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Reproductive System and Sexual Disorders: Current Research

Perspective

Two Rare Cases of Uterine Accreta: Occurring on an Uninjured Womb in the Third Trimester of the Pregnancy

Johan Botha*

Department of Obstetrics and Gynecology, University of Abuja Teaching Hospital Abuja, Abuja, Nigeria

ABOUT THE STUDY

Placenta Accreta Spectrum Disorders (PASD) is rare obstetrical conditions that can result in significant life-threatening obstetrical issues for both mothers and foetuses during pregnancy. This pathology can occur in the uterus without a history of uterine surgery, localize in an unusual location of the uterus, and result in spontaneous uterine rupture in rare cases. We present two unusual cases successfully managed in the third trimester of pregnancy at our tertiary referral hospital. Two pregnant women were admitted to our maternity hospital with a precarious diagnosis of PASD and no history of previous caesarean scar. Following suspected images of PASD on ultrasound combined with a hematoma anterior to the uterine body, particularly a sudden onset of abdominal pain and intraperitoneal bleeding, we believed uterine rupture associated with PASD because of the fluid without a clear aetiology. Furthermore, a gradual decrease in hemoglobin concentration supported this diagnosis. Following suspicion, both cases underwent immediate caesarean hysterectomy to save the mother and baby's lives. PASD associated with an unscarred uterus is a rare pregnancy placentation. PASD can occur without being associated with placenta praevia, though this is extremely rare. A timely caesarean hysterectomy can prevent adverse maternal-fetal outcomes. PASD can appear on the uterus without a previous uterine scar, resulting in unexpected pregnancy complications. Materno-foetal mortality can be reduced with close monitoring. More information is required to summarise this uncommon entity. PASD is defined as the deep invasion of part or the entire placenta into the uterine myometrium, including the placenta accreta, increta, and percreta. Recently, the high rate of caesarean section has been linked to an increased incidence of PASD caused by a defect in the endometrial-myometrial interface at the uterine scar, resulting in abnormal chorionic villi adherence. The incidence of PASD is reported to be about 1 in every 1000 deliveries, ranging from 0.04% to 0.9%. Furthermore, this calamitous event has the potential to kill many mothers and infants around the world. This unexpected situation can now be detected early using advanced imaging diagnosis modalities. However, some cases have recently been diagnosed due to atypical characteristics. This abnormality is overlooked on ultrasound in a patient with no history of uterine interventional procedures. As a result, PASD can cause uterine rupture, resulting in intraabdominal haemorrhage. This complication can occur during pregnancy and after childbirth. In some cases, the diagnosis of PASD may be delayed or misdiagnosed with other pathologies. In accordance with the SCARE 2020 guideline and a review of the literature, we have reported two atypical cases of PASD in the third trimester of pregnancy. A 28-year-old pregnant woman was transferred from a local hospital to our tertiary centre due to PASD and an anterior uterine hematoma. Her gynecologic history revealed G2P1, she had a vaginal birth without complications, and she had ovarian tumour resection in the previous years. The patient had no prior history of myomectomy, Dilation, or Curettage (D&C). The patient also had no drug history, psychosocial history, or genetic history. She had a painful posterior sternum the day before, as well as dyspnea and shortness of breath. She also suffered dysuria at the same period. At the ward care centre, she was initially diagnosed with mitral valve regurgitation and was sent to a nearby hospital. An ultrasonic scan at a nearby hospital revealed peritoneal fluid, a hematoma on the anterior surface of the uterus, and placenta accreta. As a result, she was sent to our hospital for intensive supervision. She had an unremarkable vital sign at admission, complaining of stomach pain and dysuria. Physical examination revealed that the patient had diffuse abdominal discomfort, distention, and rigidity. The painful sign, in particular, was more sensitive to palpitation at the right iliac fossa. The uterine contraction rate was roughly one contraction per minute, and the foetal heart rate at baseline was 140 beats per minute. A vaginal exam indicated a little blood clot and a closed cervix. Ultrasonography revealed a vital foetus for its age, foetal development at 34 weeks GA, complete placenta praevia, a hypoechogenic structure suggestive of subserosa fibroids, slight dilatation of the renal pelvis, and free fluid in the abdominal cavity. Six hours after being admitted to the hospital, she developed a temperature of 38 degrees Celsius. She was forced to submit to a serum laboratory test for a blood count. C - Reactive Protein (CRP) and a dengue test (conducted routinely if a patient has a fever or thrombocytopenia (low

Correspondence to: Johan Botha, Department of Obstetrics and Gynecology, University of Abuja Teaching Hospital Abuja, Abuja, Nigeria, E-mail: bothajon@213gmail.edu

Received: 28-Oct-2022, Manuscript No. RSSD-22-20744; **Editor assigned:** 01-Nov-2022, PreQC No. RSSD-22-20744 (PQ); **Reviewed:** 18-Nov-2022, QC No. RSSD-22-20744; **Revised:** 28-Nov-2022, Manuscript No. RSSD-22-20744 (R); **Published:** 05-Dec-2022, DOI: 10.35248/2161-038X. 22.11.340.

Citation: Botha J (2022) Two Rare Cases of Uterine Accreta: Occurring on an Uninjured Womb in the Third Trimester of the Pregnancy. Reprod Syst Sex Disord. 11:340.

platelet count) during Vietnam's Dengue epidemic). Laboratory testing revealed a rise in white blood cells from 12.89 to 13.61 103/uL, a drop in hemoglobin concentration from 10.0 to 7.7 g/dL, a CRP of 89.9 mg/dL, and a negative Dengue fever test. As a result, she was suspected of having appendicitis and a urinary tract infection. She was advised by a doctor in another hospital to undergo Magnetic Resonance Imaging (MRI). MRI scans, however, revealed a normal appendicle structure and mild hydro nephrosis related to the gravid uterus.