

Placenta accreta: Tomb of womb *a case-report*

¹Dr. Ujwala Maheshwari,²Dr. Abhilasha,

¹Professor, Department of Pathology, MGM Medical College, Navi Mumbai

²Post Graduate Student, Department of Pathology, MGM Medical College, Navi Mumbai

Abstract:

INTRODUCTION: Placenta accreta is a serious condition in which the placenta adheres to the uterine wall without intervening decidual barrier. It is one of the major causes for obstetric hysterectomy.

CASE REPORT:

A term primigravida married for ten years presented to OPD with complaint of pain abdomen. She was on hormonal supplements in view of infertility. On USG she had dichorionic diamniotic twin pregnancy. Patient was taken for lower segment cesarian section in view of twin gestation. She developed postpartum hemorrhage not controlled by medical management. Further, obstetric hysterectomy was done and sample was sent for histopathological examination.

CONCLUSION:

Placenta accrete is one of the major causes of fetal and maternal complications leading to obstetric hysterectomy posing a problem in young primigravida.

IndexTerms: Placenta, USG, pregnancy, decidua

I. INTRODUCTION:

Placenta accreta spectrum is a condition where the decidua is partially or completely absent leading to adherence of the villous tissue to the myometrium.[1]

Its incident in India is 1.7 per 10 thousand deliveries. [4] Previously it was known as morbidly adherent placenta, constituting increta, percreta and accreta. [3] Most common predisposing factors are history of previous cesarean section, increased maternal age or any instrumentation like dilation and curettage. [4] Role of Ultra sonography and Magnetic Resonance is unclear and cannot be relied on. The gold standard for definitive diagnosis is histopathological examination. [3]

II. CASE REPORT:

A thirty-year-old term primigravida presented to OPD with 37 weeks of gestation with complaint of pain in abdomen.

She was married for 10 years and was on hormonal supplements for 15 months in view of infertility.

Her previous doppler ultrasound scan showed dichorionic diamniotic twin pregnancy.

She was taken for LSCS in view of twin gestation. She delivered healthy twins following which she developed post-partum hemorrhage. Further, obstetric hysterectomy was done and the sample was sent for histopathological examination.

III. GROSS&MICROSCOPY:

Gross examination:

Received specimen of uterus with cervix measuring 15 x 13 x 5.5 cm.

External surface showed areas of congestion and hemorrhage. On cut section, endometrium was 0.5 cm and myometrium was 4.5 cm in thickness.

Microscopy:

Sections studied from myometrium reveal villi infiltrating the smooth muscle bundles. Also seen are cyto-trophoblast and syncytio-trophoblast along with extensive areas of hemorrhage.

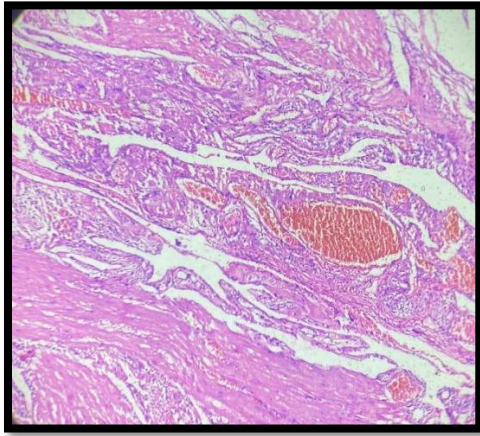


Fig No. 1: Myometrium with dilated and congested vessels. (4x)

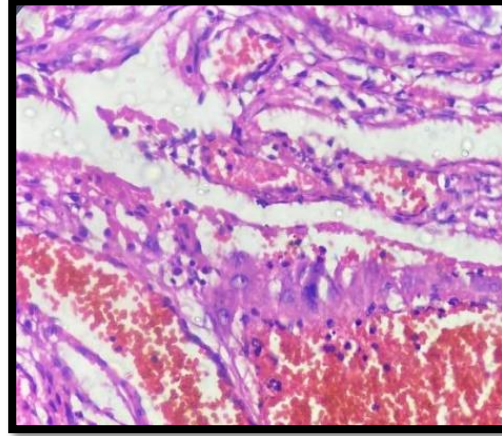


Fig No. 1: Fibrin with extravillous trophoblasts (40x).

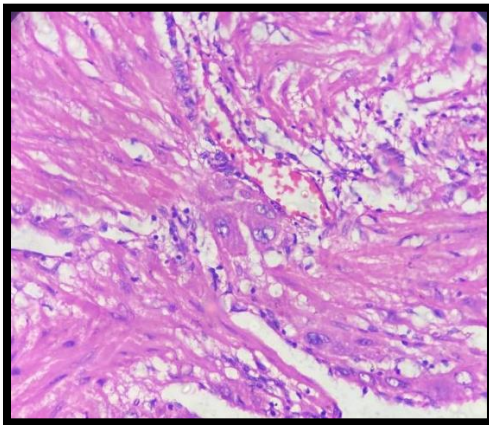


Fig No. 3: Decidual cells with bland nuclei, homogenous open chromatin and small nucleoli.(40x)

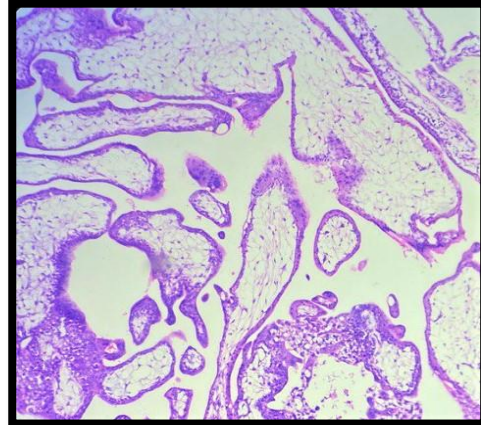


Fig No. 4: Chorionic villi (10x).

IV. CASE DISCUSSION:

Patient was given a diagnosis of Placenta accrete on histopathological examination. Placenta accrete is a condition in which the placenta morbidly adheres to the uterine wall without intervening decidua due to absence of Nitabuch's layer. Ultrasonography and Magnetic Resonance Imaging findings in asymptomatic cases are uncertain and cannot be relied on.

V. CONCLUSION:

Our case is of a primigravida whose prenatal radiological investigations are trivial. It is unexpectedly diagnosed at the time of delivery^[3]

USG doppler in late 2nd or 3rd trimester should be encouraged for early diagnosis and clinicians should keep in mind the possibility of placenta accreta spectrum to minimize maternal morbidity and death.^[2,4]

Placenta accreta can lead to maternal complications like sepsis, thrombosis, severe intraoperative bleed leading to postpartum hemorrhage and amniotic fluid embolism that could even lead to maternal death.^[3,4]

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