

A Case Report on Placenta Percreta involving Urinary Bladder

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ABSTRACT

Placenta percreta involving urinary bladder is a lethal condition which can lead to significant blood loss. It is the one of the leading cause of intractable postpartum hemorrhage requiring obstetric hysterectomy. It is associated with increase in morbidity and mortality of both mother and fetus. It is significantly associated with previous cesarean delivery or uterine curettage. Hence, presenting a case report on placenta percreta involving bladder who underwent obstetric hysterectomy.

Keywords: Placenta previa, Placenta percreta, Urinary bladder.

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INTRODUCTION

Placenta percreta is a rare obstetric complication associated with significant blood loss. Normally placenta is separated from myometrium by decidual plate but in placenta accreta, placenta is directly adherent to myometrium due to absence of decidual basalis and abnormal development of nitabuch layer. In case of placenta increta placenta partially invades myometrium where as in placenta percreta villi penetrate myometrium completely with possible invasion to adjacent organ such as urinary bladder. Ten percent of placenta previa cases are associated with placenta accreta.

CASE REPORT

A 26 years old female, gravida 4, para 3, live issues 3, no abortion, with previous three cesarean sections with 24 weeks of pregnancy, was referred to Civil Hospital, BJ Medical College, Ahmedabad, as a case of scar dehiscence or placenta percreta. She had complaint of frank hematuria since 20 hours. There were no complaints of bleeding per vaginum or abdominal pain or leaking per vaginum. On admission

she was pale, having tachycardia and her blood pressure was normal. She was conscious, well oriented with per urethral catheter *in situ* with 50 cc blood in urobag. On per abdomen examination uterus was relaxed having abnormal contour, fetal parts were not felt properly and FHS were not located with stethoscope. On per speculum examination cervix was not visualized and per vaginum examination cervix was higher up and not palpable. On admission her hemoglobin was 7 gm%, platelets counts and white cell counts were normal. Renal functional test, prothrombin time was also within normal limits. Ultrasonography was done which showed loss of demarcation of plane between urinary bladder and lower uterine wall anteriorly with possibility of placenta percreta or uterine rupture. Maturity of fetus was 23 weeks 3 days and fetal cardiac activity was present. Patient was given 1 pint (350 cc) packed cell volume and taken in operation theater for laprotomy. General surgeon and urologist were called per operative. Peroperative there were dense adhesions between uterus, anterior abdominal wall and bowel (Fig. 1). Uterus was separated from overlying rectus muscles by sharp dissection. Uterus was having abnormal contour (Fig. 2). Transverse incision was kept on uterus and a live fetus of 800 gm weight was delivered out which died soon after birth and placenta was not separated. Placenta was occupying lower part of uterus encroaching anteriorly through anterior uterine wall toward urinary bladder involving dome of the bladder. There was torrential bleeding from placenta so box stitches were taken over placenta but still bleeding continued, so decision for obstetric hysterectomy was taken. Obstetric hysterectomy was carried in stepwise manner. Lower part of uterus looked like as if made up of placenta, was not well defined. Urinary bladder was also not clearly defined. There was placenta encroaching over dome of the bladder and lower segment could not be separated from the bladder (Fig. 3). While dissecting bladder from cervix 5 cm rent was found over dome of the bladder, 500 cc clots were removed from the bladder. After that bladder was repaired in two layers and obstetric hysterectomy was completed. Abdominal drain, suprapubic catheter and per urethral catheter were kept. Peroperative patient was given 3 pint packed cell volume and 4 pint fresh frozen plasma. Postoperative patient was stable and was given higher antibiotic. On 10th postoperative day, her stitches were removed and cystogram was done on

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Fig. 1: Peroperative dense adhesion found between anterior wall of uterus with anterior abdominal wall. Uterus separated from overlying rectus muscle by sharp dissection

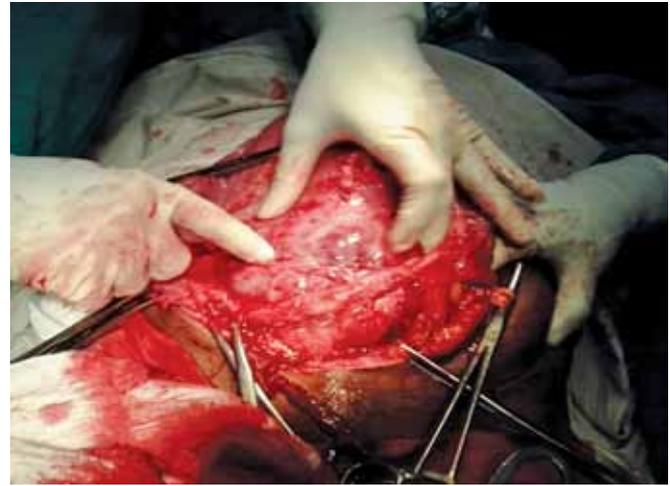


Fig. 2: Peroperative appearance of uterus

14th day which was normal. On 17th postoperative day, per urethral catheter and, on 21st day, suprapubic catheter were removed. Patient was stable on discharge. After one week of discharge, patient turned up for follow-up, patient was stable and had no complaints.

DISCUSSION

The management of placenta percreta involving urinary bladder is very challenging. Several factors need to be considered while managing placenta percreta including patient's general condition, gestational age, parity, and other morbidities.¹ Ultrasonography has 33% sensitivity, whereas, color Doppler flow has sensitivity of 100%, with, positive predictive value of 78% for diagnosing placenta accreta. However, MRI can diagnose placenta percreta better. Elevated D-dimer levels may predict significant amount of blood loss and morbidity.⁶

There can be two approaches while managing a case of placenta percreta with urinary bladder involvement,³ first, while doing cesarean section if bleeding is not significant cesarean incision to be closed with the entire placenta left *in situ* without any attempt to extract it. Methotrexate can be given postoperative.^{1,2} In few cases, placenta will spontaneously resorbed. In patients whom placenta is left intact after cesarean section are followed up by sonography for placenta absorption. However, if patient develops excessive bleeding few days after cesarean section, even after giving methotrexate then hysterectomy can be done. Second is opting for obstetric hysterectomy if torrential bleeding present along with internal iliac artery catheterization if possible for temporarily occlusion of blood supply.^{4,5}

Leaving placenta *in situ* may prevent massive hemorrhage and preserve fertility.



Fig. 3: Rent found in bladder dome at the time of dissection of bladder from cervix

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