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ADHERENT PLACENTA PREVIA;
OUTCOME OF ABNORMALLY

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ABSTRACT… Background: Abnormally adherent placenta is a condition in which all or part of the placenta is adherent to the uterine wall because of myometrial invasion by chorionic villi. In majority of cases chorionic villi are in contact with the myometrium i.e. placenta accretes. **Objective:** To detect the prevalence of morbidity adherent placenta and its outcome in terms of maternal morbidity and mortality. **Period:** Over one year from October 2006 to October 2007. **Setting:** Gynaecology Unit-II, Nishtar Hospital, Multan. **Material and methods:** All women who had pregnancy complicated by morbidity adherent placenta were identified and their case notes retrieved. Information was collected on a prescribed Performa designed for this purpose. **Results:** There was 2114 deliveries during the study period in labour ward of Nishtar Hospital, Multan. Eight women fulfilled the study criteria. The prevalence was found to be 0.4%. Complications were PPH, acute renal failure, depression, cellulities of wound site and UTI. **Conclusion:** Due to rising rate of LSCS in present era, the prevalence adherent is also on raise.

Key word: Abnormally adherent placenta, Disseminated intravascular coagulation,

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INTRODUCTION

Abnormally adherent placenta is a condition in which all or part of the placenta is adherent to the uterine wall because of myometrial invasion by chorionic villi. In majority of cases chorionic villi are in contact with the myometrium i.e. placenta accrete. In placenta increta there is extensive villi invasion in to the myometrium. Percreta defines the condition in which invasion extends to or through the uterine serosa.

Adherent placenta was rare previously but the prevalence has risen considerably. Placenta accrete is associated both with placenta previa and advanced maternal age[l].. One of the major risk factors is uterine scarring[2]. Scarring can be due to previous caesarean sections, uterine curettage, manual removal of placenta etc. rarely, abnormal adhesion may be due to Asherman syndrome and sub mucous fibroid or other conditions like multiparity which causes defective myometrium. Antenatal diagnosis using color flow Doppler[3] and MRI can be made.

As postpartum hemorrhage (PPH) is still one of the major causes of morbidity and mortality in our society. This study was conducted to detect the prevalence of morbidity adherent placenta and its outcome in terms of maternal morbidity and mortality.

MATERIAL AND METHODS

Over one year from October 2006 to October 2007 in Gynaecology Unit-II, Nishtar Hospital, Multan all women who had pregnancy complicated by mortality adherent placenta were identified and their case notes retrieved. Information was collected on a prescribe Performa designed for this purpose. Information included age, parity, time of diagnosis, history of vaginal bleeding, association with placenta previa, investigations done, type of management given. Maternal outcome was assessed in terms of complications like PPH, wound infections etc, and maternal morbidity.

RESULTS

There were 2116 deliveries during the study period in labour ward of Nishtar Hospital, Multan. Eight women fulfilled the study criteria. The prevalence was found to be 0.4%. Complications were PPH,

acute renal failure, depression, cellulites of wound site and UTI.

Age (years)	No. of cases	%
14-20	-	-
21-30	2	25.0
31-35	5	62.5
35 & above	1	12.5

Table-I. Age distribution

Parity	No. of cases	%
1	-	-
2	1	12.5
3	4	40.0
4 & above	2	25.0

Table-II. Parity wise distribution

History	No. of cases	%
Previous 1 c/sec	_	-
Previous 2 c/sec	7	87.5
D & C	1	12.5

Table-III. Past surgical history

Procedure	No.	%
Abdominal hysterectomy with conservation of both ovaries	6	75.0
Over sewing of placental site	1	12.5
Uterine artery ligation	1	**12.5**

Table-IV. Surgical treatment given

Complication	No. of cases	%
Major Severe primary PPII	1	12.5
Acutetubular necrosis	1	12.5
Minor Wound infection	1	12.5
Urinary tractinfection	1	12.5
Mental depression	1	12.5

Table-V. Complications

DISCUSSIONS

The prevalence of placenta accreta was found to be 0.4%. Mean age was 34 years. Due to trend of early marriages in our society, this is the age when women are mostly multiparous. Most of the women were multipara i.e. 50%, history of prior 2-3 lower segment caesarean section was seen 87.5% of cases which makes this a strong predisposing factor. History of D& C was present in 12.5% of patients which points the fact that placenta accrete can be caused by defective deciduas. All the cases were associated with major degree placenta previa. Two among 8 cases were diagnosed antenataly by colour Doppler.

Regarding management 75% of cases underwent total abdominal hysterectomy with conservation of both ovaries. In 12.5% of cases bleeding was controlled by over sewing of implantation site. Uterine artery ligation was undertaken in 12.5% of cases successfully to control haemorrhage. No maternal mortality was observed in this study.

One patient in whom uterus was conserved had severe PPH. She was reopened without delay and obstetrical hysterectomy was done. Other patients had minor sort of complications like two patients had wound infection, might be due to poor nutritional status and prolonged surgery. One out of 8 patients had mental depression due to loss of her reproductive capability.

Efforts should be made to diagnose the condition before surgery. On USG myometrium appear to be less than 2 cm in thickness at placental site. Colour Doppler reveals persistent blood flow between the basal placenta and the myometrium. MRI is useful in the presence of posterior placenta, for assessing deep myometrium, parametrial and bladder involvement of when ultrasound findings are equivocal. Preoperative diagnosis helps in making the required arrangements for surgery.

There is a wide range of management options like to leave the placenta in situ and monitor provided no PPH, methotrexate can be administered? , over sewing of placental site resection of implantation site if possible. Step wise devascularization may be faithful in expert hands. Obstetrical hysterectomy is often required particularly when bleeding site is lower uterine segment.

CONCLUSIONS

Due to rising rate of LSCS in Present era, the prevalence adherent placenta is also on rise. This is a life endangering situation but in skilled hands

and fully equipped centers mortality can be 0%.

REFERENCES

1. Miller DA, Choller JA. **Clinical risk factors for PP/pkacenta.** Am J Obstet Gynaecol 1997; 177: 210-4.
2. Zaki ZMS. **Risk factors and morbility in patients with PP accrete composed to PP nonacreta.** Acta Obstet Gynaecol 1998; 77: 391-4.
3. Twickler DM, Lucas NJ. **Color flow imaging for myometrial invasion inwomen with prior C/section.** J Matern Fetal Med 2000; 9: 330-5.
4. Herman A, Zinermat A. **Ultrasound.** Obstet Gynaecol 2002; 19:278-81.
5. Krapp M, Baschat A, Hankelin M. **Gray scale and colour Doppler sonography in the third stage of labour for early detection of failed placental separation.** Obstet Gynaecol 2000; 15: 138-42.
6. Levin D, Hulkda CA. **Placenta accrete evaluation with color Doppler, power Doppler and MRI.** Radiol 1997; 205: 773-6.
7. Arulkkumaran S. **Medical treatment of placenta accrete with methotrexate.** Acta Obstet Gynaecol 1986; 65: 285-6.
8. Clark SL, Phelan JP, **Hypogastric artery ligation for Obstet haemorrhage.** Obestet Gynaecol 1985; 66(3): 353-6.
9. Strong TH. **Obstet haemorrhage, obstetrics intensive care.** A practical manual. Phildelphia 1997.

PREVIOUS RELATED STUDY

Zoona Saeed, M. Ikram, shazia Tazian, M. Saeed, Roohi Saeed. PLACENTA PREVIA (Original) Prof Med Jour 16(1) 139-144 Jan, Feb, Mar 2009.

"Friends are born, not made."

Walter Winchell

AUTHORSHIP AND CONTRIBUTION DECLARATION

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