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PLACENTA INCRETA PRESENTING WITH PROFUSE BLEEDING PER VAGINUM : A CASE REPORT.

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Abstract:

The placenta accreta spectrum, also known as morbidly adherent placenta, refers to a wide range of pathologic placental adherence, including increta, percreta, and acreta.. Placenta increta is characterized as an aberrant trophoblast invasion in which part or all of the placenta invades the myometrium. Placenta increta during second trimester of pregnancy is uncommon. During or after pregnancy, the majority of people with placenta increta experience vaginal bleeding. [1]

This report presents a case of 35 yr old female presented to our hospital with profuse vaginal bleeding since 10 days before which she had spontaneous abortion at 4 months of gestational age followed by D and C in view of incomplete abortion 14 days before.

Hysterectomy specimen was sent to the histopathology section. Histopathological examination of the specimen showed features which are suggestive of Placenta Increta. We present an uncommon case with short review of literature.

Keywords: Placenta increta, accreta, morbidly adherent placenta, vaginal bleeding, spontaneous abortion

Introduction:

Placenta accreta is a usual term which refers to any placental implantation with abnormally firm adherence to myometrium .Placenta accreta, increta, and percreta are the three grades based on histology. [2]

Accreta is most common and less dangerous form, with trophoblastic villi invading the superficial myometrium. Invasion through the uterine myometrial layer is seen in increta and chorionic villi invades the uterine serosa in placenta percreta. According to the American College of Obstetricians and Gynecologists, the rate is 1 in 533 deliveries. [3] Abnormal placental attachment is more common in women who have prior cesarean section, procedure of curettage, placenta previa with history of cesarean section, manual removal of placenta, increasing age and multiparity. Abnormal placental adhesion in second trimester is a rare finding. [4]

In this study we report a rare case of placenta increta in the second trimester abortion. The patient was managed by doing hysterectomy

Case Report

On the post-abortive day, a 35-year-old P2L2A1 with two previous LSCS presented to our emergency department with the chief complaint of excessive vaginal bleeding for the past ten days. She had a spontaneous abortion at 4 months, then dilatation and evacuation 14 days later due to an incomplete abortion. Her vital signs were normal, she had a pallor, and her abdomen was soft with no guarding, tenderness, or rigidity. The uterus of per vaginum was enlarged to a size of 10 weeks. The patient was moved to OT for anesthesia-assisted evacuation, and the surgical evacuation was completed in OT. On histopathological examination, the tissue obtained was suggestive of POC. After 6 hrs of surgical evacuation patient presented with bleeding of around 100 ml. Few hours later patient again had a bout of bleeding of around 800

ml. Thus emergency hysterectomy was undertaken. The specimen of uterus was sent to the histopathology section department of Pathology at the hospital.

Grossly, on cut section of uterus, hemorrhagic areas identified? Placenta. A semicircular brownish, hemorrhagic mass identified coming outside the uterus measuring 6 x 5 x 4 cm on the lower right side of uterus. (Placental outgrowth).

Microscopically, there is evidence of part of choriodecidual tissue and chorionic villi seen embedded into the myometrium and also infiltrating into the smooth muscles. Histopathological features were suggestive of Placenta Increta.

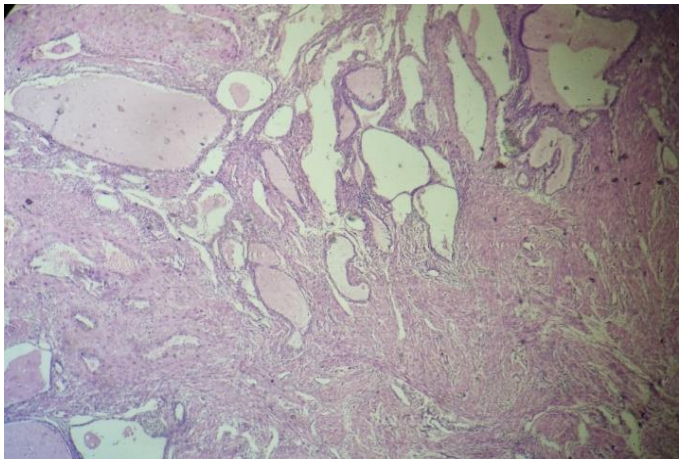

Figure 1: Histopathological examination showing placenta increta (Magnification 4x)

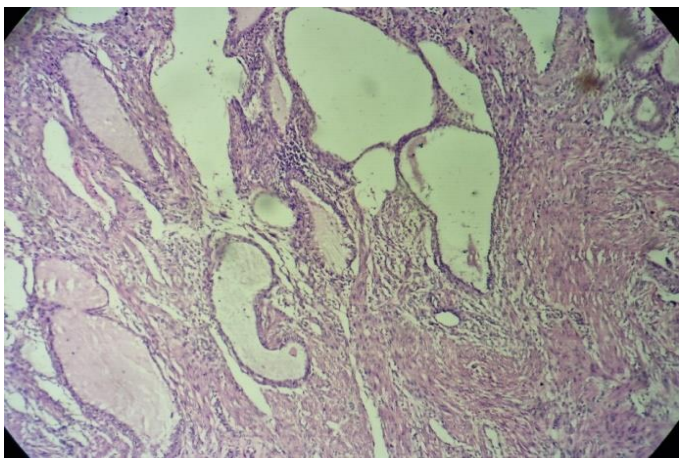

Figure 2: Histopathological examination showing placenta increta (Magnification 10x)

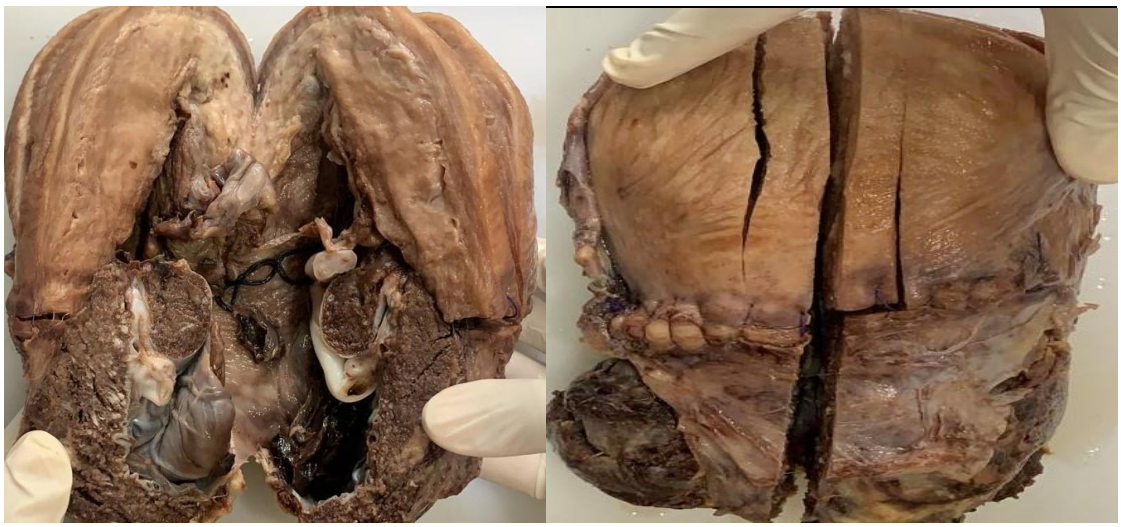

Figure 3 and 4: Cut section of hysterectomy specimen showing placenta increta

Discussion:

Placental villi attach to the uterine myometrium without an intervening decidual membrane in placenta accreta. Multiparous women, a damaged uterus after C section, prior D and C, and abortions are all risk factors for placenta accreta [2]. Placental accreta, increta, and percreta adhesions are uncommon prior 20 weeks of pregnancy, even uncommon in the first trimester. Clinical signs of placenta accreta include haemorrhage, uterine rupture, bladder invasion, and uterine inversion. [1]

Nik Lah Nik Ahmad – Zuky et al reported a case of 34 old woman at 13 weeks of gestation who had profuse bleeding per vaginum since 5 weeks of gestation. Transabdominal USG features were suggestive of placenta increta. Thus emergency hysterectomy was performed and histopathological features were suggestive of placenta increta. [5]

Nargis Iqbal et al carried out a research that lasted two years and took place at Jinnah Hospital's Gynaecology Unit III in Lahore. There were a total of 13 patients with placenta accrete in the study. According to the findings, placenta accrete is a life-threatening emergency. Maternal and perinatal morbidity will be reduced by a high index of suspicion, early antenatal diagnosis, and scheduled surgery. [6]

Chourouk Elkarkri et al conducted a study titled – Placenta Accreta in an unscarred uterus: a case report. The study was conducted at Dept of Gynecology and obstetrics, Maternity Souissi, Morocco. It was found that a 25 yr old pregnant woman without the history of scarred

uterus was admitted to the maternity emergency for delivery. The diagnosis of placenta increta was made during the caesarean section. It was concluded that placenta increta can cause maternal and perinatal complications. [7]

Invasion of chorionic villi starts at the moment of implantation rather than later in pregnancy because of decidua absorption, as evidenced by our case and previous reported examples of aberrant placental implantation in early pregnancy. [4] Our case arrived with indications and clinical features compatible with early pregnancy loss and underwent a dilatation and curettage treatment, during which significant haemorrhage was discovered, similar to earlier documented cases. Our patient, like other documented cases, had multiple risk factors for aberrant placentation, the most significant of which was a history of previous caesarean surgery. Our patient had had two previous caesarean sections and was of advanced maternal age (AMA). [4] Prenatal diagnosis of placenta increta may be done with Ultrasonography or MRI. The diagnostic importance of USG in the prenatal diagnosis of placenta increta without any symptoms, on the other hand, is debatable. Histological diagnosis is used to determine the certainty of a diagnosis.

During difficult placental removal in 3rd trimester, placenta increta usually manifests as vaginal bleeding. Pregnancy loss in 1st and 2nd trimesters can be complicated by placenta increta, which can result in a lot of post-curettage haemorrhage. Early detection of condition may help to make outcome better because this allows the obstetrician to respond quickly to an emergency. Still, because many cases of placenta increta don't have any prior clinical features, a high level of doubt for early diagnosis should be based on the above-stated causes. The diagnostic value of ultrasound in the antenatal diagnosis of placenta increta without any symptoms is unknown. Although magnetic resonance imaging is a valuable tool for diagnosis and detection of placenta increta, no additional benefit over ultrasonography has been found. [8]

The following uterine pathologies may be considered in the differential diagnosis at this time: Uterine fibroids, which are usually accompanied by a capsule but were not present in our case. As the pregnancy test result was negative, ectopic pregnancy, which is a common factor for profuse bleeding per vaginum, was not considered. Another cause could be a placental site trophoblastic tumour, in which the presence of proliferating trophoblastic tissue deeply invading the myometrium is seen. Her serum -hCG level, on the other hand, was < 2

mIU/mL, and her histological features weren't consistent with a placental site trophoblastic tumour. [8]

Placenta increta should be considered in females at risk for abnormal placental invasion who have recently had a abortion and have abnormal bleeding per vaginum or intraperitoneal bleeding. [8]

Conclusion:

The current study suggests that placenta accreta should be considered among the differential diagnoses in women at risk for abnormal placentation who present with bleeding per vaginum after a recent abortion. Despite the fact that placenta accrete/increta can be detected early with an MRI, hysterectomy is still a common procedure. This case emphasises the need for more research into the prevention of morbidly adherent placentas, which can lead to massive haemorrhage.

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