

OMINOUS INCIDENTAL FINDING OF PLACENTA PERCRETA DURING AN EMERGENCY CAESAREAN SECTION

Arthi Subramanian¹, Sasikala Selvamani¹
Our Lady of Lourdes Hospital, Drogheda, Ireland

INTRODUCTION

- Placenta percreta is a rare, life-threatening condition in which the placenta invades the uterus and nearby organs, like the bladder, occurring in about 0.2% of pregnancies.
- It's often linked to previous caesarean sections (CS), placenta previa, and multiple pregnancies. The rise in CS rates has increased the prevalence of this condition.
- Diagnosis typically occurs via transvaginal ultrasound (TVS) and magnetic resonance imaging (MRI).
- Management includes early CS delivery, followed by hysterectomy if necessary to prevent severe bleeding.

DISCUSSION

- Maternal morbidity was prevented by swift surgical management involving multiple specialists.
- A newer technique in Argentina classifies suspected placenta accreta through intraoperative invasion topography.
- Hysterectomy can be avoided using a resective-reconstructive approach that achieves haemostasis through selective ligation of blood vessels, delivers the fetus via hysterotomy of the upper uterine segment, and removes the affected myometrium and placenta en bloc.

REFERENCES:

1. Placenta accreta [Internet]. [cited 2024 Sept 25]. Available from: <https://www.brighamandwomens.org/obgyn/maternal-fetal-medicine/pregnancy-complications/placenta-accreta>
2. Palacios-Jaraquemada JM, Fiorillo A, Hamer J, Martinez M, Bruno C. Placenta accreta spectrum: a hysterectomy can be prevented in almost 80% of cases using a resective-reconstructive technique. *Matern Fetal Neonatal Med.* 2022 Jan;35(2):275-282. doi: 10.1080/14767058.2020.1716715. Epub 2020 Jan 26. PMID: 31984808.



CASE PRESENTATION

- A 40-year-old female, P3, was admitted with contractions and underwent an emergency CS at 37+1 due to posterior placenta previa, three previous CS, and essential hypertension.
- During the CS, the placenta was found to have penetrated the cervix and bladder. A single live baby was delivered via vertex through cystotomy at the bladder apex and ruptured CS scar incision.
- Massive postpartum haemorrhage (PPH) of 2750 ml was managed per protocol. The patient had a hysterectomy, bilateral salpingectomy, cystotomy repair, and adhesiolysis of bowel, omentum, and rectus muscle.

CONCLUSION

- Early diagnosis of placenta accreta via TVS and MRI antenatally is crucial for planning elective CS, preventing excessive bleeding, and minimising hysterectomy.
- Despite these measures, PPH may still occur.
- A resective-reconstructive approach could help preserve the uterus and reduce blood loss in about 80% of cases.