

Placenta Percreta in a booked Multiparous Woman with minimal Risk Factors and Challenges of Management in a low Resource Setting

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ABSTRACT

Retained placental membranes and tissues are responsible for 5% to 10% of postpartum hemorrhage. Placenta accreta occurs in approximately 1 in 2500 pregnancies of which placenta percreta constitutes about 5% of placenta accreta. This portends the rarity of placenta percreta especially in a 32 year old woman with minimal risk factors. Our patient was a G₄P₃⁺⁰ woman with 2 living male children who presented at 39 weeks plus 2 days gestation in latent phase of labour and transverse lie. She had emergency caesarean hysterectomy due to primary postpartum haemorrhage secondary to placenta percreta. There should be a high index of suspicion of placenta percreta in women with the risk factors and whoever does caesarean section should have the skills for hysterectomy in case of any encounter with placenta percreta not amenable to conservative management.

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INTRODUCTION

Obstetric haemorrhage is a major cause of maternal morbidity and mortality and accounts for about 23-25% of maternal mortality.^{1,2} Retained placental membranes and tissues are responsible for 5% to 10% of postpartum hemorrhage.² Placenta accreta is classified according to its degree of invasion into the myometrium : placenta accreta vera, placenta increta, and placenta percreta. *Placenta accreta vera* is a term used to denote a placenta with villi that adhere to the superficial myometrium. *Placenta increta* occurs when the villi adhere to the body of the myometrium, but not through its full thickness. *Placenta percreta* occurs when the villi penetrate the full thickness of the myometrium and may invade neighbouring organs such as the bladder or the rectum.¹ Placenta accreta occurs in approximately 1 in 2500 pregnancies.^{2,3} Of these, approximately 75% to 80% are placenta accreta vera, about 17% are placenta increta, and the remaining 5% are placenta percreta.²

The incidence of placenta accreta in Aba, Southeast Nigeria was 1 in 282 deliveries while that in Ife, Southwest Nigeria was 44 in 1371.^{4,5} It is because of the rare occurrence of placenta percreta and the challenges of its management that a case report of placenta percreta in a woman with minimal risk factors is made.

CASE REPORT

A 32 year old Ibo woman, who was G₄P₃⁺⁰ with 2 living male children. Her past obstetric history showed that her first confinement was in 2004. She received antenatal care at a maternity home. Pregnancy was uneventful and was carried to 40 weeks gestation. She had a spontaneous vertex delivery of a live male baby that weighed 3.0kg. The baby however died at the age of 1½ years due to febrile illness. Her 2nd and 3rd confinements were in 2006 and 2008 respectively. She received antenatal care at the same maternity home. The pregnancies were carried to term with the spontaneous vertex deliveries of live male babies that weighed 3.4 and 3.0kg respectively. They are alive and well.

Her mother was hypertensive but there was no family history of diabetes mellitus, sickle cell disease, asthma and twinning. She is a teacher while her husband is a petty trader. She neither took alcohol nor tobacco in any form.

HISTORY OF INDEX PREGNANCY

The patient booked the index pregnancy at UNTH, Enugu at 33 weeks gestation. Prior to booking, she registered at the same maternity home at 16 weeks gestation. She received 2 doses of Tetanus Toxoid at 20 weeks and 24 weeks gestation respectively. At booking, she had no complaint and she still felt fetal movement. Her booking weight and height were 96kg and 165cm respectively. The other examination findings were essentially normal except the transverse lie of the fetus. Her booking investigation results were essentially normal.

She was regular with her antenatal visits. She took a dose of intermittent preventive therapy for malaria with sulphadoxine pyrimethamine at 33 weeks gestation. At 36 weeks gestation, the pregnancy was uneventful and examination findings were normal except the maternal obesity and the persistent fetal transverse lie. Obstetric ultrasound scan done at 36 weeks gestation showed a single viable and active fetus in transverse lie with the head to the right maternal flank. There was satisfactory gross body movement and the fetal heart rate was 142 beats per minute. The placenta was anterior-fundal with normal thickness and echo-texture of grade 2 maturation. The liquor volume was adequate and clear and ultrasound estimated fetal weight was 3.0kg. She was counselled for external cephalic version at 37 weeks gestation. She however had a failed external cephalic version. She was

therefore counselled and booked for elective cesarean section at 38 weeks gestation but she defaulted.

She presented at labour ward at 39 weeks plus 2 days gestation in latent phase of labour with fetal transverse lie. Prior to her presentation at labour ward, she went to the same maternity home from where she was advised to come to UNTH, Enugu for expert management. She was counselled for emergency caesarean section and her consent was obtained.

FINDINGS

- Well formed lower uterine segment.
- Flabby and paper thin uterus especially at the fundus.
- Adequate clear liquor.
- Live female baby in transverse lie, weighing 3.15kg at Apgar scores of 3,5 and 8 at the 1st, 5th and 10th minutes respectively.
- The placenta was anterior-fundal and attached to the fundus up to the serous layer.
- The fallopian tubes and ovaries were normal.
- The uterus removed together with the placenta excluding the cervix.
- Estimated blood loss-2000mls.
- 4 units of blood were transfused intra-operatively.

The histology report confirmed intra-operative finding of placenta percreta.



Placenta firmly attached to the serosa.

DISCUSSION

Though the overall incidence of placenta percreta is extremely low, the appearance of this rare disorder seems to be increasing due to the performance of more cesarean deliveries, placenta previa, grand multiparity, maternal age of at least 35 years, previous uterine curettage, and previously treated Asherman syndrome.^{5,6,7} Antenatal diagnosis of placental accreta is usually difficult.^{8,9} Compared to magnetic resonance imaging, obstetric ultrasonography is less sensitive and specific in the diagnosis of placenta accreta.⁸ Our patient was a 32 year old multiparous woman who had previous vaginal deliveries with no previous history of uterine scar and puerperal complication.

The fact that she had upper uterine segment placenta percreta makes it extremely rare in a woman with minimal risk factors. Lack of Antenatal diagnosis of placenta accreta witnessed in this woman is supported by previous studies in Aba and Kuwait.^{4,10} Magnetic Resonance Imaging(MRI) machines are not readily available in most centres in Nigeria and even where they are available, they cannot be afforded by the majority of patients that need it. The intra-operative blood loss of 2000 millilitres is similar to the average blood loss in Aba.⁴

In conclusion, placenta percreta is associated with high maternal morbidity and mortality. It is usually diagnosed intra-operatively in our environment. There should be a high index of suspicion of placenta percreta in women with the risk factors and whoever does caesarean section should have the skills for hysterectomy in case of any encounter with placenta percreta not amenable to conservative management. Skills and modern facilities for antenatal diagnoses of placenta percreta in our environment is vital to help plan the delivery.

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