

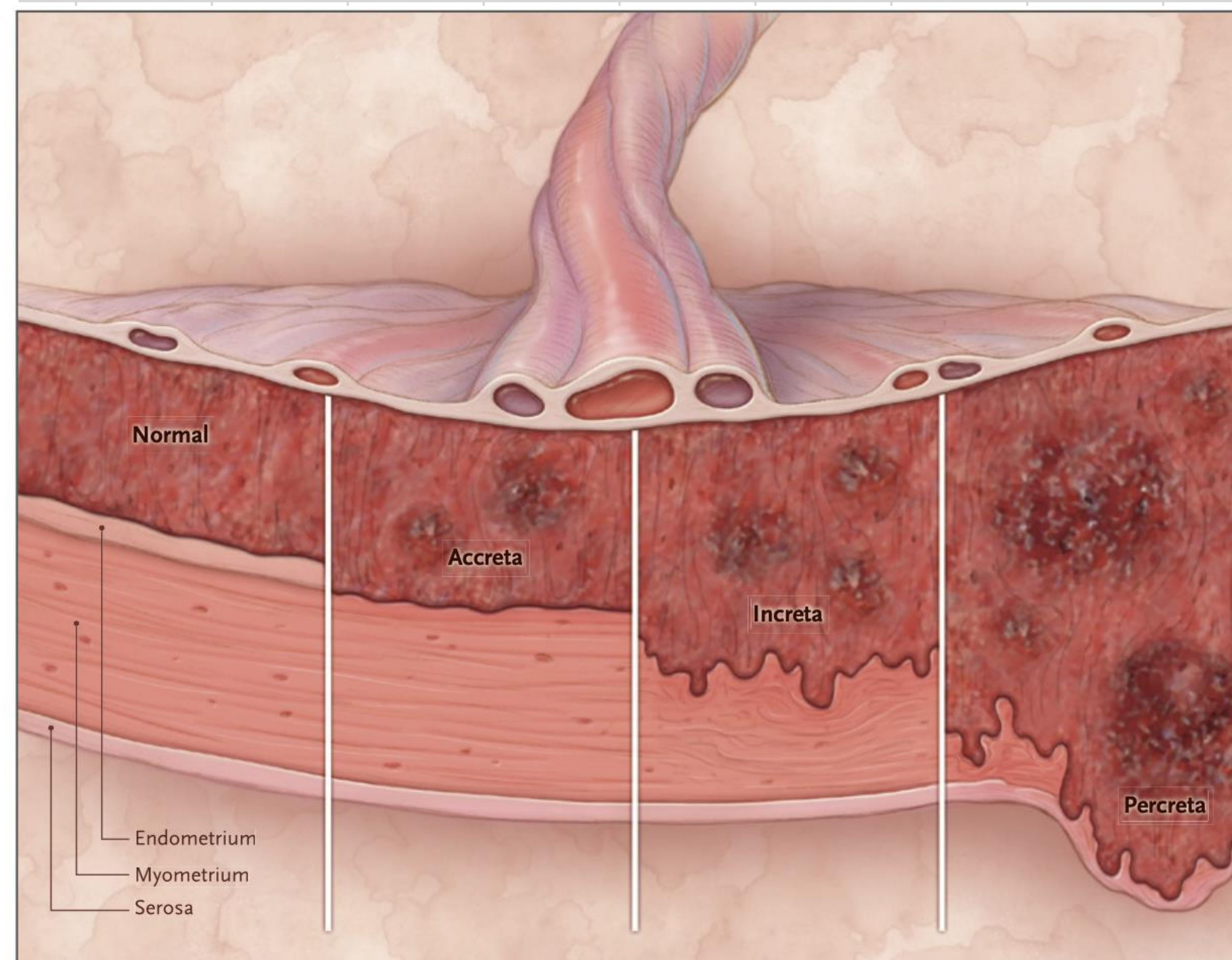
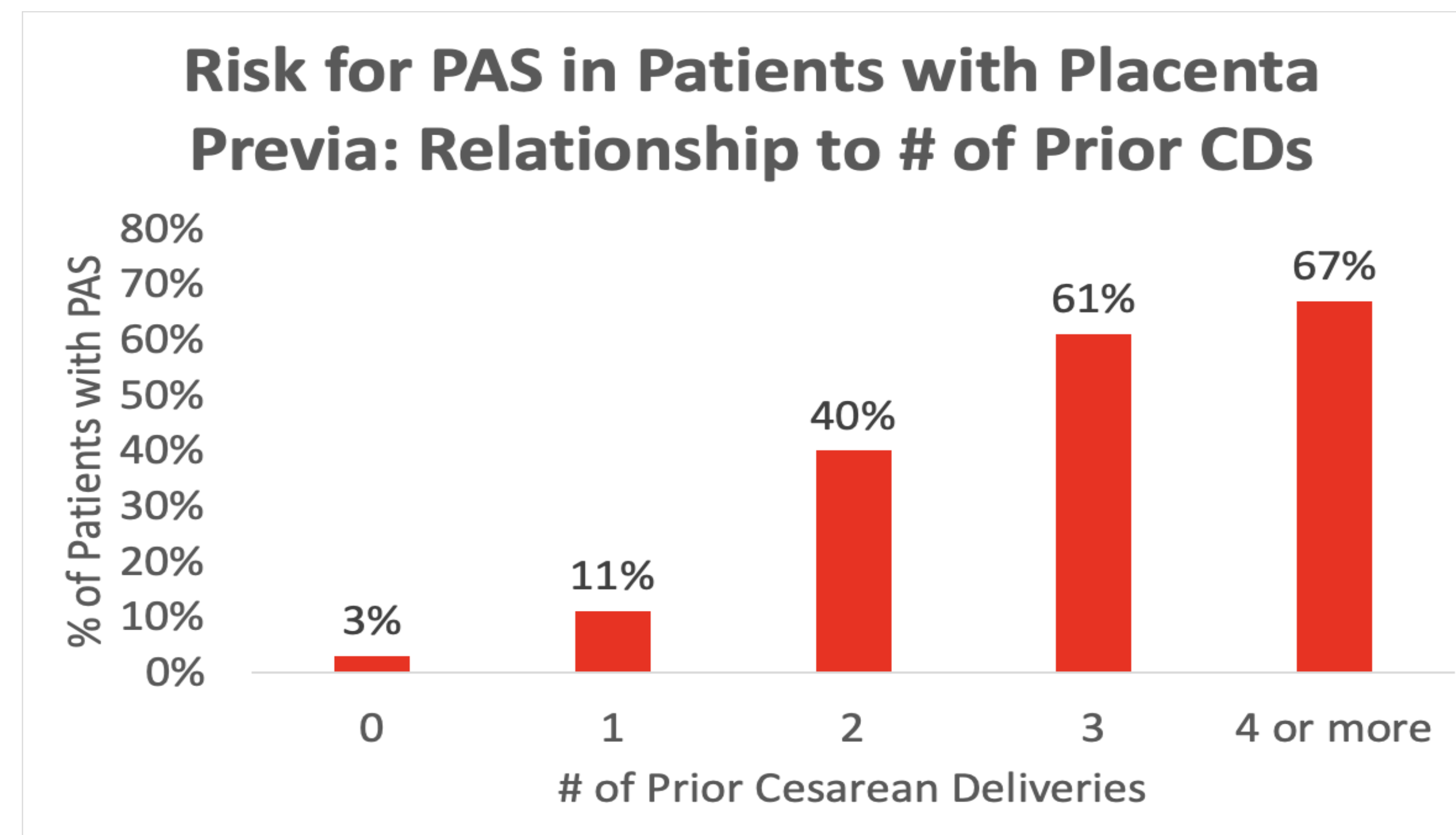


Undiagnosed Placenta Accreta Spectrum in a Second Trimester Dilation and Evacuation for Intrauterine Fetal Demise

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Introduction

- The biggest risk factors for placenta accreta spectrum (PAS) are prior cesarean delivery (CD) and established placenta previa
- As the rates of CDs have increased, so has the incidence of PAS
- PAS can lead to significant maternal hemorrhage and morbidity
- PAS can be difficult to diagnose and can complicate second trimester D&Es.



Case Presentation

36-year-old G4P2012 at 24w5d with a history of preeclampsia and 2 prior CDs was transferred to our institution from an outside hospital and diagnosed with intrauterine fetal demise (IUFD). No placenta previa seen on initial assessment.

INDUCTION OF LABOR (IOL)

- Mifepristone and Misoprostol initiated
- Cervical ripening balloon placed
- Epidural placed for analgesia



HEMORRHAGE

- Following cervical balloon placement, patient lost 1500 mL of bright red blood
- Labs revealed a drop in fibrinogen (216 from 349) and hemoglobin (7.6 from 11.8)



PLANNING FOR URGENT D&E

- Induction stopped
- Blood transfusion initiated
- Patient proceeded to urgent D&E using her existing epidural for anesthesia



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D&E

- D&E started, TXA was administered
- Patient became unresponsive, appeared to be seizing
- Brisk bleeding was noted from the cervix and vagina
- Patient was intubated and focus TTE was done to rule out amniotic fluid embolism
- Multiple intrauterine hemorrhage devices were placed, but failed to minimize the bleeding



A: Abnormal vascularity in the lower uterine segment. Bridging vessels between bladder and uterus.



B: Post hysterectomy specimen showing invasion of the myometrium by the placenta.

Hysterectomy

- Vasopressors were administered, CVC and A-line were placed and massive transfusion event was initiated
- Obstetricians decided to proceed with hysterectomy as patient was too unstable to go to interventional radiology
- Upon opening the abdomen, the lower uterine segment was noted to have increased vascularity and an adherent portion of placenta, consistent with PAS



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OR Resuscitation Management

- Thromboelastography guidance used to resuscitate the patient
- 23 units of PRBCs, 18 units of FFP, 5 units of platelets, 4 units of cryoprecipitate, and 3 grams of fibrinogen
- Uterotonics given: methylergonovine maleate, oxytocin, and carboprost

Outcome

- Quantitated blood loss was 11L
- Abdomen left open
- Patient taken to the SICU intubated
- Abdomen closure 48 hours later was uneventful

Discussion

- Diagnosis of placenta accreta can be missed, especially when a distracting factor such as IUFD is noted on initial ultrasound evaluation
- May be prudent to perform an official ultrasound before initiation IOLs on patients transferred from an outside hospital with a history of prior uterine surgery
- Consider patient's risk factors including multiple CDs
- Correct decision made to open abdomen and perform hysterectomy rather than transferring an unstable patient to interventional radiology suite

References

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