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Placenta Accreta Managed by Total Hysterectomy in Tanzania: A Case Report

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Abstract

Background: Placenta accreta spectrum is one of the most serious complications of placenta previa, which is associated with maternal and perinatal mortality and morbidity. The management of placenta accreta includes the gold standard, Total hysterectomy, but occasionally conservative management can also be done. The incidence of placenta accreta varies in different studies from 1 per 272, 9 per 1000, and 4.3 per 10,000. The increase in the incidence of placenta accreta is directly related to the increased rates of previous cesarean section scars. The incidence of placenta accreta will also increase due to a history of previa. A case of Mrs. W.J.K a34 years G8 P4 + 3 at a gestation age of 40 weeks, with a history of three previous scars comes with presenting complaints of per vaginal bleeding for the past four hours, diagnosis of placenta previa was made on a clinical basis and obstetrics ultrasound, the patient was prepared for caesarian section and a female baby scored 7 - 10 weighted 2.2 kg was delivered and found also was placenta accrete were by it was difficulty in repairing uterus due to excessive bleeding from the placenta niche and finally total hysterectomy was done. The patient recovered well in the ward and was discharged on 3/11/2024 in good condition. **Discussion:** Lower section caesarian section followed by a hysterectomy has been shown to reduce the risk of poor fetal and maternal outcomes. Prenatal screening of pregnant women with risks by doing first, second, and third-trimester obstetric ultrasound and Planned delivery at 34+ and 36 + 6 has been associated with a significant reduction in bad obstetric outcomes. **Conclusions:** Placenta accreta is becoming an increasingly common complication of pregnancy. The reason for the rate increase is the increase in rates of the caesarian sections. Prenatal diagnosis is a key factor in Planning for the counseling, treatment, and outcome of women with placenta accreta. Cesarean hysterectomy is the gold standard and probably the preferable treatment. Conservative management can only be used in

highly selected cases.

Keywords

Placenta Accreta, Pregnant Women, Total Abdominal Hysterectomy, Case Report, Tanzania

1. Introduction

Placenta accreta is associated with a significant increase in maternal and perinatal morbidity and mortality. It is also associated with complications, which will end up with a cesarean hysterectomy, blood transfusions, sepsis, and other surgical complications. It is defined as the penetration of the trophoblast tissues through the decidua basalis into the underlying myometrium. [1] The incidence of placenta accreta varies between studies. One study done in the United States in 2016 revealed a higher incidence of 1 in 272 [2]. Other studies revealed the incidence of placenta accreta to be 4.3 per 10,000 patients, and a study done in Mania, Egypt, showed the incidence of 9 per 1000 patients [3] [4].

Among the risk factors for placenta accreta is an increase in the rates of previous scars [5]. Other risk factors that are associated with placenta accreta include increased maternal age, a previous history of placenta previa, grand multiparity, smoking, and chronic hypertension [4]. The diagnosis of placenta accreta can be made during prenatal times by taking a proper history and performing a physical examination. Risk factors can be identified in the early prenatal period. Ultrasound is the first-line tool for placenta accreta diagnosis and can be done in the first, second, and third trimesters. MRI is another emerging investigation used to diagnose placenta accreta [6]-[8].

Timing of delivery is important to patients with suspected placenta accreta to reduce fetal and maternal morbidity and mortality. The decision to deliver a patient with placenta accreta will always depend on the risk factors and ultrasound results identified during the prenatal period. Increased gestation age for the patient with placenta accreta is associated with increased complications during delivery. Several studies recommended that a patient with placenta accreta should be planned for delivery at the GA of 35 + 0 and 36 + 6 weeks [9].

Caesarian hysterectomy is the management of choice and the Golden method for the unplanned delivery of placenta accreta. It is associated with significant blood loss and possible surgical complications, so preoperative care should be done before the operation [10]. Apart from caesarian hysterectomy, conservative management can also be done for the patient with placenta accreta by leaving the entire placenta or part of the placenta in the uterus to control bleeding [11]. Above all, Methotrexate can be used as part of the medical management of placenta accreta [12].

2. Case Report

Case Description

W.J. K Registration number: 08-48-37, Age: 34 years, Marital Status: Married Occupation: Peasant; Address: Ngokolo-Shinyanga Municipal; Gravida 8, Parity: 4, living 4 + 3. 1. L.N.M. P 23/01/2024, E.D.D 29/10/2014, GA by date 40 weeks, Date of Admission: 29/10/2024 Date of Operation L. S.C.S and total hysterectomy was on 29/10/2024.

Date of Discharge: 3/11/2024, the patient was a self-referral from home.

3. Summary

A 34 years G8 P4 + 3 at a gestation age of 40 weeks, with a history of three previous scars comes with presenting complaints of per vaginal bleeding for the past four hours, diagnosis of placenta previa was made on a clinical basis and bed sound obstetric ultrasound, the patient was prepared for caesarian section and a female baby scored 7 - 10 weighted 2.2 kg was delivered and found also was placenta accrete were by it was difficulty in repairing uterus due to excessive bleeding and finally total hysterectomy was done. The patient recovered well in the ward and was discharged on 3/11/2024 in good condition.

3.1. Presenting Complaints

Per vaginal bleeding 1/7.

3.2. History of Presenting Illness

The patient had been doing fine up to almost four hours ago before admission when she started experiencing a sudden onset of vaginal bleeding, she reported that the bleeding was so severe that in the past four hours, she exchanged pieces of kanga three times and the kanga was completely soaked with blood, she reported that nature of bleeding was fresh, bright red blood and was painless. She reported that after excessive bleeding, she started experiencing general body weakness, heartbeat awareness, and dizziness, but she denied a history of losing consciousness. She reported having no history of having per vaginal discharge, pain during urination, or fever. She denied a history of accidents before the onset of bleeding. She reported experiencing normal fetal movements.

3.3. Review of Other Systems

All other systems were reviewed and were found to be essentially normal.

3.4. History of Index Pregnancy

Booked at the antenatal clinic at 28 weeks GA, she attended the antenatal clinic four times. Her weight was 62 kg, her Blood pressure was within the normal range, her booking hemoglobin level was 11.5 g/dl, and Syphilis and HIV were checked, and the result was negative. She was given prophylaxis mebendazole, Iron sulfate,

and Folic Acid. She didn't do any prenatal obstetrics ultrasound.

3.5. Past Obstetric History

She delivered the previous three pregnancies by cesarean section in 2017, 2020, and 2022 at the hospital. She reported that the reason for all those operations was due to cephalopelvic disproportion, and she reported having no complications during the operation and the puerperal period. Both children are alive, and they are doing fine.

3.6. Past Gynecological History

Menarche at age 13, 28-day cycle with normal light flow up to three days, no pain No history of using family planning methods, no history of sexually transmitted diseases.

3.7. Past Medical and Surgical History

No previous hospital admissions due to medical condition, no history of hypertension, no history of chronic/allergic rhinitis, no history of blood transfusion, no history of allergic reaction to food or drugs,

3.8. Family and Social History

She is married and living with her husband. She denied smoking or alcohol use, had no history of familial diseases like hypertension and diabetes in both paternal and maternal lineage, and had no other first-degree relatives with the same problem.

4. General Examination and Systemic Examinations

Alert, moderately pale, not dyspneic, not cyanotic, not dehydrated, has no palpable lymph nodes.

4.1. Vital Signs

Temperature 36.5 c. BP 90/60 mmHg. RR 21 Cycles per minutes. Heart rate 100b/m. The saturation pressure of oxygen in room air was 94%.

4.2. Abdominal Examination

Distended abdomen with sub-umbilical midline incision, Fundal height 38/40, mild tender on palpation, Longitudinal lie, Cephalic presentation, Level was 5/5. Liver, Spleen, and Kidney were not palpable, and bowel sound was heard and normal.

4.3. Per Vaginal Examination

It was not done because the patient was having excessive vaginal bleeding.

4.4. Cardiovascular System

Heart rate 100 beats/minute regular, full volume non collapsing, Blood Pressure

90/60 mmHg, no neck veins distension, apex beat at 5th intercostals space to the left midclavicular line, first and second heart sounds audible, with no murmurs or added sound.

4.5. Respiratory System

Respiratory rate 21 breaths/minute, normal chest contour, trachea centrally located, symmetrical chest expansion, chest with resonant percussion note, and vesicular breath sounds were heard on auscultation.

5. Provision Diagnosis

Three previous scars with placenta praevia.

Investigation

An urgent Full blood picture, grouping, and cross matching was done: Her hemoglobin level was 8.7g/dl, and she was blood type O positive.

At the bedside, an obstetric ultrasound was done, and it revealed grade 3 placenta previa. On the same day, the patient was prepared for an emergency caesarian section

6. Pre-Operative Management

- Two large borehole cannula size 14 were inserted, and intravenous fluid DNS alternating with lingers lactate 3 liters to run for the first 30 min.
- Two units of blood were prepared.
- Pre-operative antibiotics Ceftriaxone and Metronidazole were given before the operation.
- The informed consent form was signed by the patient.

In the theater, the procedure was done:

- In a supine position under General anesthesia, the patient was cleaned with spirit and povidone-iodine respectively and was draped sterilely.
- The abdomen was opened through a sub-umbilical scar after dissecting and removing the old scar.

Findings:

- Adhesion to the lower segments and the bladder was also found adhered in a well-formed lower segment of the uterus.
- Done:
- Adhesion lysis, which was followed by a lower segment cesarean section; a female baby, scored 7-10, and a weight of 2.2kg was extracted.
- Found placenta in the anterior wall, adhered to the muscles of the uterus; it was difficult to remove, and after removing a few parts, the patient continued to bleed profusely from the placenta bed. Oversewing was done to the placenta bed, but the patient continued to bleed.
- The decision was made to do a stepwise total hysterectomy, and finally, hemostasis was achieved.

- The abdomen was then closed into layers, and hemostasis was achieved.
- Intraoperative patient was given Oxytocin 10i.u Intramuscular and 20i.u Intravenously.
- She was also given two units of blood and an Injection of Tranexamic acid 1gm stat.
- Blood loss was approximately 1.7 Liters.

7. Post-Operative Diagnosis Was 3 Previous Scars with Placenta Accreta

Post-Operative Managements

The post-operative period was uneventful, without any complications. She controlled the full blood picture of day 3 post-operation, and her hemoglobin level rose from 8.7g/dl to 9.2g/dl. She was discharged on day 5 with hematinic, and later on, she followed up postpartum as per Tanzania guidelines.

8. Discussions

Abnormal placentation is a major cause of maternal morbidity and mortality worldwide. It is associated with maternal complications such as life-threatening maternal hemorrhage, large-volume blood transfusion, and peripartum hysterectomy [13]. Those complications occurred to our patient; she bled a lot and ended up with a total hysterectomy. Placenta accreta is defined as the penetration of the trophoblastic tissue through the decidua basalis into the underlying uterine myometrium; the degree of invasion into the myometrium is <50% [1].

The incidence of placenta accreta continued to increase as time went on, and it is likely to be related to the increased rate of caesarian sections [1]. One study done in the United States in 2016 revealed a higher incidence of 1 in 272. Other studies showed the incidence of placenta accreta to be 4.3 per 10,000 patients, and a study done in Mania, Egypt, showed the incidence to be 9 per 1000 patients [2]-[4].

Among the risk factors for placenta accreta is a previous caesarian section, and the risk increases as the number of caesarian sections increases. Literature reported that the rate of placenta accreta spectrum has risen from 0.24% in women with one previous cesarean delivery to 6.74% for women with five or more cesarean deliveries [14]. Our patient had three previous scars, so according to the literature, she had a >0.57% chance of having placenta accreta. Other risk factors for placenta accreta include a history of having placenta previa, a history of having submucosal myoma, Prior curettage, advanced maternal age, grand multiparity, smoking, and a history of chronic hypertension [4]. A prior history of placenta accreta has also been found to be a major risk factor for further placenta accreta.

Diagnosis of placenta accreta in our patient was made post total hysterectomy, where the placenta was found adhered to the uterus. We delayed diagnosing placenta accreta to our patient because she didn't do any prenatal obstetrics ultrasound, and she had three previous scars, which are the risk factor for placenta

accreta.

Literature suggested that placenta accreta should be considered in all patients with a previous history of placenta previa, patients with a history of previous caesarian section, and previous uterine surgery [4]. Our patient presented with three previous scars that are risk factors for placenta accreta. For all patients with risk factors for placenta accreta, the literature suggested that they should undergo a routine antenatal ultrasound. It was not done to our patients and led to delayed diagnosis. The reason for not doing routine prenatal ultrasounds was being unaware of the importance of prenatal ultrasounds. Tanzania antenatal care guidelines recommend at least 2 free antenatal ultrasounds for all pregnant women to ensure early diagnosis of placenta accreta and other obstetrics conditions.

An antenatal ultrasound will help in knowing the position of the accreta and the timing for delivery [6]. Currently, the recommended type of ultrasound is three-dimensional Doppler ultrasound, and sometimes Magnetic Resonance imaging to add some missing information [7] [8] [15].

Our patient was managed by caesarian hysterectomy, which was emergent, but the literature suggested that if the diagnosis is known, it is better to manage the patient by planned operation to avoid complications that may arise intraoperatively. This was not done to our patient because it was not diagnosed earlier. It is also suggested that planned caesarian sections should be done between 34+ and 36 + 6 gestation age because as the gestation age increases, the chances of complication also increase. Our patient was late because she was operated on at 40 GA [16].

Apart from hysterectomy, conservative management can also be done in patients who aim to preserve their fertility. This is done by leaving the entire placenta or part of it or removing the placenta accreta niche to control bleeding. It was not done to our patient because she didn't need more children; she had four children at the time of the operation. This method is associated with a lot of complications, including postpartum hemorrhage, post-operative intravascular coagulopathy, and infection, and may require laparotomy. Conservative management is used together with adjuvant methotrexate, though its role is unknown [11] [12] [17].

9. Conclusions

Placenta accreta is becoming an increasingly common complication of pregnancy. The reason for the rate increase is the increase in rates of the caesarian sections. Prenatal diagnosis was found to be a key factor in Planning for the counseling, treatment, and outcome of women with placenta accreta. Cesarean hysterectomy is the gold standard and probably the preferable treatment. Conservative management should only be used in highly selected cases.

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Obstetrics and Gynecology and the theater team for their support.

Consent for Publication

Written informed consent was obtained from the patient for publication in this case report.

Authors' Contribution

Augustino Maufi managed the patient and drafted the manuscript; Daniel Shishi, Martin Adriano, Abduel Mdee, Emmanuela Hope, and Stella Ntobisangu managed the patient and contributed to manuscript writing, and they critically reviewed and contributed to the manuscript. All authors read the final draft of the manuscript and approved publication.

Conflicts of Interest

The authors declare no conflict of interest related to this publication.

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