

## A Case of Placenta Accreta with Scar Dehiscence Managed

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**Abstract:** *Placenta Accreta is a major cause of maternal morbidity and mortality. It is an abnormal placental invasion encompassing placenta accreta increta and percreta. we present a case report of placenta accreta in which we could save both the mother and baby with prompt clinical diagnosis and prompt management. The management includes internal iliac artery ligation and hysterectomy.*

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### I. Introduction

Placenta accreta is abnormally adhered placenta to the uterus. Classified as placenta accreta, increta and percreta. Accreta is when placental villi are attached to the myometrium. Placenta Increta is invasion of placental villi into the myometrium. Placenta Percreta is when placental villi fully penetrate the myometrium including cases breaching the serosa and invading the surrounding structures, such as bladder, broad ligament or sigmoid colon.(1) here we present a case report of a female with antenatally diagnosed placenta accreta with scar dehiscence managed promptly to save both mother and child.

### II. Case Report

A 30yrs old female, came referred to us with Gravida 3 para 2 living 2 previous two LSCS one 6years back next 5years back. With 37.3 weeks of gestation with USG suggestive of morbidly adherent placenta. On admission patient had tachycardia hypotension, patient had pallor. Per abdomen examination uterus was term with cephalic presentation. Uterus was irritable and a healed Pfannenstiels scar was seen with scar tenderness. Fetal heart sound was heard on doppler. On per speculum examination cervix and vagina were found to be healthy. There was no leaking per vaginum. Cervical os was closed on per vaginal examination. Tachycardia was persistent so decision of emergency caesarean section was taken. CVTS surgeon was informed for internal iliac artery ligation. Adequate blood and blood products were arranged. Anesthesia pediatrician urosurgical teams were informed. With all required consents patient was shifted to OT with preoperative medication and Foleys catheterization. Patient was taken for emergency LSCS within 1 hour of arrival. Midline vertical incision was taken and abdomen was opened in layers previous LSCS scar dehiscence was seen. Incision taken through the placenta and a male baby of 2.6kgs was delivered which was handed over to the pediatrician for further management. Uterus was then exteriorized, placenta was found to be adhered to the anterior wall of uterus. Blood transfusion was started. Placenta was also adhered to bladder. Decision of internal iliac artery ligation taken and was done under supervision of CVTS surgeon. Bleeding was partially controlled so decision of hysterectomy was taken. subtotal hysterectomy was done. Urosurgeon confirmed bladder patency and a methylene blue dye test was done which was found to be normal. An intraperitoneal drain was secured. And abdomen was closed in layers. Intra operative 5 pint packed cell, 4 pint fresh frozen plasma were transfused. Patient was monitored in ICU for 24 hours. Patient was started with orals on post operative day 1 and was discharged with stable vitals and healthy suture line with a healthy male baby.

### III. Discussion

Incidence of placenta accreta has increased 13 fold. Women with prior cesarean section with placenta previa as well as placental implantation over the prior scar in current pregnancy have highest risk of placenta accreta.(2). Timing of delivery must be individualized, but generally around 34-35 weeks of gestation. even with early and accurate prenatal diagnosis, hysterectomy remains the most common surgical procedure in placenta previa accreta (3). Alternative approaches, such as leaving the placenta in situ without hysterectomy, have increased risk and should be reserved for patients who strongly desire for preservation of fertility. Planned caesarean hysterectomy with no attempt of removal of placenta is the treatment of choice. In emergency prompt action can save lives of both mother and baby.

### References

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