Journal of Pharmaceutical Care & Health Systems

ISSN: 2376-0419

Aravind et al., J Pharma Care Health Sys 2018, 5:2
DOI: 10.4172/2376-0419.1000191

Case Study Open Access

A Case Study on Placenta Percreta

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Received date: 23 April, 2018; **Accepted date:** 7 May, 2018; **Published date:** 24 May, 2018

Abstract

Placenta percreta is a serious pregnancy condition that occurs when blood vessels and other parts of the placenta grow the deeply into the uterine wall. Placenta percreta is a rare but a life-threatening condition. Control of massive haemorrhage is the first priority; however, the patient's desire for future fertility has to be taken into consideration. Here we present a case where we had to do a quick subtotal hysterectomy because of torrential bleed due to placenta percreta with severe abdominal pain.

Keywords: Placenta percreta; Hysterectomy

Introduction

The placenta grows onto the upper part of the uterus and stays there until your baby is born. During the last stage of labour, the placenta separates from the wall of the uterus, and your contractions help push it into the vagina (birth canal). This is also called the afterbirth.

Placenta percreta is a serious pregnancy condition that occurs when blood vessels and other parts of the placenta grows deeply into the uterine wall. In other words, the placental blood vessels innervate into the uterine wall and gets attached to the uterus. Typically, the placenta detaches from the uterine wall after childbirth [1]. With Placenta accreta part or the entire placenta remains firmly attached, this can cause severe blood loss after delivery. Placenta percreta and accreta are the same conditions but the position of the placenta attaching to the uterus is different. Due to this condition in most of the women was suffering with anemia after delivery to due severe blood loss and even leads to death. While treating these cases the doctor looks for the risk to benefit ratio and counsel the patient regarding the abortion and hysterectomy.

Causes

Placenta percreta is thought to be related to abnormalities in the lining of the uterus, typically due to miscarrying after a C-section or other uterine surgery. This might allow the placenta to grow too deeply into the uterine wall, sometimes, however placenta occurs even without the history of uterine surgery [2]. The pregnancy after the age of 35 is also one of the rare cause for this condition [3].

Pathology

It is characterised by transmural extension of placental tissue across the myometrium with serosal breach. Placenta invasion of the myometrium is related to a thinned decidual endometrium at the site of implantation and this can happen for a number of risk factors.

Risk Factors

The risk factors of this condition are previous caesarean section, placenta previa, advanced maternal age, uterine anomalies, intrauterine adhesion bands, and other uterine and placental surgeries [4].

Diagnosis

Placenta percreta is diagnosed by the radiological tests like ultrasound or magnetic resonance imaging (MRI), NT scans [5].

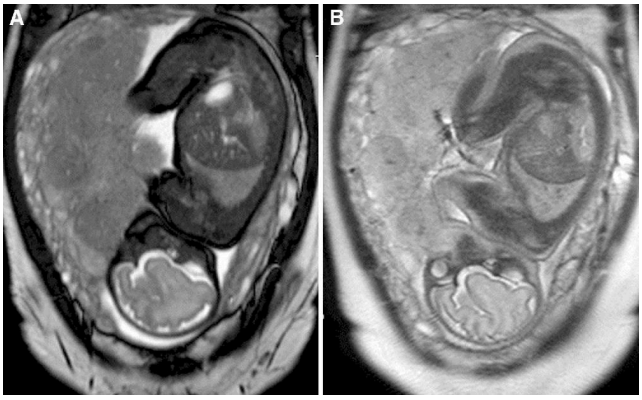

Figure 1: NT scan of 21 year old female patient pain in abdomen at right lower side on and off for one day, pain over the previous scar site of caesarean delivery.

Case Study

A 21-year-old female patient was admitted in hospital with chief complaints of pain in abdomen at right lower side on and off for one day, pain over the previous scar site of caesarean delivery, she was assessed as G3P2L1A0D1 with 33 weeks period of gestation with 2 LSCS, scar tenderness. The doctor after conducting NT scan diagnosed as placenta percreta and with partial cystectomy. The advised treatment is hysterectomy (Figure 1).

Discussion

Placenta percreta cases are increasing from the past two decades due to high caesarean cases rate. Other conditions are instrumentation of the endometrium, placenta praevia, uterine malformations, septic endometritis, previous manual removal of placenta and multiparity. The present case risk factors like caesarean section and short inter-pregnancy interval. The women with this condition should be screened by ultrasound, MRI or NT scan techniques [6].

Treatment for placenta percreta is primarily surgical with hysterectomy being the treatment of choice in 95% of cases. Conservative management is also desirable in the rare cases involving the adjacent organs such as the bowel or the bladder, because of the increased risk of uncontrollable haemorrhage. A non- surgical conservative method is to leave the placenta in situ to reabsorb and institute treatment with chemotherapeutic agents, such as methotrexate. Uterine or internal iliac artery ligation and transcatheter arterial embolization has also been described as a choice of treatment [7,8].

Maternal death is not an infrequent outcome ranging from 7-10% of reported cases of placental adhesions. Foetal death occurs in approximately 9% of the cases, usually due to complications of prematurity [8]. Other complications reported are disseminated intravascular coagulopathy, surgical injury to the ureters, bladder and other viscera, adult respiratory distress syndrome, renal failure and infection, usually in the post- operative period. Psychological counselling is required to prevent depression of the patient [9].

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