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Case Report

Atypical presentation of placenta percreta post-partum-a conservative surgical approach

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ABSTRACT

We report our experience with an atypical presentation of placenta percreta, presenting as a mass-like bulge in the uterine fundus. A hemodynamically stable young lady status-post preterm delivery at 26 weeks was referred to our center on the third post-partum day after multiple failed attempts at removal of a retained placenta. Magnetic resonance imaging (MRI) showed an atypical fibroid with part of an adherent placenta. Uterine artery embolization was done prophylactically. After a failure at removal under USG guidance, a diagnostic laparoscopy revealed an 8x6 cm highly vascular mass in the fundus extending to the right cornua with intact serosa, possibly placenta percreta. The procedure converted to laparotomy and the mass removed. Histopathology confirmed a placenta percreta. However, the neonate admitted at the referring hospital expired on day 14 due to sepsis. Post-partum adherent placenta in the fundal region on MRI can mimic an atypical fibroid.

Keywords: Pregnancy, Female, Placenta Accreta, Placenta diseases, Placenta

INTRODUCTION

Scarring of the uterus is one of the major high-risk factor for adherent placenta. Cesarean section, dilatation and curettage (D and C), myomectomy, increase the incidence of complications such as adherent placenta, rupture uterus leading to significant morbidity and mortality. The morbidly adherent placenta is now termed as placenta accreta spectrum (PAS) due to abnormal invasion of trophoblast into myometrium and can extend up to serosa.

PAS is subdivided-placenta accreta (placental villi attach to the myometrium), placenta increta (placental villi penetrate the myometrium) and placenta percreta (placental villi penetrate the myometrium till serosa or adjacent organs).

Placenta accreta accounts for 2/3rd and percreta for nearly 1/5th of PAS. Increta accounts for only a small proportion

of around 15%.¹ We are presenting a case of fundal placenta percreta with previous history of uterine curettage for an anembryonic gestation who reported to us with retained placenta 3 days following preterm vaginal delivery.

CASE REPORT

We present the case of a 32-year-old lady, with an obstetric score of PIL1A1, referred with suspected PAS, on the third postnatal day, referred with suspected PAS.

At 26 weeks and 3 days of gestation, she was taken to the local hospital for leaking per vaginam. She was started on a PPRM (Preterm premature rupture of membrane) regimen according to the hospital protocol. However, these measures failed and after 48 hours patient went into active labor and delivered a preterm, live female baby weighing 700 gm. Active management of the third stage of

labor was attempted, failing which manual removal of placenta was tried. During this process, the cord snapped. There was no torrential bleed and she was hemodynamically stable. Two more failed attempts were made, on subsequent days, to remove the retained placenta under anesthesia. An ultrasound was done at the hospital and was suspicious of an adherent placenta. Antibiotics were continued. She was then referred to us for further management. At our hospital she was hemodynamically stable, well oriented, without pallor. Bimanual examination showed uterus of 18weeks size, non-tender, with minimal bleeding per-vaginum and no foul-smelling discharge.

MRI reported an ovoid well-defined mass in right lateral fundal wall extending to cornua, measuring 8×6.6 cm, with an enhancement probably representing atypical fibroid. Inferior aspect of mass had a focus within the endometrial cavity suggestive of retained placenta (Figure 1 C).

Concurrently, a time-resolved imaging of contrast kinetics (TRICKS), did not show early draining veins or any prominent arterial feeders or arteriovenous malformations near the retained placenta. Since there was no blood supply to the placenta after delivery, it mimicked an atypical fibroid.

A complete blood count done and showed haemoglobin of 10.7 gm/dl, a platelet count of 215 Ku/ml, and a total count of 12.82 Ku/ml. Liver function test, renal parameters, and electrolytes were all within normal range. Her urine routine examination at admission showed numerous pus cells. Urine was then sent for a culture and sensitivity. A disseminated intravascular coagulation (DIC) panel was sent since the patient was being taken up for uterine artery embolisation (UAE) and there is a high risk of thrombosis after the procedure.

UAE was done one day before the planned procedure (Figure 1 A and B). Blood products were arranged and parenteral antibiotics continued. Consent was taken for possible laparotomy and hysterectomy.

A per vaginal approach to remove the retained placenta was attempted under USG guidance and placenta was inaccessible. Hysteroscopy was not attempted, due to its limitation in identifying the extent of placental invasion into the myometrium.

A diagnostic laparoscopy was then done for better visualization of the uterus and revealed an 8×6 cm mass in the uterine fundus extending to the right cornua, with a thin, translucent intact serosa. There was a large fundal mass with tortuous vessels on its surface (Figure 2 A and B). A decision was taken to do a laparotomy and remove mass.

Through a Pfannenstiel incision, the uterus was delivered out (Figure 2 C). After vasopressin instillation into the mass, an elliptical incision was made around it. After

clamping and ligating the feeding vessels placental mass was excised. The uterine cavity was found open. On exploration, there was no tissue retained inside the uterine cavity. The dead space was obliterated and the abdomen was closed keeping a drain in situ. One unit of packed red blood cell (PRBC) was transfused intra-operatively. The specimen was sent for histopathology and was reported as a placenta percreta (Figure 2 D and E).

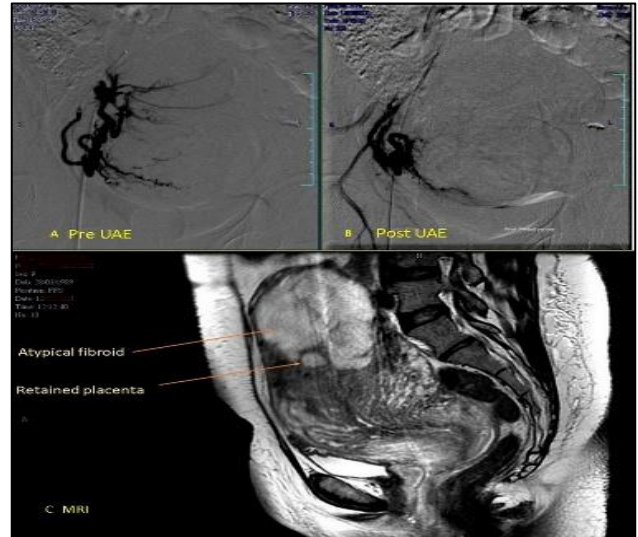


Figure 1 (A-C): Uterine artery embolization, before embolization, after embolization and MRI.

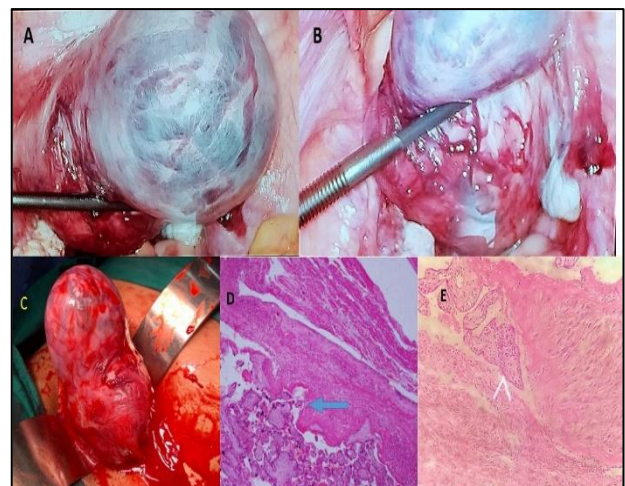


Figure 2 (A-E): Laparoscopy finding-fundal mass, serosa intact, thinned out-placenta percreta, vascular posterior surface, picture at laparotomy, histopathology showing placental villi encroaching uterine myometrium (H and E 10x) and villi reaching the serosa (H and E 50x).

On the third postoperative day, she developed sepsis. Parenteral antibiotics were given for 10 days as per sensitivity report. As the baby expired on the fourteenth day 1 mg of cabergoline was given to the patient for suppressing lactation.

After postnatal counseling, she was discharged on the 16th day and was reviewed after 6 weeks with no major complaints. She resumed her menstruation. A repeat ultrasound scan was normal.

DISCUSSION

Retained placenta occurs in about 3% of deliveries with the gestational age of 26-37 weeks.² PAS is suspected in patients with prior history of cesarean section and uterine intervention like hysteroscopic resections, in-vitro fertilization conception, and prior D and C. In PAS, a separation plane cannot be created and attempts at extraction invert the uterus. A quick evaluation of the patient to conserve the uterus has to be considered, if there is no significant hemorrhage. There are few anecdotal reports of methotrexate administration as an option for this condition.³ The retained placenta also increases the chances of sepsis, hemorrhage and may need a hysterectomy. Hence, a prophylactic embolization can be performed to devascularise the area and to prevent secondary hemorrhage. It increases placental reabsorption. However, there is always a possibility of ischemia or gangrene of uterine tissue. Since we had approached conservatively (UAE and placental mass excision), we could avoid hysterectomy. The pregnancy success rate reported after UAE is 60.9%, the live birth rate is 43.5%, and miscarriage is 20%.⁴ Henceforth, patient should be monitored closely and considered for a similar event in a subsequent pregnancy.

CONCLUSION

A history of previous uterine intervention should alert the possibility of the adherent placenta. When an antenatal

patient reports for an anomaly scan with doppler, an attempt should be made to rule out PAS. Postpartum adherent placenta in the fundal region on MRI can mimic an atypical fibroid.

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Ethical approval: Not required

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