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Case Report

Previous two lower segment caesarean section with placenta previa and placenta accreta woman with COVID-19 suspect: case report

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ABSTRACT

A pregnant woman with gravida 3, para 2, living 2 and gestational age of 37 weeks and 3 days was referred to a zonal hospital as previous two lower segment caesarean section (LSCS) term pregnancy with placenta previa for safe confinement with complaints of dry cough. She was admitted with a diagnosis of COVID-19 suspect. During her hospitalization, oxygen (O2) saturation was normal. On investigations her counts were normal. Patient was planned for elective LSCS. COVID-19 test i.e. real time-polymerase chain reaction (RTPCR) report was suspect and asked for repeat sampling. During elective LSCS, delivered single live female baby with intra operative findings of placenta previa with adherent placenta and permpartum hysterectomy was done for same. Uterus with placenta was sent for histopathological examination (HPE). During the surgery her oxygen concentration was normal. Her postoperative recovery was uneventful.

Keywords: COVID-19, LSCS, Placenta previa, Adherent placenta

INTRODUCTION

The outbreaks of COVID-19 that occurs in December 2019 in China, resulted in a widespread ongoing transmission worldwide including Iran.[1] Novel coronavirus, rapidly develops into alveolar injury and progressive respiratory failure.[2,3]

The health of pregnant women has become particularly important because maternal organs undergo many changes due to the effects of pregnancy. In china, all studies of COVID-19 pregnant women included single fetuses and no maternal deaths were reported by the virus.[4,5]

CASE REPORT

A pregnant woman (gravida 3, para 2, living 2, abortion 1, and gestational age of 37 weeks and 3 days) was referred to a zonal hospital as previous two lower segment caesarean section (LSCS) term pregnancy with placenta previa for safe confinement with complaints of dry cough. She was admitted with a diagnosis of COVID-19 suspect.

During her hospitalization, oxygen (O2) saturation was normal. On investigations her counts were haemoglobin (Hb)-10 g/l, total leucocyte count was 6400/cmm, polymorphs-65, lymphocytes-20, monocytes-03, eosinophils-03, and platelet-150000. Urine routine and microscopy was normal, placenta was anterior and reaching up to the internal os (orifice of the cervix). Patient was planned for elective LSCS with high risk consent and consent for hysterectomy. Blood demand was sent and confirmed. COVID-19 test real time-polymerase chain reaction (RTPCR) report was suspected and was asked for repeat sampling.

Patient was taken up for elective LSCS. All staffs in theatre were wearing appropriate personal protective equipment (PPE) according to departmental protocol. Abdomen opened with Pfannenstiel incision, intra-operatively

engorged vessels seen on lower uterine segment with pulled up and adherent urinary bladder. With above findings and suspicion of adherent placenta midline vertical incision was given on uterus and delivered single live female baby. Intra-operative findings of placenta previa with adherent placenta, immediately decision was made for permpartum hysterectomy. Peripartum hysterectomy was done with approximate blood loss of 1700 ml with urinary bladder injury which was repaired intra operatively with vicryl 2-0 in double layer. Uterus with placenta was sent for histopathological examination (HPE). During entire surgery her oxygen concentration was normal. Patient was transfused two units of packed red blood cells (RBC) and four units of fresh frozen plasma (FFP).

Post-operative recovery was uneventful. Repeat COVID-19 test was positive and patient was isolated for same. New born COVID-19 test was negative. Folys catheter was removed after 15 days with normal voiding functions. The histopathology report of uterus with placenta was suggestive of placenta accreta.

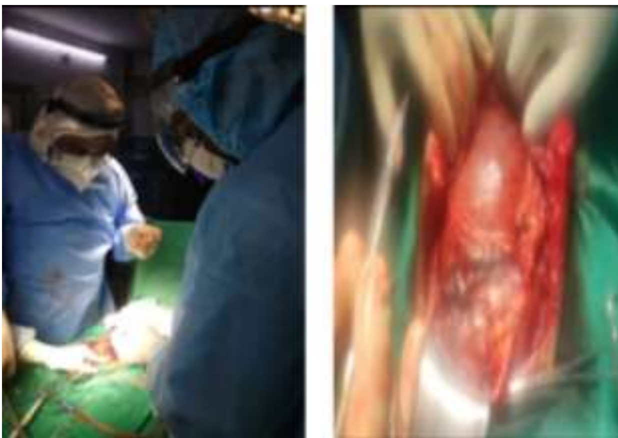

Figure 1: Peripartum hysterectomy.

DISCUSSION

Placenta accreta is defined as abnormal trophoblast invasion of part or all of the placenta into the myometrium of the uterine wall. Prevalence rate of placenta accreta is 1 in 533 from 1982 to 2002.[6] The most generally accepted approach to placenta accreta spectrum is cesarean hysterectomy with the placenta left in situ after delivery of the fetus (attempts at placental removal are associated with significant risk of hemorrhage).

Pregnancy is undoubtedly a risk factor for immune system defense against COVID-19. There is robust evidence that these patients need much more sophisticated care.

Our experience with this patient demonstrated that previous two LSCS with placenta previa with placenta accreta with COVID-19 positive status with mild symptoms in pregnancy might end with a good prognosis.

CONCLUSION

Pregnancy is undoubtedly a risk factor for COVID-19 due to altered immune system. There is robust evidence that these patients need much more sophisticated care. Pregnancy with COVID-19 with mild symptoms end up with good prognosis.

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