Management of placenta percreta. A case report

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Introduction

The placenta accreta designates an abnormality of the placental insertion characterized, on the anatomopathological level, by an absence of deciduous deciduous between the placenta and the myometrium. This insertion anomaly may interest all or only part of the placenta. We distinguish within this terminology the terms of:

- placenta accreta when the placenta is simply attached to the Myometrium.
- placenta increta when the placenta invades the myometrium.
- placenta percreta when the placenta enters the serosa uterine, or even the neighboring organs (bladder, peritoneum, etc.) [1]. Placentas accretas are a high-risk situation for severe postpartum hemorrhage and its inherent complications such as disseminated intravascular coagulation, hemostasis hysterectomy, surgical wounds to the ureters, bladder, multiple organ failure, or even maternal death, particularly in the case of placenta percreta [2,3]. Risk factors for placenta percreta include a history of cesarean, uterine curettage or manual removal of placenta, presence of placenta previa, endometriosis, high parity and advanced maternal age [4]. We report the case of a 30-year-old woman, IIGIIP, who had a previous cesarean section during her first pregnancy and who had a placenta percreta and who underwent cesarean section during her first pregnancy and who had a placenta percreta and who underwent hysterectomy without cystectomy and without ligation of the hypogastric arteries.

Observation

We report the case of a patient, 2nd gesture, 2nd parent, 30 years old, with a history of cesarean section 2 years ago received in our structure for the management of bleeding on a pregnancy of 31SA + 2 days. At 28 weeks of gestation, the ultrasound finds a marginal placenta previa. The patient was admitted to the ward for bleeding episodes twice at 28 and 30 weeks, but ultrasound did not reveal the placenta percreta. On admission, she complained of repeated vaginal bleeding but her general condition was preserved; the general condition was good, the normal-colored mucous membranes, the conscience clear. The obstetrical examination found a uterus with a long longitudinal axis, a uterine height of 27 cm, a palpated head in
suprapubic and the seat at the level of the
erine fundus, the sounds of the fetal heart
present and calculated at 140 beats per minute;
on vaginal contact, the cervix was posterior,
sftened, semi-long with an internal opening
barely open and admitting the pulp of the
finger, and red blood at the fingertip. The pelvis
was normal. Thus, it was a parturient, IIGIIP
with one cesarean section in her history, in
which the diagnosis of a marginal placenta
previa was made on a non-term pregnancy. She
received antenatal corticosteroid therapy and a
preoperative workup for a semi-emergency
cesarean. The Caesarean section performed
using the Misgaw-Ladakh technique with
transverse incision and extraction required a
longitudinal fundic corporal hysterotomy. The
placenta alone formed the usual lower segment
area extending on the posterior surface of the
bladder and subperitoneally, surrounding the
uterus up to the two uterosacral ligaments. We
performed a hysterectomy without cystectomy
or ligation of the hypogastric arteries.

Preoperative antibiotic therapy was
administered and immediate postoperative
follow-up was simple with no genital bleeding
or hematuria. The patient was transferred to the
intensive care unit and received an iso-group
iso-rhesus blood transfusion with 4 pockets of
pellet and 2 pockets of fresh frozen plasma. A
pelvic control ultrasound did not show any sign
of peritoneal effusion that would favor
persistent bleeding. An anatomo-pathological
examination of the operating room confirmed
that it was indeed a percreta placenta.

Discussion

The placenta percreta is the rarest form of
placental abnormalities representing 5% to 7%
of all placenta accreta [5,6]. Well-known
traditional risk factors for placenta percreta are
a history of cesarean or uterine surgery,
placenta previa, manual removal of the
placenta, dilation and curettage, multiparity and
advanced maternal age [5]. Our patient had well
identified risk factors such as a previous
cesarean and placenta previa; her age being
intermediate and she was pauciparous.
However, in recent studies, IVF pregnancy is
newly recognized as an independent risk factor
for accelerated placenta [7,8]. Uterine rupture
due to placenta percreta is very rare, occurring
in 1 in 5000 pregnancies, and it occurs mainly
later in the second and third trimester. Its
occurrence during the first trimester is rarely
described [9, 10]. Our patient did not
experience a uterine rupture during pregnancy
but rather endless episodes of bleeding that
motivated a cesarean for placenta previa. The
main clinical features of uterine rupture often
include signs of shock, severe abdominal and
pelvic pain associated with vaginal bleeding
[11]. In front of a placenta accreta, a
hysterecaoty associated with a cystectomy is
often performed, sometimes associated with
ligation of the hypogastric arteries. Chauveaud-
Lambling described a management of a percreta
placenta extending on the posterior face of the
bladder and in subperitoneal surrounding the
uterus until the two uterosacral ligaments,
bulging in the cul-de-sac of Douglas or a
conservative treatment was carried out with a
placenta left in place. Ligation of the
hypogastric arteries and round ligaments was
performed in conjunction with an in situ
injection of Methotrexate [12]. In our patient, a
radical treatment using the electrosurgical unit
was done with a satisfactory hemostasis; reason
why the hypogastric arteries were not ligated.
Conservative management in the event of
placenta accreta is very advantageous in order
to preserve the subsequent fertility of patients
[13]. In our case, and perhaps in all cases of
placenta percreta, for the sake of avoiding
catastrophic hemorrhage, conservative
treatment could not have been done even if the
patient was pauciparous with two living
children. In our African societies, although
multiparity is strongly anchored in mentalities
and this can often make the surgeon doubt, the
life of the patient and the child must remain at
the center of care. A similar case of placenta
percreta invading the bladder was reported by
Jaffé R in the American Journal of Obstetrics
and Gynecology [14] with failure of
conservative treatment and resumption at 7
weeks by hysterectomy, partial cystectomy and
ureteral reimplantation. Ligation of the
hypogastric arteries was also performed.
Another case was reported in Obstetrics and Gynecology by Legros RS in 1994 [15] for which the development was more favorable. The placenta percreta had been diagnosed at the time of the attempt of manual delivery after natural delivery; it had been left in place. MRI confirmed the total invasion of the myometrium and the patient was treated with weekly doses of Methotrexate (610 mg total dose). The ultrasound inversion of the placenta was very slow (several months) compared to the rapid drop in the blood level of βHCG. Eight months after delivery, a hysteroscopy was performed to remove the residues and two years later, the patient delivered again by natural means without abnormal delivery.

Conclusion

At present, it is quite difficult to suggest a standard course of action for the placenta percreta. The majority of publications on this subject are clinical cases. If a conservative treatment is better indicated in front of a woman wanting a pregnancy, it is important to know how to assess the clinical situation of the patient and the risk of cataclysmic hemorrhage to preserve her vital prognosis.

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