

Case Report

Placenta Accreta in A Healthy Uterus: A Rare Case Report

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Abstract

Placenta accreta is a placenta that is abnormally adherent to the myometrium, resulting in delayed or impossible delivery of the placenta, or even a massive hemorrhage if the patient's management is delayed. It is a rare pathology whose main risk factor remains the history of uterine scarring. We report an interesting case of placenta accreta on a healthy uterus diagnosed during delivery, complicated by a post partum hemorrhage. A hemostasis hysterectomy was performed with simple postoperative follow-up. The number of patients with placenta accreta has increased in recent decades. Ultrasound remains the first-line examination for the diagnosis of this pathology. In view of the risk of placenta accreta in a healthy uterus, it is essential to study the placenta during the second trimester ultrasound. In addition, a placenta accreta must be suspected in the presence of a pathological delivery in a healthy uterus. Finally, the management is currently codified between conservative and radical treatment depending on the hemodynamic state of the patient, as long as the diagnosis is made in time.

Keywords: Placenta accreta; Pathological delivery; Healthy uterus and placentation anomaly

Introduction

Placenta accreta is a placenta that is abnormally adherent to the myometrium, resulting in delayed or impossible delivery of the placenta. Placental function is normal, but the trophoblastic invasion extends beyond the normal border (called the Nitabuch layer). In such cases, manual removal of the placenta, unless scrupulously done, results in massive postpartum hemorrhage. The antenatal diagnosis is based on ultrasound [1]. We report an interesting case of placenta accreta in a healthy uterus diagnosed during delivery.

Case Presentation

A 30 year old woman, primigravida, with no history of uterine surgery, admitted to the maternity ward for delivery, 40 weeks of amenorrhea, with a poorly attended pregnancy. The clinical examination revealed a pulse at 75 beats per minute, blood pressure at 110/60 mmHg, afebrile patient, obstetrical examination showed uterine height at 32 cm, uterine contractions present without hyperkinesia, fetal heart sounds perceived, vaginal touch revealed a soft anterior cervix 70% effaced, dilated to 4 cm, cephalic presentation, membrane ruptured since two hours, without externalized bleeding. The fetal heart rate did not reveal any abnormalities. Obstetrical ultrasound revealed an evolving monofetal pregnancy, normal and regular fetal heart rate, and cephalic presentation, a measurement

corresponding to the term, fetal weight was estimated at 3100 g, the quantity of amniotic fluid was reduced, and the placenta was fundal. Labor was rapid without injection of oxytocics. The delivery by vaginal route took place 5 hours after her admission giving birth to a male newborn Apgar 10/10 birth weight is 3000 gm. The directed delivery was marked by the non detachment of the placenta and the failure of the artificial delivery with the appearance of a heavy bleeding. The patient was taken to the operating room for conditioning, hemodynamic resuscitation and surgical exploration. A median laparotomy was performed which confirmed the diagnosis of a placenta accreta on a myomatous uterus. A subtotal and interannexal hemostasis hysterectomy was performed (Figure 1). The patient was transfused with whole blood intraoperatively. The postoperative course was simple. The patient was declared discharged at D7 postoperatively accompanied by her baby.

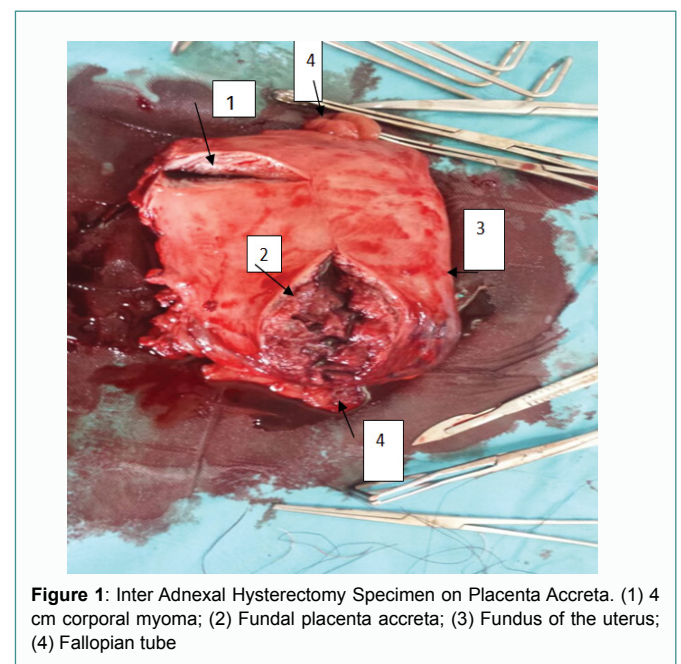


Figure 1: Inter Adnexal Hysterectomy Specimen on Placenta Accreta. (1) 4 cm corporal myoma; (2) Fundal placenta accreta; (3) Fundus of the uterus; (4) Fallopian tube

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Discussion

Historically, placenta accreta was observed in 0.01% to 0.05% of pregnancies. Merger, in his 1985 *Précis of Obstetrics*, reports a figure of 0.05%. Morison, in a large study conducted in Northern Ireland over a period of 20 years, described 67 cases in 645,000 births (0.01%). Read, in 1980, found a rate of 0.025% in Los Angeles. Finally, an Australian study in 1981 put the rate at 0.011% over 10 years. Current data show a clear trend towards an increase in cases of placenta accreta (up to 0.1% on average). The incidence is estimated to have increased 10-fold over the past 50 years in the United States according to the American College. This epidemiological change has been linked by Wu to the increase in the rate of cesarean sections (12.5% in 1982 vs. 23.5% in 2002; last incidence of placenta accreta, 1 case per 533 births). Thus, if the average incidence of placenta accreta is currently estimated at 1 case per 2,500 births, studies sometimes find values two or three times higher [2,3]. Risk factors for placenta accreta include a history of cesarean delivery, uterine instrumentation and intrauterine scars, smoking, maternal age over 35 years, high multiparity and recurrent miscarriage. In most cases, placenta accreta is a combination of several factors [4-8]. Three variants of invasive placental defect are recognized: placenta accreta, in which placental villi invade the surface of the myometrium; placenta increta, in which placental villi extend into the myometrium; and placenta percreta, in which villi penetrate through the myometrium to the uterine serosa and may invade adjacent organs, such as the bladder. [In contrast to many publications, where a placenta accreta has been diagnosed in patients with a scarred uterus [9], our patient had no uterine scars or known risk factors.

The clinic is often silent during pregnancy. The diagnosis is usually suspected in the presence of risk factors and explored by pelvic ultrasound, which has become the main screening tool for women at risk of placenta accreta associated with Magnetic Resonance Imaging (MRI) [10,11]. Ultrasound is the first-line examination for the detection of placenta accreta; the ultrasound signs classically described are the presence of placental lacunae, the absence of a hypoechoic border between the placenta and the myometrium, and an interruption of the hyperechoic zone located at the interface of the uterine serosa and the bladder [10]. MRI is currently not indicated for first-line screening. A recent series evaluated its sensitivity at 88% and its specificity at 100% when used as a second-line examination after suspicion of placenta accreta on pelvic ultrasound [12]. MRI also appears to be useful in providing details of the location of the placenta and possible invasion of adjacent tissues and organs, among the diagnostic criteria proposed are abnormal bulging of the lower segment, heterogeneity of placental signal intensity in T2, intraplacental black bands in T2 [13]. The diagnosis is sometimes made at the time of delivery, as in our case, due to difficulty in detaching the placenta. Certain differential diagnoses can be problematic during delivery, such as incarcerated placenta, choriocarcinoma, and it is the anatomico-pathological study that confirms the diagnosis [14].

The management is based on extraction by the upper tract, by scheduled caesarean section from 34 weeks of amenorrhea. Hysterectomy is considered the "gold standard" and is performed after the birth of the child without attempting artificial delivery when the prenatal diagnosis of placenta accreta is made [10]. This option could reduce maternal morbidity, but it necessarily results in the loss of fertility of the patients. Conservative treatment with the placenta left in place can be considered if there is no bleeding. In case of moderate

bleeding, arterial ligation possibly associated with uterine packing (in case of cesarean section) or arterial embolization (in case of vaginal delivery) can be performed, but a hysterectomy should be performed in case of failure or severe bleeding from the beginning. Conservative treatment with the placenta left in place can be considered if there is no bleeding. In case of moderate bleeding, arterial ligation possibly associated with uterine packing (in case of cesarean section) or arterial embolization (in case of vaginal delivery) can be performed, but hysterectomy should be performed in case of failure or severe hemorrhage from the beginning. Conservative treatment, leaving all or part of the placenta in place, has been successfully described by several authors [15,16]. Failure of conservative treatment has also been the subject of clinical case reports describing the occurrence of secondary hemorrhage remote from the cesarean section, sometimes involving the potentially fatal outcome of the patient. A retrospective study of 50 cases of placenta accreta, of which 26 initially received conservative treatment (placenta left in place during cesarean section), was published by Bretelle et al. only five patients (19%) required hysterectomy. This therapeutic option therefore seems interesting for young patients who wish to become pregnant. In our case, the radical treatment was performed immediately given the hemodynamic instability and the importance of the bleeding.

Conclusion

Placenta accreta is a pathology at serious risk of hemorrhagic complications during pregnancy and postpartum. It is a pathology whose incidence is greatly increasing with the increased number of cesarean sections and gynecological surgeries. However, the ultrasound criteria for placenta accreta should be systematically sought during the second trimester ultrasound because of the risk of placenta accreta occurring in a healthy uterus.

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