

Placenta Percreta with Bladder Involvement: A Case Report

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Abstract

Placenta percreta with bladder invasion manifesting with haematuria is a relatively rare complication of pregnancy. This is a case report of Mrs. O.V; a 41 year old unbooked Para 4+1 teacher with a history of 2 previous caesarean section. She was admitted at 25 weeks for conservative management for bleeding major placenta praevia. At 28 weeks gestation she developed total haematuria. She subsequently had an emergency subtotal caesarean hysterectomy, bilateral internal iliac artery ligation and bladder repair.

Key Words: Placenta Percreta, haematuria, Urinary Bladder [Trop J Obstet Gynaecol, 2005, 22:85-86]

Case Report

Mrs. O.V. an unbooked 41 year old Para 4⁺¹ (3 alive) teacher presented via the casualty section of the department of Obstetrics and Gynaecology of the University of Benin teaching hospital Benin City, at 25 weeks gestation with a history of recurrent painless unprovoked vaginal bleeding. The estimated blood loss for the episode of antepartum haemorrhage leading to presentation was about 100 mls. She had had 2 previous caesarean sections for fetopelvic disproportion and abruptio placentae in her 2nd and 4th deliveries respectively.

At presentation, her general condition was stable, her pulse rate was 90/min, regular and of good volume. The blood pressure was 120/70mmHg. The uterus was compatible with 32 weeks gestation and this was larger than her gestational age of 25 weeks, it was soft and not tender. The fetal heart rate was 168/min. Vaginal inspection revealed no active bleeding.

Her packed cell volume was 30%. An ultrasound revealed a type 3 placenta praevia with a viable fetus at 26 weeks and 4 days gestation. A conservative approach to management was adopted as she was remote from term and she had stopped bleeding. Two units of whole blood was cross matched and reserved for her in case of eventuality. A course of intramuscular dexamethasone was administered. A gentle speculum examination excluded any local cause of bleeding on the 3rd day on admission.

At 27 weeks and 3 days gestation, she developed total haematuria and the packed cell volume dropped to 20%. A clinical impression of placenta praevia with possible bladder involvement was made. Clotting time was normal. She was then taken for emergency caesarean section. Findings at surgery were placental percreta involving the posterior wall of the bladder. Removal of the placenta resulted in defects of the anterior wall of the uterus and the posterior wall of the bladder with torrential haemorrhage. (see Appendix) A subtotal

hysterectomy and bilateral internal iliac artery ligation were carried out to secure haemostasis and the bladder defect was repaired in two layers with chromic catgut. A live 0.9 kg female neonate was delivered (suffered early neonatal death from respiratory distress syndrome). She lost about 3 litres of blood intraoperatively. She was transfused 5 units of whole blood intraoperatively. Post operatively she had an extra unit of blood and she made an essentially uneventful recovery.

Discussion:

Placenta percreta, a variant of morbidly adherent placenta is a relatively rare complication of pregnancy in which chorionic villi penetrates through the myometrium to the serosa¹. It constitutes 5% of cases of morbidly adherent placenta². The true incidence of morbidly adherent placenta is however unknown but estimates vary from 1 in 2000 to 1 in 7000 deliveries² with an expected increased incidence due to increasing uterine surgeries.

The risk factors for morbidly adherent placenta include placenta praevia, previous caesarean section³ and uterine curettage. Mrs. OV had placenta praevia and previous caesarean section.

The usual presentation of morbidly adherent placenta is that of placenta retention (with or without primary post partum bleeding) after a spontaneous vaginal delivery or may be encountered at caesarean section when the placenta is found to be penetratingly adherent to the uterine wall to varying degree. Other forms of presentation have been reported. Antenatal uterine perforation with intraperitoneal haemorrhage presenting as acute abdomen has been described from

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this center⁴. Another rare presentation of a Placenta percreta is haematuria from bladder invasion by the placenta villi¹.

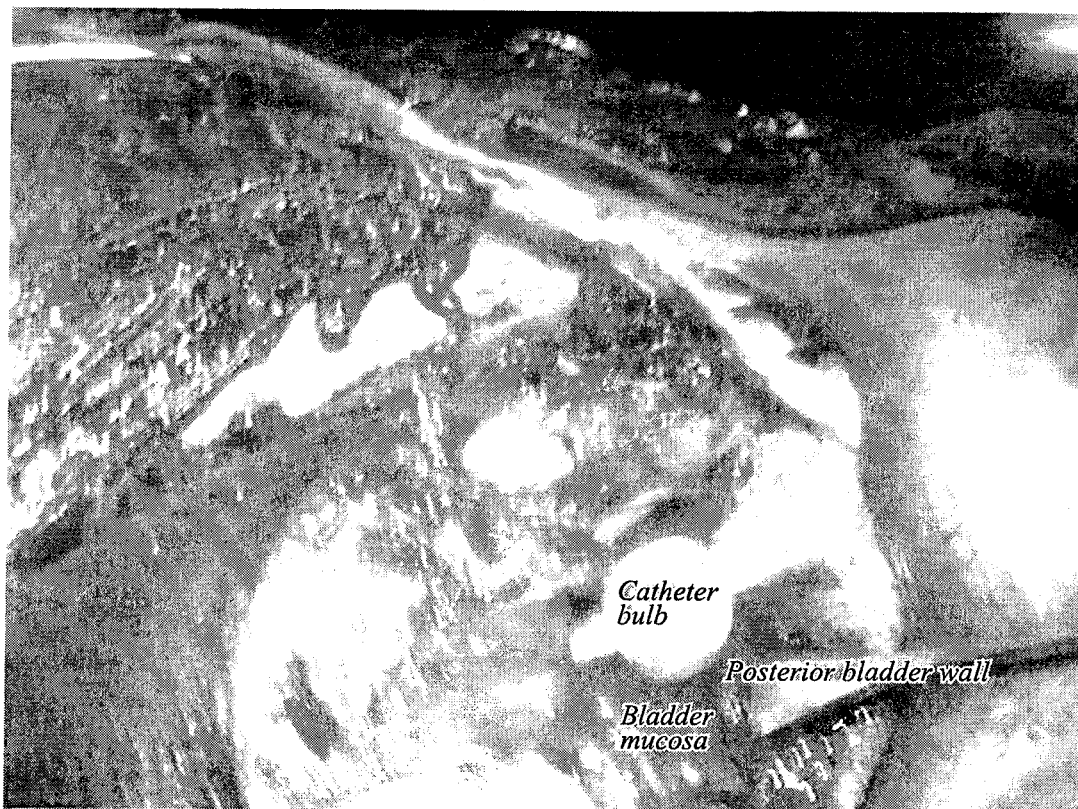
Antenatal diagnosis of morbidly adherent placenta is difficult but a high index of suspicion if the risk factors are present plus the use of Ultrasonography (USS) and Magnetic Resonant Imaging (MRI) where available would help detect some of these cases early enough for optimum management.

This case highlights the close association between a low lying placenta, previous caesarean section and morbid placental adherence. The authors of this paper are not aware of a similar report from this environment. An unexplainable haematuria should raise the suspicion of a possible percreta with bladder involvement especially if there is an anteriorly sited placenta in patients with

risk factors for placenta percreta like Mrs. OV. An earlier Ultrasonography confirmed a major placenta praevia in this patient but unfortunately there was no mention of morbid adherence in the report. Inexperience on the part of the sonographer may have been responsible for this.

The treatment of placenta percreta involves adequate resuscitation and surgery. A hysterectomy with bladder repair (or partial cystectomy) as was done for this patient may be required. There is a high risk for severe haemorrhage, with up to 90% of patients losing more than 3 litres of blood intraoperatively⁵.

This patient lost about 3 litres of blood and had a total of 6 units of whole blood transfusion. It should be emphasized therefore that such surgeries be carried out in centers with the requisite skills and efficient blood transfusion services.



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