20. MANAGEMENT OF PREGNANCY WITH PLACENTA PREVIA PERCRETA

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Introduction. Placenta percreta is a condition of abnormal placental invasion, the most rare and severe manifestation of accreta, where chorionic villi invade through the uterus and the serosa into the peritoneal cavity or bladder, is one of the most serious complications of placenta previa. Its incidence has been rising in recent years and this appears to correlate with the increase of caesarean section rates. The condition is associated with a high risk of maternal morbidity and mortality secondary to catastrophic haemorrhage. We present a clinical case of placenta previa percreta diagnosed by ultrasound, in which we accomplished a scheduled cesarean followed by cesarean hysterectomy for massive hemorrhage, with a good postoperative recovery period.

Case presentation. A 35-year-old woman (gravida 7, para 3) with a history of prior cesarean section due to placental abruption. During a routine sonographic examination at 16 weeks of gestation the placenta previa was diagnosed. At 24 weeks of gestation transvaginal Eco-Doppler images suggested the diagnosis of placenta previa percreta. During pregnancy the patient often presented spotting and weak abdominal pain and she was many times spitalized for monitoring and treatment. At 35 weeks of gestation a caesarean section was planned. The patient was informed with the possible complications and approval has been given. The abdomen was entered with a median incision under the umbilicus. After opening the abdominal wall, intra-abdominal inspection showed the “Medusa head” infiltration of the uterine anterior wall by the placenta. The placenta has invaded the lower segment and part of the bladder, left broad ligament and the upper vagina. Muscle tissue in the lower uterine segment and cervix was absent. The tissues were very fragile due to placental invasion. Was decided to make a transverse corporeal uterine incision - placenta cesaree with active bleeding from placental vessels. A healthy neonate was delivered. Because of severe acute bleeding and placental invasion of the upper part of the vagina, a total hysterectomy was performed. On the bladder wall hemostatic sutures were applied. After vascularised areas on the bladder and the abdomen were checked for bleeding, the operation was completed by putting two drain tubes, in the Douglas space and right side flank. Finally, the abdomen was closed using a regular technique. The total blood loss was 5000 mL. Intraoperative allogeneic red blood cells and free-frozen plasma were transfused. The patient was cared for in intensive care for two days. The postoperative course was uneventful, and the patient was discharged on day 7 in good conditions.

Discussion. Placenta previa, previous caesarean section, endometrial dilatation curettage, mother aged over 35 are risk factors for abnormal placental invasion. In our case, all these factors are present. In the studies, in placenta previa cases, where there is no uterine surgery, the rate of placenta accreta was reported to be 5%. The risk ratio for those who had one or two caeserean sections is respectively 24% and 50% and even 67% for those who had four or more operations. There are two procedures to handle invasion abnormalities, which are surgical and conservative. Surgical treatment depends on the degree of placental invasion. With conservative approach, complications such as vaginal bleeding, infection and disseminated intravascular coagulation can be detected and patients may need to be hysterectomized. For this reason, more randomised controlled studies about conservative approaches must be carried out.

Conclusion. A pregnancy complicated with placenta previa and previous cesarean delivery, should be evaluated by doctors with experience in the diagnosis of placenta accreta spectrum by Doppler sonography. Antenatal diagnosis is a key element to improving maternal and perinatal outcomes.