A Case of Placenta Accreta Percreta Following Wedge Resection of Cornual Ectopic Pregnancy

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RANZCOG Annual Scientific Meeting 2022 GOLD COAST

Transformation: Making Waves

Background

Disorders of placental adherence are becoming more common as the rates of Caesarean sections and advanced maternal age are increasing, both of which are risk factors for placenta accreta[1]. The incidence currently across Australia and New Zealand is estimated to be 44/100000 births[2]. There are three histopathological classifications[2]. Firstly, placenta accreta is invasion of the placental villi into the surface of the myometrium[2]. This is the most common and least severe form[2]. Placenta increta is invasion deeper into the myometrium, and percreta is the most severe form, with invasion beyond the myometrium into the serosa, and occasoinally into adjacent organs[2]. Placenta accreta disorders can lead to major life threatening haemorrhage, and as such need appropriate surveillance and management[3]. This usually involves hysterectomy at the time of Caesarean section, which has major implications for the future fertility of women diagnosed with a placenta accreta disorder[3].

Case Presentation, Investigations and Initial Management

A 35 year old female, G6P0 K26+6 presented with severe abdominal pain to her local hospital. She had no vaginal bleeding, membranes were intact and fetal status was reassuring. She had no other symptoms that indicated a cause for her pain and was haemodynamically stable. Her obstetric history was significant for an open wedge resection of a right cornual ectopic two years prior, with conservation of the right Fallopian tube. She had otherwise had two previous suction curettages for miscarriage. Her pregnancy had otherwise progressed normally up until this point. On presentation to her local hospital, she underwent an ultrasound that demonstrated 29mL free fluid in the abdomen, and a right sided fundal placenta with loss of the placental myometrial interface at the site of the previous wedge resection, concerning for a placenta accreta disorder, rupture or abruption. At this stage, the patient was transferred urgently to a tertiary hospital following administration of steroids. On arrival, magnesium sulphate loading was commenced. She underwent a tertiary ultrasound which demonstrated deficiency of the myometrium at the right cornua, with bleeding into the subserosal space and a small amount of fluid in Morrison's Pouch. The differentials at this stage were either dehiscence at the site of the wedge resection, or placental invasion into the scar. Given her severe pain and imaging findings, the patient was transferred to theatre for operative management.

Operative Management and Findings

The patient underwent an emergency laparotomy, Caesarean section and hysterectomy. Findings at laparotomy were of a 100mL haemoperitoneum, with a right cornual placenta accreta percreta. There was a small area of bleeding externally, but the uterus appeared grossly intact (Image A). The fetus was delivered breech via a classical incision, with the placenta left in situ (Image B). A hysterectomy was then performed (Image C). Histopathology showed a right cornual placenta accreta percreta with serosal perforation.

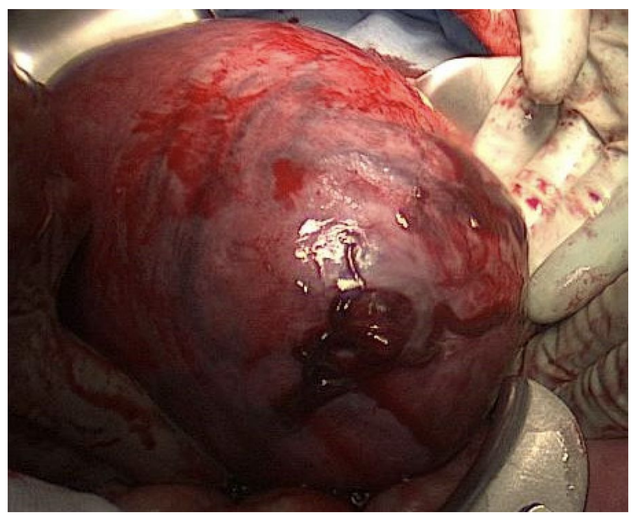

Image A: Placenta accreta percreta noted at time of laparotomy with small area of bleeding at point of perforation.

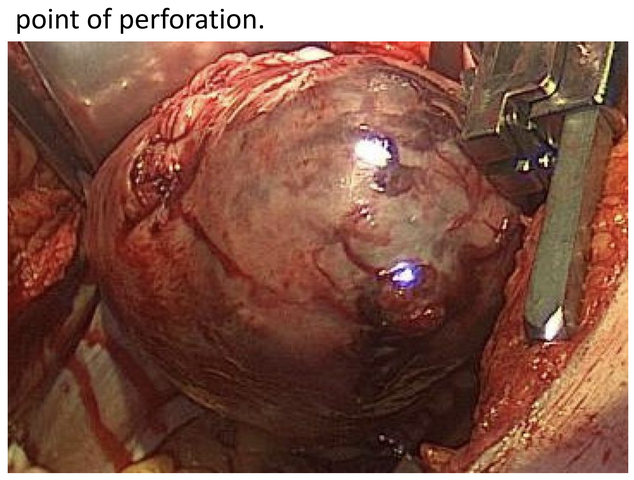

Image B: Placenta left in situ post Caesarean section

Image C: Uterus post hysterectomy with right cornual placenta accreta evident.

Discussion & Conclusion

This case demonstrates the vast spectrum of placenta accreta disorders, and ways in which they can present. These disorders are also associated with extensive maternal and neonatal morbidity and mortality[2]. One third of women with a placenta accreta disorder are admitted to ICU postoperatively[2]. With hysterectomy being the mainstay of treatment, future fertility is also significantly impacted[2,3]. In addition, there is a high preterm birth rate among women with placenta accreta disorders, leading to increased NICU admissions and poorer neonatal outcomes[2]. In this case, the patient recovered well postoperatively and did not require ICU admission. After an initial admission to NICU, the baby was discharged home from special care.

References

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