Case Report

# Placenta percreta: A rare case report

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## Abstract

**Background:** Placenta Percreta, a rare complication of pregnancy, is associated with significant postpartum hemorrhage often requiring emergency hysterectomy. Majority of these cases are seen in patients with history of previous LSCS with anterior low-lying placenta. Here we present a rare case of Placenta Percreta which was diagnosed in a woman who was taken for emergency LSCS.
**Keywords:** Placenta Percreta, Subtotal hysterectomy, LSCS.

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## INTRODUCTION

Placenta percreta, the rarest and most severe form of placenta accrete spectrum, occurs when placenta extend through the entire myometrial layers and uterine serosa. The overall incidence of placenta percreta is extremely low with an incidence of 1 in 21000 pregnancies and majority of these cases are seen in patients with history of previous LSCS with anterior low lying placenta. The fundus of the uterus has thick myometrial lining and is seldom or almost never involved in percreta unless there is an history of fundal surgery in the past. Here we present the case of placenta percreta which presented as an obstetric emergency.

## CASE REPORT

A 34 years, 3rd gravida with 34 weeks amenorrhea, housewife from Latur was brought with c/o Bleeding per vaginum since morning (6 hours) and pain in abdomen since 2 hours. Patient was asymptomatic till morning, when she noticed spotting per vaginum, sudden onset, painless and causeless with one pad being partially soaked and stopped on its own after one hour. She then experienced 2nd episode of bleeding which was more than previous bleeding, but this time, she also had pain in abdomen, colicky type confined to lower abdomen and radiating towards thighs. Pain was relieved on its own temporarily reappearing after 30 minutes, so she visited nearby PHC after which she was referred to us.

### History of Present Pregnancy

Spontaneous conception. 1st trimester – uneventful (1st scan normal); 2nd trimester- uneventful (2nd scan normal). No h/o bleeding, HTN, GDM, trauma. 3rd trimester – 3rd scan at 28 weeks s/o – low lying placenta 2 cm away from os and one cervical fibroid of 3*3 cm (risk was explained) Last scan done one-week back s/o- 33-34 weeks maturity with placenta previa 1.5 cm away from os with breech and a cervical fibroid of 3*4 cm.

### Menstrual History

Regular/28 days cycle/bleeding 4-5 days/ average/ not associated with pain. LMP- 20/4/20

### Obstetric History

G3P1L1A1
Married since 8 years
G1: FTND, 7 years female child
G2: MTP; conceived due to contraception failure.
G3: Present Pregnancy

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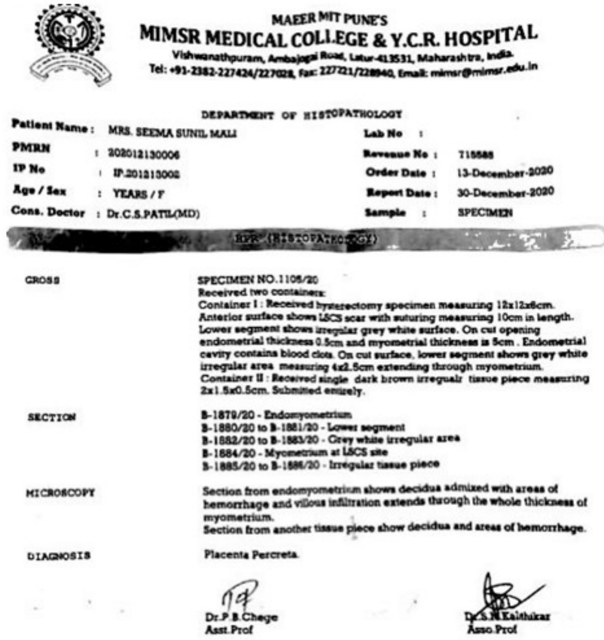
**Past History:**
H/o laparoscopic surgery (cystectomy) done for Left ovarian cyst (chocolate cyst)
**Family History:** Not significant
**General examination:**
Conscious, oriented.
Pulse rate- 90 beats/min, RR- 16/ min, BP- 110/80 mm Hg
**Systemic examination: P/A -**
Fundal height 34 weeks
Breech presentation with
Mild contractions
FHS- 110/min, regular
Non tender
P/S- Bleeding present but cervix not visualize properly and a mass is seen.
P/V- Not done.
**Provisional diagnosis:**
G3P1L1A1 with 34 weeks pregnancy with APH (placenta previa) with breech presentation with cervical fibroid in preterm labour.
**Differential diagnosis:**
Placenta Previa or Abruption
**Investigations:**
CBC- Hb-9.3, TLC-14600, PLT-197000; BT-3min, CT-4:30 sec
BSL-78.9, RFT- BUN-10.6, sr. creat-0.54
LFT- Sr.protein – 6.3, albumin- 3.0, globulin- 3.3, sr. total bilirubin- 0.40, direct bilirubin- 0.19
SGOT-20, SGPT-14.7, Alk. Phosphatase- 121
Urine R/M- Albumin- nil, sugar- nil.
In view of Ante Partum Bleeding and preterm labour, she was taken for Emergency LSCS.
**Operative Notes:**
Baby ddelivered. Placenta and membranes expelled out spontaneously. Uterus was closed in layers and it was found that both the ovaries were stuck to posterior uterine wall (Kissing ovaries) with ruptured chocolate cyst. Continuous bleeding present on posterior wall of uterus, uterus became atonic, Inj. Carboprost and Inj. Methargin were given; but bleeding was not controlled neither uterine tone was regained. Systemic devascularization done but still bleeding was not controlled and uterine tone was not regained. All uterine sutures were removed. Posterior wall was observed from inside, which revealed a rent connecting from inside out and tissues were resembling with placental tissues, suspicious of Placenta Percreta or Infective Endometriosis. Patient was landed in atonic PPH, so the decision of obstetric Hysterectomy was taken as a life saving measure. Specimen was sent for Histopathology report which suggestive of placenta percreta.



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DEPARTMENT OF HISTOPATHOLOGY

Patient Name : MRS. SEEMA SUNIL MALI | Lab No :
PMRN : 202012130006 | Revenue No : 715585
IP No : IP.201213002 | Order Date : 13-December-2020
Age / Sex : YEARS / F | Report Date : 30-December-2020
Cons. Doctor : Dr.C.S.PATIL(MD) | Sample : SPECIMEN

HPR (HISTOPATHOLOGY)

GROSS
SPECIMEN NO.1106/20
Received two containers:
Container I : Received hysterectomy specimen measuring 12x12x6cm. Anterior surface shows LSCS scar with suturing measuring 10cm in length. Lower segment shows irregular grey white surface. On cut opening endometrial thickness 0.5cm and myometrial thickness is 5cm . Endometrial cavity contains blood clots. On cut surface, lower segment shows grey white irregular area measuring 4x2.5cm extending through myometrium.
Container II : Received single dark brown irregualr tissue piece measuring 2x1.5x0.5cm. Submitted entirely.

SECTION
B-1879/20 - Endomyometrium
B-1880/20 to B-1881/20 - Lower segment
B-1882/20 to B-1883/20 - Grey white irregular area
B-1884/20 - Myometrium at LSCS site
B-1885/20 to B-1886/20 - Irregular tissue piece

MICROSCOPY
Section from endomyometrium shows decidua admixed with areas of hemorrhage and villous infiltration extends through the whole thickness of myometrium.
Section from another tissue piece show decidua and areas of hemorrhage.

DIAGNOSIS
Placenta Percreta.

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Asst.Prof

Dr.S.N.Kalthikar
Asso.Prof

Figure 1

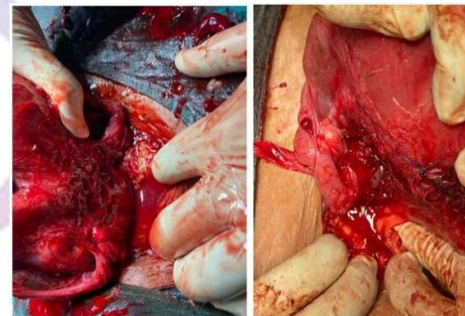

Figure 2

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