

## CASE SERIES

# Morbidly Adherent Placenta managed Conservatively: A Case Series

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## ABSTRACT

Placenta accreta refers to any abnormally invasive placental implantation. Diagnosis is suspected postpartum with failed delivery of a retained placenta. Massive obstetrical hemorrhage is a known complication often requiring peripartum hysterectomy. We report a series of cases of placenta accreta in patients desiring future fertility who were managed conservatively.

**Keywords:** Manual removal of placenta, Methotrexate, Piecemeal, Placenta accrete.

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## INTRODUCTION

Placenta accreta is a rare complication of human placentation having potentially life- and fertility-threatening sequelae. Incidence of morbidly adherent placenta has increased 10-fold in the last 50 years. Presently, the incidence of placenta accreta is as high as 1 in 533 deliveries (ACOG 2012b). Ideally, the diagnosis should be made antenatally. This could allow for predelivery planning to reduce maternal morbidity and mortality. But more often it is diagnosed when placenta is retained. When future fertility is not a concern, caesarean hysterectomy has been the preferred strategy. But when future fertility is the main concern, other nonsurgical options are considered. We hereby present a few cases of morbidly adherent placenta managed conservatively.

## CASE REPORTS

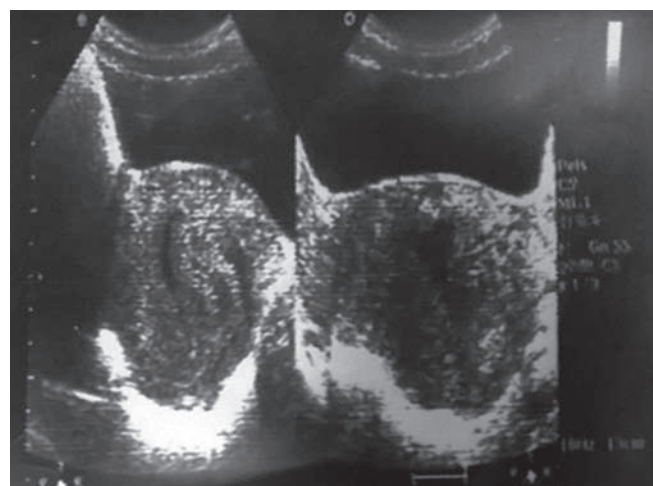
### Case 1

A 21-year-old primipara patient came to RHP from children hospital (CH) Barnala with retained placenta

after preterm vaginal delivery. Manual removal of placenta was tried but failed. Ultrasonography (USG) showed placenta accreta confirmed by color Doppler (Fig. 1). Injection methotrexate (50 mg I/M) given. Patient expelled placental tissue on 8th day of MTx (Fig. 2), which was confirmed by histopathological examination report (Fig. 3). On 16th postpartum day (PPD) USG confirmed empty uterine cavity (Fig. 4).

### Case 2

G7P2L1A4 patient came with 5 months 26 days present on admission (POA) with preterm labor. Patient delivered



**Fig. 1:** Ultrasonography suggestive of retained product of conceptions with increased peripheral vascularity



**Fig. 2:** Placental tissue expelled on 8th day of methotrexate

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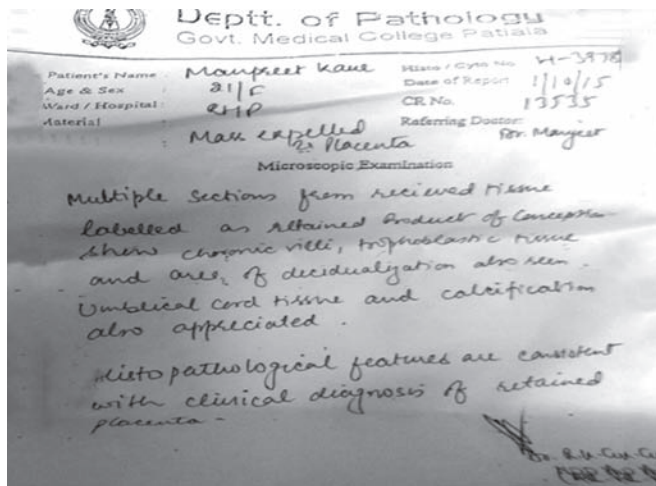


Fig. 3: Histopathology report of the expelled mass suggestive of placental tissue

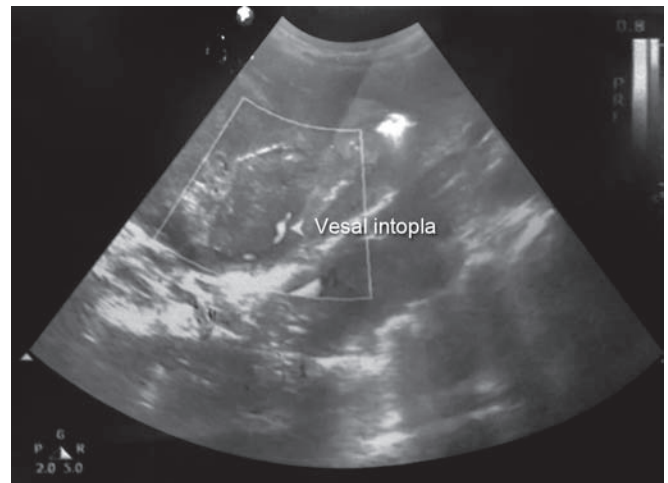


Fig. 4: Ultrasonography done on 13th day of methotrexate injection showing empty uterine cavity



Fig. 5: Placental tissue expelled on 5th postpartum day

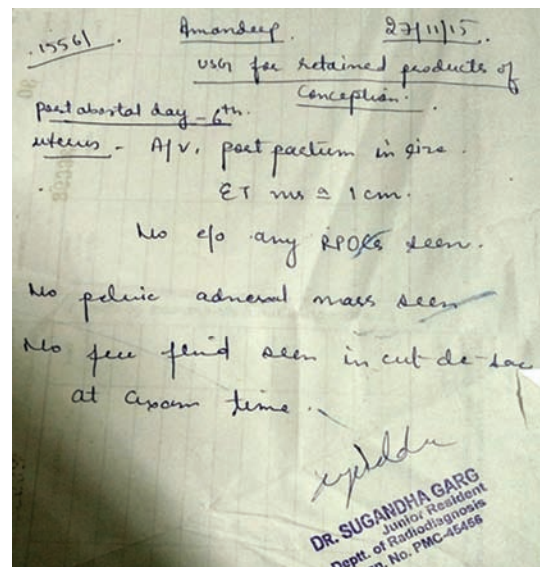


Fig. 6: Ultrasonography report showing no RPOCs on 7th postpartum day

single live male baby of 600 gm on 21 November 2015 at 8:15 pm. Placenta not expelled. Urgent USG got done along with color Doppler which diagnosed placenta accreta. Tablet mifepristone 200 mg given on 22 November 2015 followed by tab. misoprostol 400 mcg after 48 hours after which patient expelled placental tissue on 25 November 2015 (Fig. 5). Ultrasonography on 27 November 2015 confirmed empty uterus (Fig. 6).

### Case 3

A 19-year-old primipara referred from CH Ludhiana on 21 November 2015 following full-term normal delivery with root medio lateral episiotomy at CHC Masooran at 9:55 pm on 20 November 2015 with postpartum hemorrhage and left-sided perineal hematoma. There was no h/o prolonged labor, instrumental delivery, or manual removal of placenta. There was h/o postpartum

intrauterine contraceptive device. On arrival blood pressure was 90/60 mm Hg, pulse rate 108/minute was feeble, RR 20/minute, Palor +. Patient was resuscitated and taken up for immediate exploration. On exploration there was a large hematoma over the left lateral vaginal wall extending up to fornix which was drained. It was very difficult to explore the cervix and uterine cavity as cervix was highly pulled up but intact. Lower uterine segment was full of blood clots which were removed along with multiload Cu-T 375. It was difficult to reach the upper uterine segment. Procedure was abandoned due to very friable vaginal tissues and vaginal packing done. Ultrasonography suggested placenta accreta measuring 10\*5 cm, which was confirmed on color Doppler. Injection methotrexate was given after preliminary investigations. Patient was under supervision but she left against medical advice and lost follow-up.

#### Case 4

G2P1L1 patient came with 7 months 10 days POA with pain abdomen and leaking per vaginum with previous lower segment cesarean section. Patient delivered a preterm baby vaginally; placenta was not delivered. Manual removal of placenta was done under anesthesia. Small portion of placenta removed as piecemeal. Remaining part of placenta could not be taken out as it was adherent. Intrauterine packing was done. Urgent USG with color Doppler confirmed the diagnosis of placenta accreta. Injection methotrexate was given. After 36 hours the patient had severe bout of bleeding through packs. Patient was taken to operation theater. Packs were removed and attempt for placental removal done, but it was still adherent. Uterine packing was done again. Patient was then referred to higher center, PGI Chandigarh where her uterine artery embolization was done.

#### Case 5

P1L1A1 patient came to RHP on 31 October 2015 with referral from CH Mansa due to retained placenta with USG showing placenta accreta. Patient delivered a full-term female by vaginal delivery on 30 October 2015. On arrival patient was stable with minimal bleeding per vaginum but USG showing large placental tissue measuring 10 × 9 × 7 cm in fundal region invading myometrium. After preliminary investigations and under the cover of antibiotics inj. methotrexate 50 mg (I/M) was given. Follow-up USG on PPD 9 (1 week after inj. methotrexate) showed placenta accreta but with cystic areas and decreased color flow. Injection methotrexate was repeated and the following week USG showed placental tissue slightly decreased in size with multiple areas of cystic degeneration with only mild color flow. Then the patient was given tab. mifepristone 200 mg on PPD 21, following which repeat USG done on PPD 35 that showed placental tissue in uterine cavity with minimal vascularity. Till now, patient was asymptomatic. The patient was put on conservative management under cover of antibiotics and discharged with advice to follow-up. On weekly follow-up required investigations got done to rule out any sepsis. Patient expelled the placental tissue on 16 January 2016. Her USG done on 17 January 2016 showed empty uterine cavity.

#### DISCUSSION

Occurrence of placenta accreta is due to abnormal invasion at placental implantation site due to a defect in decidua basalis.<sup>1</sup> Principle risk factors for placenta accreta are placenta previa or previous uterine scars including

cesarean section and prior uterine curettage. Other risk factors are maternal age >35 years, multiparity, and prior uterine infections.<sup>2</sup> Though risk factors arouse suspicion of placenta accreta, the definite diagnosis is established by USG.

Various USG features of placenta accreta are:

- Irregularly shaped placental lacunae (vascular spaces) within the placenta;
- Thinning of myometrium overlying the placenta
- Loss of retroplacental clear space
- Protrusion of placenta into the bladder
- Increased vascularity of uterine serosa-bladder interface
- Turbulent blood flow through lacunae on Doppler USG.<sup>3</sup>

Traditionally, cesarean hysterectomy at the time of delivery has been the preferred management strategy for placenta accreta. This approach not only precludes future fertility but it is also a procedure synonymous with significant perioperative risks.<sup>4</sup> For women who wish to conserve their fertility, there are other nonsurgical conservative management options. These options include: (1) Leaving the placenta undisturbed with prophylactic antibiotics and uterotonics;<sup>5</sup> (2) medical management with methotrexate MTx acts by inducing placental necrosis and expedites a more rapid involution of placenta. This contradicts the belief that MTx acts on rapidly dividing cells given that trophoblast proliferation fails to occur at term;<sup>6</sup> (3) alternate medical management with mifepristone and misoprostol. Mifepristone causes decidual necrosis which leads to placental detachment;<sup>7</sup> The other strategies include (4) wedge resection of placental site<sup>8</sup> (if area of accreta is focal); and (5) bilateral uterine artery embolization.<sup>9</sup>

Follow-up to ensure resolution of placental tissue is done with combination of clinical assessment, USG examination, and serial hCG assay.<sup>8,10</sup>

#### CONCLUSION

Morbidly adherent placenta is not so rare these days and should be kept in mind even in pregnancies without any risk factors. When future fertility is desired, conservative management with methotrexate/mifepristone-misoprostol can be an option.

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