

## Case Report

# Alternative Management of Placenta Accreta: A Case Report

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## Abstract

The present study describes the case of a woman with full term pregnancy diagnosed with bipartite placenta during gestational monitoring. She presented intrapartum placenta accreta, subjected to conservative management and with intrauterine retained placenta. Subsequent ultrasound monitoring evidenced a decrease in size and vascularization of the retained placenta. After confirming stabilization of the condition, surgical hysteroscopy was performed, with resection of the retained placental tissue and complete resolution of the disorder.

**Keywords:** Postpartum hemorrhage; Placenta accreta; Conservative management; Balloon

## Introduction

The present study describes the case of a woman with full term pregnancy diagnosed with bipartite placenta during gestational monitoring. She presented intrapartum placenta accreta, subjected to conservative management and with intrauterine retained placenta. Subsequent ultrasound monitoring evidenced a decrease in size and vascularization of the retained placenta. After confirming stabilization of the condition, surgical hysteroscopy was performed, with resection of the retained placental tissue and complete resolution of the disorder.

## Case Presentation

A 31-year-old woman in week 40 of pregnancy was diagnosed in week 20 with bipartite placenta; one of the lobes was located close to the Internal Cervical Os (ICO), without constituting placenta previa. Pregnancy was finally resolved through eutocic delivery. Retained placenta was noted at birth, and manual extraction was only partially successful.

Abdominal ultrasound was performed to evaluate the size and location of the retained placental tissue. A cotyledon measuring 37 mm × 25 mm in thickness was observed in the inferior uterine segment, with suspected invasion of over 50% into the posterior surface of the myometrium. Intrapartum placenta accreta was tentatively diagnosed, and the attempts to extract the retained placental tissue were suspended. As this was a young and hemodynamically stable woman in her first pregnancy, conservative management as contemplated in our postpartum hemorrhage protocol (uterine massage, bladder

catheterization and the administration of intravenous fluid therapy and uterotonic drugs) was decided.

Despite these measures, excessive bleeding persisted and an intrauterine balloon was therefore placed in the inferior uterine segment where the retained placenta was located, filling it with 250 ml of saline solution. This resolved the bleeding problem. The intrauterine balloon was removed the next day, evidencing scant bleeding and with hemodynamic stability of the patient. The blood tests showed hemoglobin 7.9 g/dl and beta-hCG 5661 MU/ml, as reference for posterior control.

Discharge took place on day 5 postpartum, followed by outpatient controls including ultrasound and laboratory tests. The serial ultrasound evaluations showed a progressive decrease in size and vascularization of the retained placenta (Figures 1-3).

At the same time, the beta-hCG levels were seen to gradually decrease, with successive weekly concentrations of 102.7 MU/ml, 30.78 MU/ml, 11.82 MU/ml, 6.16 MU/ml, 1.52 MU/ml and 0.91 MU/ml, and finally 0.11 MU/ml two months after delivery. Given the clear decrease in size of the retained placenta (though without disappearing entirely) and of the vascularization, we decided to perform hysteroscopy 6 months after delivery. On the posterior surface of the inferior uterine segment, whitish tissue adhered to the endometrium was observed, suggestive of calcified retained placental

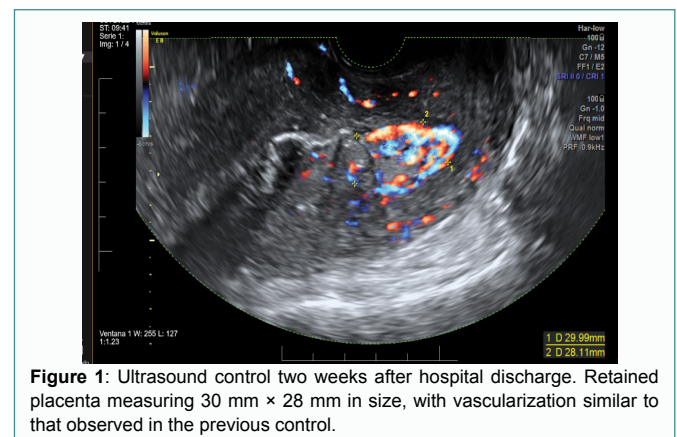
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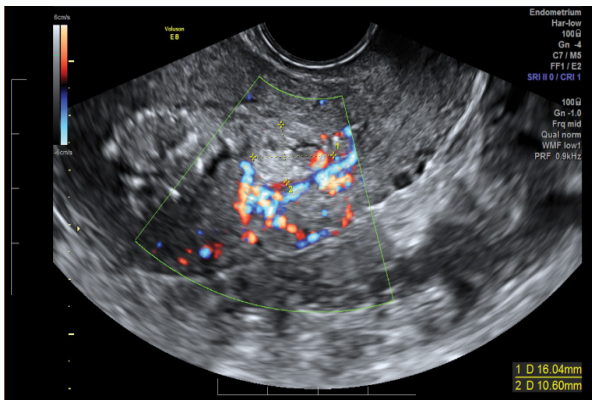
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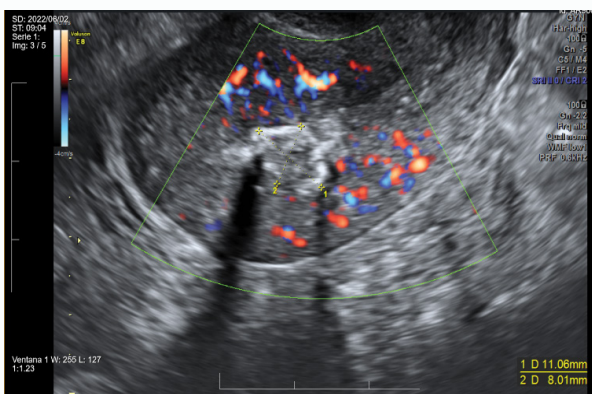
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**Figure 1:** Ultrasound control two weeks after hospital discharge. Retained placenta measuring 30 mm × 28 mm in size, with vascularization similar to that observed in the previous control.



**Figure 2:** Ultrasound control one month after hospital discharge. Retained placenta measuring 16 mm × 10 mm in size, showing some decrease in vascularization with color Doppler.



**Figure 3:** Ultrasound control three months after hospital discharge. Retained placenta measuring 11 mm × 8 mm in size, showing an evident decrease in size and vascularization.

tissue, which was easily resected. The pathology report indicated secretory phase endometrium with areas of hyaline fibrosis and the presence of multiple calcifications.

The subsequent ultrasound control performed one month after diagnostic-therapeutic hysteroscopy revealed a thin endometrium, with complete resolution of the condition.

## Discussion

Placenta accreta is infrequent in pregnancy. It is characterized by abnormal insertion of part or all of the placenta into the myometrium [1], and its incidence has increased largely due to the rise in number of cesarean sections. The main problem associated with placenta accreta is the high risk of massive hemorrhage. The principal risk factor for placenta accreta is a history of cesarean section or any type of uterine surgery, associated to low placenta implantation [1-3]. When diagnosed during delivery, the condition manifests as difficult or incomplete extraction of the placenta, with or without postpartum hemorrhage [4], as in our case.

Ultrasound is the diagnostic technique of choice. Magnetic resonance imaging is also useful for establishing the diagnosis of placenta accreta, though its detection capacity has not been shown to exceed that of ultrasound, except in certain specific cases such as a high maternal body mass index, posterior placenta, or suspected placenta praevia [3].

When placenta accreta is suspected, strict monitoring is required to confirm the diagnosis and allow timely management. The general recommendation is for pregnancy to end in elective cesarean section at 36 to 37 weeks, which has been associated to lesser morbidity-mortality [4]. In our patient, placenta accreta constituted an intrapartum finding. In such cases it is important to take into account that if the placenta is not easily extracted, traction upon it must be avoided, since this increases the risk of massive hemorrhage.

The patient was initially hemodynamically stable, since there was no heavy bleeding. Furthermore, this was a young woman in her first pregnancy, and with a desire to preserve fertility. Conservative management was therefore considered to be a reasonable option. In cases of conservative management, the administration of uterotonic drugs, the placement of an intrauterine balloon, the use of uterine compression sutures, or embolization may prove useful [4].

Following conservative management, long-term follow-up is essential, as there is a non-negligible risk of complications in the form of abundant vaginal bleeding, endometritis and/or sepsis, the formation of placental polyps or vesicouterine fistulas. None of these complications were observed in our patient [3]. Long-term follow-up consists of clinical-echographic controls and laboratory tests. Low beta-hCG levels have not been associated with complete resolution of the condition [4], as evidenced in our case, since the retained placental tissue persisted after negative conversion of beta-hCG. In those patients where conservative management proves successful, spontaneous placental reabsorption has been reported in 75% of the cases after an average of 13 weeks [4,5]. In our patient, retained placenta persisted three months after delivery, though the tissue had decreased in size, with a clear reduction of its vascularization. Hysteroscopy to remove the retained tissue was therefore decided, with complete resolution of the condition.

Among the gynecological-obstetric disorders amenable to surgical treatment, placenta accreta is one of the most challenging conditions due to its pathophysiology, possible complications and management. The difficulties encountered in suspecting, diagnosing and managing placenta accreta have given rise to numerous publications, such as our own, seeking to unify criteria.

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