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## Title: A Case of Placenta Accreta Spectrum

**Introduction:** Placenta accreta spectrum is aberrant placentation characterised by abnormally implanted, invasive or adhered placenta. Accreta syndromes have significant contribution to maternal morbidity and mortality and they are leading cause of intractable intrapartum & postpartum haemorrhage and emergency peripartum hysterectomy.

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| **Objective** | **Highlight importance of early diagnosis through advanced imaging modalities such as ultrasound and MRI.** | **Outline multidisciplinary approach for optimal management , focusing on surgical techniques, blood loss prevention and peripartum care.** | **Promote best practices in antenatal care and delivery planning for patients at risk of PAS.** |

**Case Report:** A 32 years old female G2P1L1 ( previous LSCS ) presented at OPD at 32 weeks of gestation with USG suggestive of complete placenta previa. She had no history of bleeding p/v or pain abdomen . Repeat USG with colour doppler of placental bed was suggestive of placenta accreta syndrome with numerous placental lacunae showing hypervascularity. A decision was taken to terminate the pregnancy and perform Cesarean hysterectomy at 34 weeks of gestation by team of experts.

**INTRAOP Findings:** Abdomen opened by infraumbilical midline incision. Uterus – engorged dilated veins bulging in lower segment traversing towards dome of bladder , whole lower anterior uterine wall laterally upto the both side of broad ligament area was looking bluish with dilated vessels. Uterus was opened by classical incision. A live Baby of 2.1 kg delivered by breech extraction and cried immediately after birth .As clinically it was suggestive of placenta percreta intra op decision for caesarean hysterectomy was taken with placenta in situ. Bleeding from avulsed posterior bladder wall was managed by haemostatic suture. Histopathological findings also confirmed the diagnosis of placenta percreta .

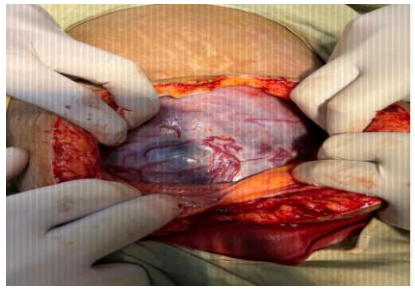

Fig 1 : Increase dilated blood vessels in LUS

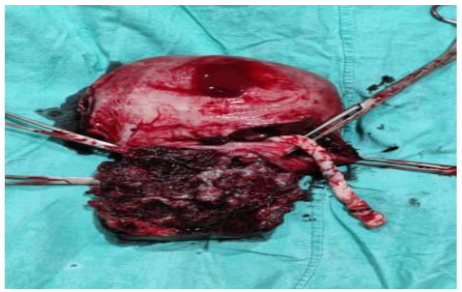

Fig 2 : Hysterectomy specimen with insitu placenta

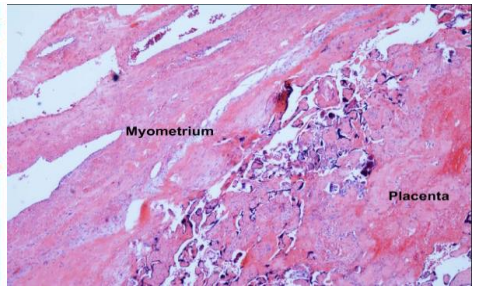


Fig 3 : Histopathological findings of placenta percreta

**Discussion:** The patient was apparently asymptomatic till 32 weeks of gestation when she presented on routine anc visit with a hidden life-threatening pathology which was revealed on critical evaluation with a perceived idea to avoid catastrophe. Our intense suspicion with radiological evidence guided us strategically to this pathology with a favourable fetomaternal outcome which on histology proved to be a case of placenta percreta approaching to bladder wall.

**References: Williams Textbook of Obstetrics**

**Declaration: All authors declare no conflict of interest.**

**Conclusion: This case highlights the complexity and critical nature of managing placenta accreta spectrum ( PAS ) , a life-threatening condition. As Cesarean delivery rates continue to rise globally, the incidence of PAS is expected to increase, emphasizing the need for heightened awareness and risk factor identification.**