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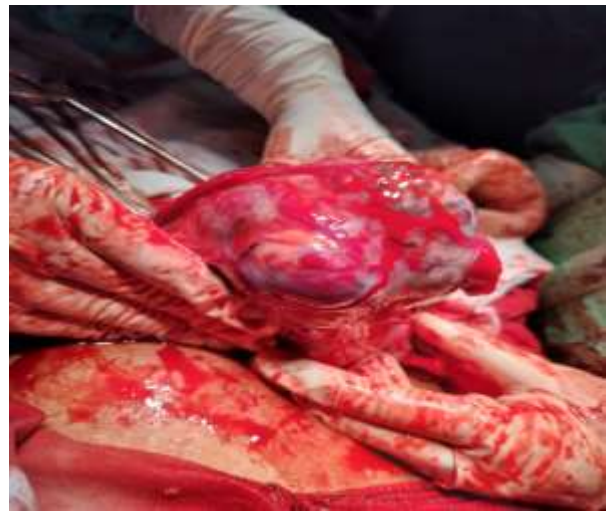
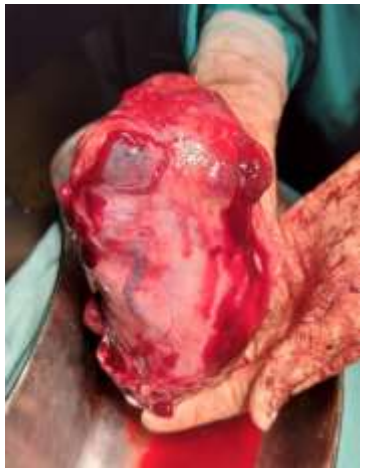
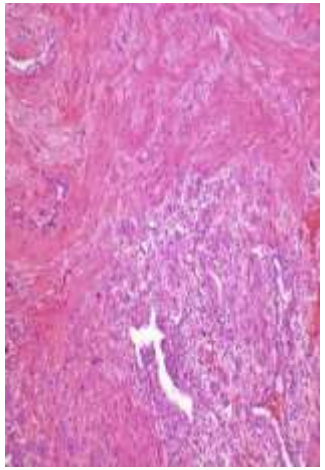
Title: A CASE REPORT ON PLACENTA PERCRETA

INTRODUCTION: Placenta percreta is a condition in which the placenta penetrates through the myometrium and into the uterine serosa. The incidence is 1 in 21000 pregnancies and majority of these cases are seen in patients with history of previous LSCS with anterior low lying placenta. Incidence of this condition is on the rise because of increased rates of cesarean sections. This is an intraoperatively diagnosed case of placenta percreta at fundal region and its successful management.



CASE REPORT: A 31-year-old G2P1L1 with a previous cesarean section at 28weeks of gestation was referred from a private hospital with complaints of leaking per vaginum since 3days. She had no other associated symptoms. Her antenatal period was uneventful with all routine investigations within normal limits. A 2nd trimester scan was done at 24weeks of gestation. The scan was corresponding to the period of gestation with borderline oligohydramnios(AFI-5.6cm) and placenta at fundoposterior location. A decision was taken to perform an emergency cesarean section in view of the previous cesarean section with preterm premature rupture of membranes(PPROM) and failed induction with Poor bishop score. After delivery of the baby when the placenta was tried to be removed, it could not removed even with gentle traction. No plane of cleavage was identified between the uterine wall and placenta. The uterus was exteriorized and the placenta was found to have firmly adhered to the uterine wall and serosa on the fundal region. An intraoperative diagnosis of morbidly adherent placenta was made. A decision to perform an emergency obstetric hysterectomy was taken. A subtotal hysterectomy was done after counselling and taking necessary informed consent. Histopathology of the specimen was consistent with the findings of placenta percreta.





DISCUSSION: Placenta percreta is the rarest and most dangerous form of placenta accreta spectrum, because of its propensity to cause life threatening hemorrhage. It is one of the leading causes of peripartum hysterectomy. In this case, though there was previous history of cesearean section, the site of invasion was not the lower segment or previous scar but at the fundus. We assume abnormal or excessive trophoblast invasion to uterine fundus as the pathophysiology of aberrant placentation or manual removal of the placenta in her previous cesarean section could have been the reason for the unnatural location of the placenta percreta. The diagnostic value of sonography in prenatal diagnosis of asymptomatic placenta accreta spectrum is uncertain. Hysterectomy is the treatment of choice and life saving. Conservative management is exclusively used in rare setting of the adjacent organ involvement such as bowel or bladder.

CONCLUSION: Placenta percreta is a threatening condition to mother and baby. It usually occurs at the site of previous scar. This case highlights need of detailed placental evaluation at 18-20weeks irrespective of location of placenta and previous scar and to avoid the malpractice of manual removal of the placenta to avoid complications in future pregnancies.

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