Case Report: Obstetrics

PAS : In an Undiagnosed Case of Emergency Caesarean Section in Primigravida

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ABSTRACT

Placenta Accreta Spectrum is a state where placental tissue is abnormally invaded into uterine wall below the Nitabuch's layer. PAS (placenta accreta spectrum) has become very common these days due to raised rate of caesarean sections. In ultrasonographically prediagnosed cases, management of case can be defined but in undiagnosed cases i.e., if found during emergency caesarean section, it becomes very difficult to manage it, more so in situations where blood transfusion, skilled gynaecologists & anaesthetist, other depts doctors, SNCU etc not available.

Introduction

PAS is the second most common cause of obstetrical haemorrhage ie. 25-30 % following uterine atony. The incidence of PAS is about 0.35 % after one CS but raised to 6.75 % after four CS[1]. PAS contributed to 30 % to maternal mortality in undiagnosed cases and the mortality increases if associated with placenta previa[2]. There are many risk factors contributing to PAS like previous uterine surgeries like caesarean, myomectomy, D&C, placenta previa, age >35 yrs, smoking, multiple pregnancies[3] etc.

Diagnosis :

PAS is categorised by FIGO classification as placenta accreta, increta & percreta depending upon invasion of trophoblastic tissue into myometrium and beyond. It can be diagnosed with ultrasonography (gray scale = absence of hypoechoic retroplacental layer, large intraplacental lacunae, myometrial thickness < 1 mm etc. In color doppler these lacunae show turbulent blood flow. The anterior placenta may be associated with bridging vessels towards U.bladder[4]. MRI is helpful in posterior placenta previa.

Main Body of Case Report:

This was a case of 37 yrs old, elderly primigravida, conceived after 8 yrs of marriage. She came to DHH Baripada, Mayurbhanj, Odisha at 5 PM on 12/12/24 for safe confinement at term. She had left her ultrasonography reports at home. Her blood profile was sent for investigation and USG form was given. At 9 PM she came to labour room with a severe bout of bleeding PV and labour pains. Her pulse, BP, temperature, respiratory rate was normal. Per abdomen examination showed cephalic presentation with mild contractions. FHS was 120 /min. P/V examination showed 3 cm dilated os with high up head and bleeding. Soft structure could be felt near os. She was advised a pint of blood transfusion and immediate caesarean section. LSCS was done under SA. On opening the uterus transversely, placenta was seen in lower segment. It was cut through, to deliver

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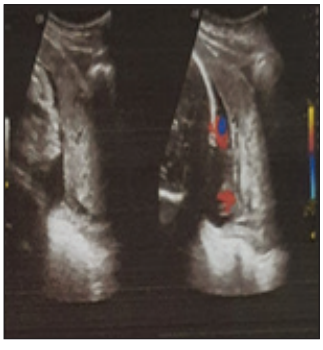
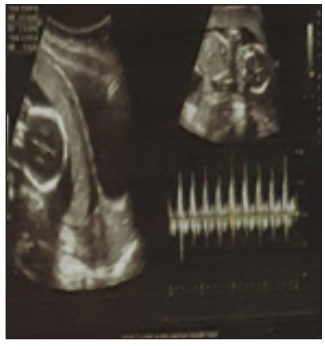
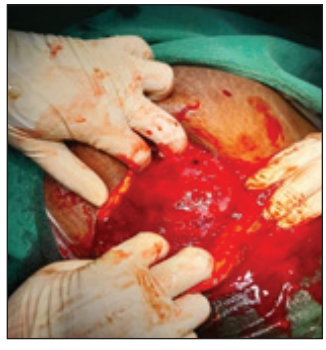
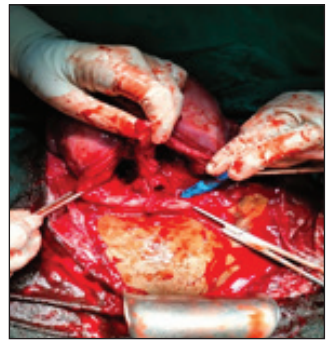
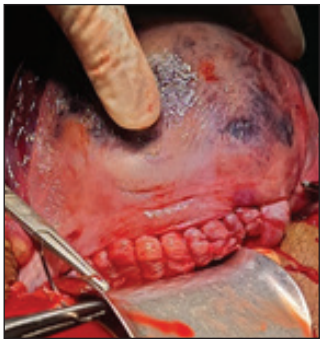
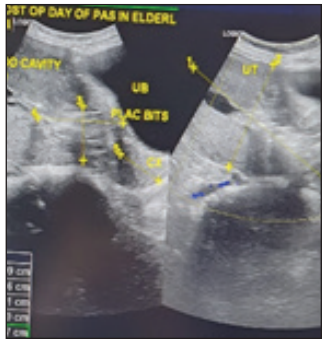
the 2780 gms baby, at 10.28 PM. Baby cried after 30 seconds of resuscitation. The upper part of placenta could be removed easily but 5x4 cm near cervical os was morbidly adherent. But it was not bleeding much. It was tied in base with chromic catgut no 1 and left in uterine cavity. Steps of devascularisation performed. Patient was given all postoperative advises along with a repeat USG scan before hospital discharge. Her postoperative period was satisfactory. Later on, her relatives got the ultrasonography report which revealed anterior low-lying placenta at 34 wks gestation. Her postoperative USG report on 5th day showed normal involuting uterus with placental tissue near internal os measuring 4x5 cm without vascularity. So patient was discharged with all warnings and follow up after 6wks.

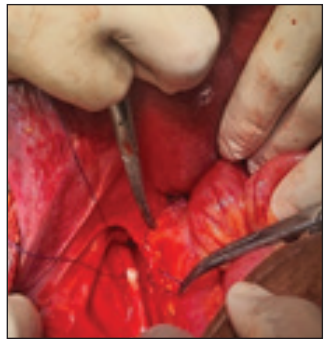
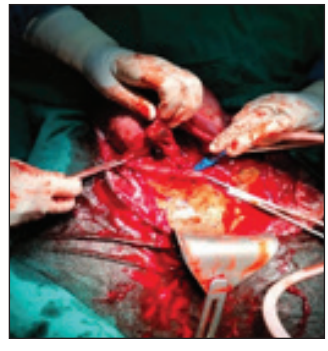
Discussion :

PAS is emerging as one of the most serious obstetric condition causing a significant maternal and foetal morbidity and mortality, so its management has to be judicious. In prediagnosed cases of PAS, there should be comprehensive multidisciplinary team approach with frequent antenatal check-ups. Correction of co-morbidities like anaemia etc. After antenatal corticosteroid, magnesium sulphate for neuroprotection, delivery is to be done in 35-36 wks gestation at tertiary hospital with adequate blood transfusion[5] and skilled doctors of various dept. Best standard approach to PAS is caesarean hysterectomy with placenta in situ. But if patient wants future fertility or in absence of skilled doctors in the facility, conservative surgeries can be undertaken[6]. Some conservative surgeries are= leaving placenta in situ followed by inj methotrexate and follow-up scans along with beta Hcg, to find out complete resorption of placenta. Focal PAS (involving < 50% uterine surface) can be managed with removal of healthy myometrium along with placenta followed with suturing the myometrial base. Cho square stitch can be given on surface if bleeding doesn't stop. Tripple-P procedure is done in three steps. Firstly do placental localisation by TAS USG so as the deliver baby above the superior border of placenta. In the second step do devascularisation steps. Thirdly placental nonseparation with large myometrial excision and reconstruction of uterine wall. But there are some post conservative surgeries complications like uncontrolled haemorrhage leading to delayed or secondary hysterectomy, sepsis, urologic problems etc

Conclusion:

PAS is a very high risk condition and if encountered during undiagnosed emergency caesarean section in small periphery hospital or without preparation in higher stations, the best strategy is to deliver the baby, clamp the cord then close the uterus with placenta in situ and transfer the pregnant women to the higher center for judicious management or wait for delayed hysterectomy.

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