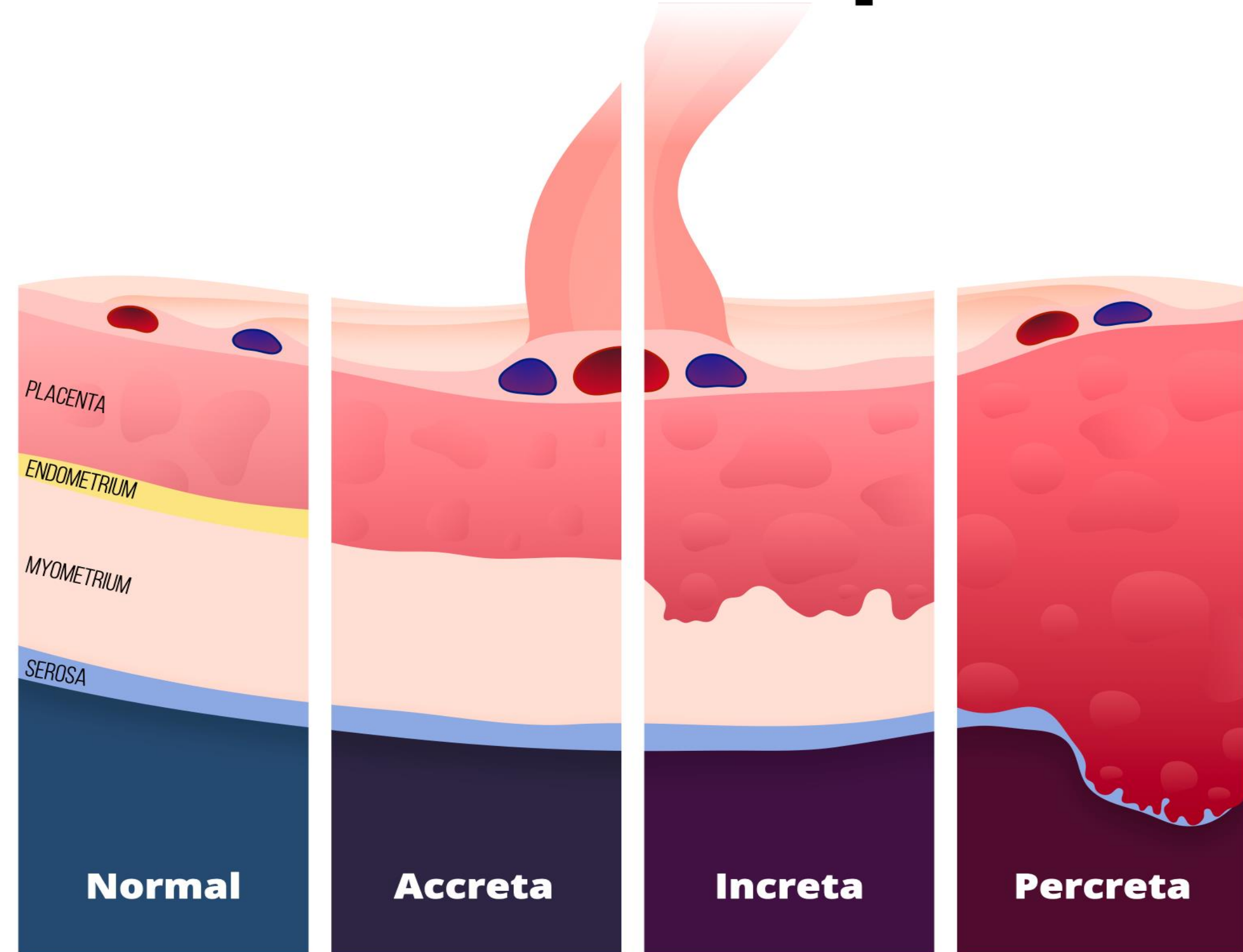


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Objective

Placenta accreta spectrum (PAS) is a severe obstetric complication with significant maternal morbidity and mortality. While antenatal diagnosis improves outcomes, some cases remain undetected until delivery. This case highlights an unexpected PAS, encountered during an elective caesarean section, necessitating uterine artery embolisation (UAE) and subsequent hysterectomy. It underscores intraoperative challenges, the role of interventional radiology and the implications of prior uterine surgery as a risk factor.

Placenta accreta spectrum



Case report

A 35 years old, gravida 3 para 0, with a history of two dilation and curettage (D&C) procedures previously, underwent an elective caesarean delivery at 40 weeks for maternal request. The removal of placenta during caesarean delivery resulted in uterine inversion revealing abnormal adherence of placenta. Manual uterine repositioning triggered significant bleeding. Given clinically diagnosed PAS, massive obstetric haemorrhage protocol was initiated, including blood product availability and discussion regarding a potential hysterectomy. Haemostatic packing was performed before transferring the patient for UAE. Despite initial haemodynamic stabilisation post UAE, persistent haemorrhage required further surgical intervention. Following multidisciplinary input, a hysterectomy was deemed necessary. The patient received massive blood transfusions. Postoperatively, she was managed in intensive care and subsequently recovered without further complications.

Key facts

Incidence:
Globally: ~1 in 533 deliveries. In women with placenta previa and prior caesarean section → risk ↑ to ~1 in 20–50

Main Risk Factors: Prior caesarean section, Placenta previa, prior uterine surgeries (e.g., D&C, myomectomy)

Types of PAS:
Placenta accreta (most common, ~75%).
Placenta increta (~15%).
Placenta percreta (~10%)

Maternal Outcomes:
maternal mortality: ~7% (if undiagnosed/poorly managed), major haemorrhage risk: >90%, blood transfusion requirement: ~82–90% of PAS cases, Hysterectomy: ~50–60% in severe cases

Perinatal Outcomes:
Preterm delivery common (planned around 35–36+6 weeks), Neonatal intensive care often needed

Diagnosis and Planning: Antenatal detection by targeted ultrasound: sensitivity ~90%, MRI: useful adjunct in complex or posterior placenta cases, MDT management improves outcomes

Discussion

Undiagnosed PAS increases maternal morbidity, particularly in non-specialist settings without multidisciplinary support. While interventional radiology plays a role in haemorrhage control, definitive surgical management is often required. Previous uterine surgery, including surgical miscarriage management, is a recognised risk factor for PAS due to endometrial trauma and scarring. Current screening guidelines focus on placenta previa and multiple caesarean sections, but whether women with prior uterine instrumentation warrant targeted surveillance remains unclear. This case raises the question of whether early second trimester ultrasound for placental assessment should be considered in this cohort.

References

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Conclusion

This case reinforces the need for vigilance in women with PAS risk factors, even in the absence of antenatal diagnosis. Further research is needed to determine whether routine screening should include those with a history of surgical miscarriage management. Institutional preparedness, including access to interventional radiology and clear referral pathways, is critical in optimising outcomes. Future studies should explore whether first- or second-trimester ultrasound can aid earlier PAS detection.