

## INTRODUCTION

Placenta accreta spectrum (PAS) is a potentially life-threatening obstetric complication leading to mortality as well as morbidity. It can be placenta accreta, increta, and percreta depending upon depth of placenta invasion [1]. Despite the advances made in obstetric imaging, multiple studies have shown that a significant number of PAS cases are diagnosed during delivery [4-6].

## OBJECTIVE

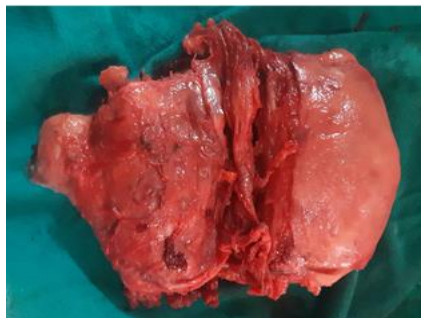
To highlight importance of clinical suspicion over imaging and to acquire required skills to manage any obstetric emergency to improve maternal health

## CASE

G3P1L1A1 at 32wk with central placenta previa on regular ANC check up. USG with Doppler was advised to localize placenta which confirmed placenta previa without any feature of morbid adherent placenta. Being a doctor herself, she went for MRI at 34wk, Which showed the same findings as that of USG. She had no symptoms and was working till 9 month. She was planned for elective LSCS after 37+ weeks. Single live baby, 2.7kg delivered. Intraoperatively she had severe PPH from placental site and it was found to be placenta percreta with bladder invasion. B/L internal iliac ligation was done, but because of continuing bleeding decision for emergency hysterectomy was taken. Multiple blood and blood products were given. Caesarean hysterectomy with bladder repair was done. Postoperatively she went into DIC and had prolonged ICU stay and discharged from hospital after 28 days. Postoperatively She also developed VVF which was successfully repaired after 10 month.

## DISCUSSION

It is characterized by invasive placentation due to the absence of the decidua basalis layer, resulting in placental anchoring villi coming in direct apposition with the myometrium due to a deficient Nita Buch's layer. In placenta accreta, placenta attached to the myometrium without invading it, whereas in increta, it penetrates into the myometrium. It is very important to recognize various risk factors for PAS during the antenatal period like previous LSCS, placenta previa, advanced maternal age, multiparity, history of previous uterine surgeries or curettage, and Asherman syndrome, IVF [14,15]. Ultrasound and MRI is helpful in antenatal diagnosis of PAS. In morbidly adherent placenta, loss of hypoechoic zone between the myometrium and the placenta, turbulent lacunar blood flow and increase in sub placental vascularity are common findings of PAS. A meta-analysis conducted in 2013 concluded that the overall detection rate of abnormally invasive placenta with ultrasound imaging and MRI was almost the same. They also demonstrated that MRI is superior to ultrasound in detecting posterior PAS, degree of placental invasion, and myometrium lateral extension [33] but its cost and availability make it less favorable diagnostic tool. Management includes resuscitation by fluids and blood products, ICU care and surgical management. Conservative management with leaving behind the placenta after baby delivery can be tried with proper counselling and care. Triple P technique can be tried. Most followed approach to manage PAS is cesarean section with concurrent obstetric hysterectomy in prior diagnosed cases. Uterine artery embolization also if available is very effective. Mental counselling and family support of patient plays a vital role as complete recovery may take longer even after acute event.



## CONCLUSION

- Identification the high risk cases during ANC
- Doppler USG for high risk cases to rule out PAS, if required MRI
- Delivery in tertiary care set up
- Counselling and consent of patient before LSCS in high risk cases and keeping blood products ready
- Training and skill development of obstetrician to manage such emergency
- Mental well being and keep hoping for healthy and positive outcome

## REFERENCE

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