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Title: A RARE UNSUSPECTED CASE OF PERFORATING PLACENTA PERCRETA IN A PRIMIGRAVIDA

INTRODUCTION

Adherent placenta accounts for 7-10% of maternal mortality cases worldwide.[1] Adherent placenta disorders, encompassing conditions like placenta accreta, placenta increta, and placenta percreta, pose significant threats to maternal health during pregnancy[2]. Placenta percreta, the most severe form of placenta accreta, is a rare pregnancy disorder in which the placenta penetrates the uterine myometrium and serosa and can invade the surrounding organs.[3] Women who are considered at risk of adherent placenta are those with placenta previa, 2 or more caesarean deliveries, advancing maternal age (≥35 yrs), second-trimester serum levels of AFP and free β-hCG greater than 2.5 multiples of median[4], previous uterine surgery, previous uterine curettage, multiparity. Here, we present the case of 27yrs old primi gravid with no known risk factors diagnosed intraoperatively to have placenta percreta.

CASE REPORT

- A 27 year old primigravida 38 week pregnancy with breech presentation came with complain of leaking per vaginum since approximately 3 hours and pain in abdomen and backache on and off since 1 day. Patient has 2 year married life conceived naturally. Patient was vitally stable.
- ***On examination***
- P/A-uterus 36 week size Head at fundus ,contraction ++, FHS-+/reg/150bpm P/V-Os 2cm dilated, cervix 10-20% effaced, Presenting part soft at -2 station with membrane absent.
- She had one antenatal 3rd trimester USG scan showing SLIUF with breech presentation with corresponding gestational Age and placenta fundoposterior with no abnormality.

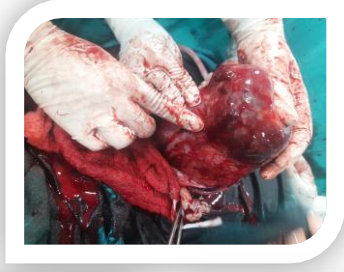
CASE REPORT

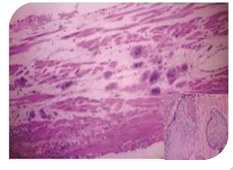
She was taken for Emergency cesarean section baby was delivered by breech and placental removal was attempted after failure of which the uterus was exteriorized. Uterus was 18-20 week size flabby with placenta tissue invading through myometrium breeching serosa at fundus. Piece meal removal of placental tissue was done and repair of uterine wall was attempted homeostasis could not be achieved. Patient was getting vitally unstable due to excessive blood loss. Immediate decision of obstetric hysterectomy was taken. ***Histopathology report showed hyperplastic edematous muscle fibre with large area of hemorrhage along with chorionic villi at perforated area invading myometrium up to Serosa.*** Patient and neonate are doing well after 3 month of surgery.

DISCUSSION

- Prenatal diagnosis seems to be a key factor in optimizing maternal outcome[3] . The initial method of diagnosis of placenta percreta is high resolution ultrasound with doppler subsequently confirmed with magnetic resonance imaging (MRI) Although our patient underwent antenatal ultrasonography examinations, adherent placenta was not diagnosed probably due to fundal location. There is an ongoing debate whether to go for cesarean hysterectomy or conservative management leaving placenta in situ with or without elective delayed hysterectomy[5] Which Depends on patient intraoperative vitals and hemorrhage, PPH, chances of infection, parity, desire to conserve fertility, health care facility.
- The role of a conservative approach with additional procedures such as injection methotrexate and UAE to decrease vascularity may be considered as a safe management option Therefore, detailed counseling of the patients, informed consent, and multidisciplinary approach for management is mandatory these cases for an optimum outcome.

IMAGES/ FINDINGS





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