A case Report on complete Placenta previa with percreta

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Abstract:

Mrs. Kalpana Rani, 26 years old multigravida mother admitted in maternity hospital for safe confinement, she was diagnosed as fourth degree of placenta previa with percreta along with bladder wall invasion; her obstetrical score was $G_3P_2L_2A_0D_0$ with 2 previous caesarean section. She delivered a male baby birth weight of 3.3kg on12/4/19, Apgar 1 mint 8/10 through caesarean section .Due to the invasion of placenta into the bladder she underwent with hysterectomy with partial cystectomy and suprapubic catheter placed to drain the urine . She lost 3,880 ml of Fluid and blood throughout her surgery, which was compensated with 6 units of whole blood, 5 units of FFP's and IV fluids like RL, NS and 5% Dextrose.

Background:

Placenta percreta is an abnormal adherent of the placenta .It is a condition in which the placenta villi penetrates through the uterine myometrium .Normally the placenta located at the anterior part of the fundus at decidua ,due to defective decidua the placenta deeply implanted in to the myometrium or perimetrium is called abnormal adherent of the placenta. If the placental villi penetrate through the uterine myometrium is defined as placenta Percreta. The incidence ranges between 2.5 -3.5% in western countries, the cases are increasing from the past two decades due to high caesarean cases rate. Other conditions are instrumentation of the endometrium, placenta praevia, uterine malformations, septic endometritis, previous manual removal of placenta and multiparity.

Causes:

The causes are increased vascularity of the uterine serosa, Irregular spaced placental lacunae, thinning of myometrium overlying of placenta, typically due to scarring after a C-section or other uterine surgery.

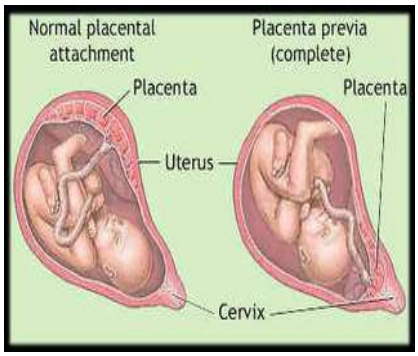
Risk factors:

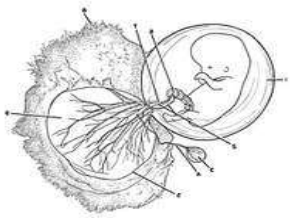
The risk factors of placenta percreta are previous caesarean section, placenta previa, advanced maternal age, uterine anomalies, intrauterine adhesion bands, and other uterine and placental surgeries.

Case Presentation:

Mrs. Kalpana Rani, 26 years old muti gravida mother admitted in maternity hospital for safe confinement, based on 7th month report, she was diagnosed as IV degree of placenta previa with percreta along with bladder wall invasion, Her obstetrical score is $G_3P_2L_2A_0D_0$ with previous caesarean section .She delivered a male and female baby birth weight of 2.6 & 2.9 in the year 2013 and 2015 through caesarean section due to severe oligo hydromnios with PIH.

For the present pregnancy, she had slight fresh vaginal bleeding especially in third trimester; she continued the pregnancy till the EDD. Her haemoglobin was 11.5 mg/dl and her MRI of pelvis revealed that single intrauterine fetus in cephalic presentation, placenta- left lateral, lower segment completely covering the internal os, indenting urinary bladder with multifocal loss of T2 hypo intense interface and associated prominent vasculature noted in proximity. Based on USG and MRI she was diagnosed as complete placenta previa with bladder wall invasion –likely placenta percreta.





Treatment for placenta percreta is hysterectomy .She underwent with elective caesarean section, emergency hysterectomy and partial cystectomy on12/4/19 and she shifted to medical intensive care unit. Under the aseptic precaution abdomen was cleaned and draped pfanner kid incision was given excising the previous scar. Abdominal wall opened up in layers; there were no demarcation between lower uterine segment and posterior wall of bladder. Transverse incision was given over the upper uterine segment a male active baby of 3.3kgs was delivered with APGAR 8/10 /1mint at 11.20 am uterotonic was given .placenta occupying the anterior and uterine walls by uterine segment covering the os invading posterior wall of the bladder, bilateral uterine artery ligated.2/3rd of the placenta separated followed by torrential bleeding proceeded with hysterectomy. Bilateral round ligaments clamped cut and ligated, bilateral tubo ovarian ligaments and uterine arteries clamped cut and ligated. Posterior peritoneum ligated. The invaded 1/3rdof placenta into the bladder was removed with partial cystectomy by urologists. After the cystectomy suprapubic cystectomy catheter was placed .The total blood loss was 3,880ml and the client was infused with whole blood 6 units and FFP's with 5 units.

After the surgery her HB was 7.5mg/dl PCV-40%, Platelet-2, 30, 000, BT-4 min, CT10mtPt-12 Seconds and TLC 4.9×10^3.urine examination results showed that, no bacterial growth, albumin Normal and mild Haematuria. She was on treatment for 7days with Inj. Peptaz 4.5mg/IV/BD, Inj.Metrogyl 100ml/IV BD,Inj.

Rantac -150gm/IV /BDInj. PCM 1gm /IV/ TDS and Inj.Voveran 1amp/IV/BD. Her intake and output chart maintained with intravenous fluids i.e-1000mlof RL,NS,500ml of DNS and 500ml of 5% of Dextrose .she was on continuous cardiac monitoring .Q_{12}H dressing was done and wound healing process were assessed . Q2H Back care and comfort devices provided to prevent bedsore .After the 7th day of POD supra pubic catheter was removed. Active and passive exercises like deep breathing, coughing, and circulatory exercises were given to prevent the complication. Success fully the mother and baby was survived.

Maternal death is not an infrequent outcome ranging from 7-10% of reported cases of placental adhesions. Foetal death occurs in approximately 9% of the cases, usually due to complications of prematurity.

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