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Case Report

Placental Accretism in a Rural Place. A Case Report

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Abstract

We reported a case of a pregnancy without a regular prenatal control that developed a very serious hemorrhage that was solved only by the skill of the practitioners and the anesthesiologist. We underscore the importance of the adequate prenatal control to avoid this kinds of emergencies totally avoidable and the use of spinal anesthesia in order to keep the patient awake and avoid accidents related with a patient not well prepared to go under general anesthesia.

Keywords: *Placental Accretism; Vaginal Bleeding; Maternal Morbidity*

Introduction

Few things are so dangerous as a non-controlled pregnancy. Anything could happen and without prenatal control, the obstetrician do not have information enough to make a right decision. In this cases is necessary a high level of suspicion besides a high level of training and skills by the obstetrical team to solve the emergency without fetal and maternal morbidity and mortality. In spite of the international recommendations against this attitudes for the patients and the efforts of the different medical systems to encourage a right prenatal control, there are still cases that come at Hospital with an unchecked gestation and a pregnancy emergency and obligate the physicians on duty to react quickly enough, not always with the best outcomes.

Case Report

She is a pregnant woman of 28 years old, first pregnancy.

Among their personal health background, she suffered of chronic anemia without evident cause and hypothyroidism. She took oral iron and levothyroxine 50 mcg once a day. She did not have relevant gynecological diseases either.

Her first prenatal control was at 9.3 weeks of gestational age. She did totally 6 prenatal controls, two of them with a family physician who in the last control at 34 weeks of gestational age asked an obstetrical ultrasound study that the patient did not performed.

She had an only ultrasound evaluation at 25 weeks of pregnancy and this ultrasound describe a placental location posterior and right side of the uterus. The study does not say nothing special about the placental implantation.

At 35.4 weeks of gestational age she came to the emergency service with moderate to severe vaginal bleeding. Under speculum inspection, an intense vaginal discharge of blood was seen.

At the vaginal examination, she was with a 5cm of cervical dilation, the cervix was 50% effaced, not rupture of membranes, fetal heart rate positive, and very intense uterine contractions.

Under suspicion of possible placental abruptio, the obstetrician decides to perform immediately a cesarean section under spinal anesthesia. The cesarean section was done without complications, the newborn was vigorous, Apgar score 6/8 and weight 2.800 grams and 36 weeks of gestational age by physical examination. The newborn did not need ventilatory assistance.

The problems started at the time of placental extraction. An abnormal placental adherence is noted that not allow the normal placental extraction with the characteristics of placental accretism (Figures 1 and 2). Besides, the uterus started to be atonic in spite of the administration of oxytocin and carbetocin. In front of this situation and before the patient started to develop a hemorrhagic shock, a subtotal hysterectomy was decided and performed successfully. A Kehr tube was left in the Douglas space exteriorized by vagina.

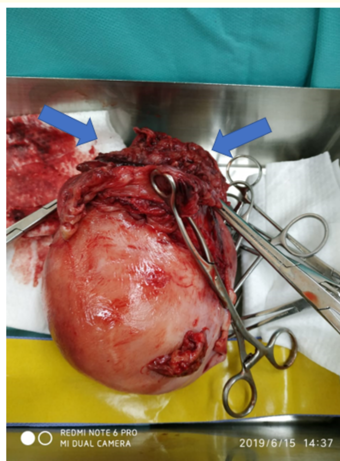

Figure 1: *We can see the places of abnormal placental implantation (arrows)*

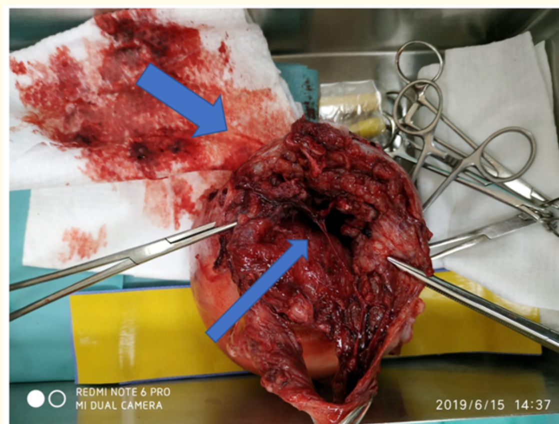

Figure 2: *The areas of abnormal placentation are showed more clearly (arrows).*

The immediate postoperative hematocrit was 23% and 7.3g of hemoglobin concentration. The patient received a blood transfusion of two units of red blood cells, 2 grams of cephalosporine preoperative and 1g additional 12hs post surgery. No compromise of the urinary tract was observed. She recovered well and was discharged from Hospital 72 hours later.

Discussion and Conclusion

This is a very clear example about something that should not happen in a modern obstetrical assistance. From our point of view, there are two main points to be underscored in this case. The one is the lack of prenatal control. It continue happen in spite of the efforts of the medical systems and the International recommendations. In a previous study from one of the authors about late fetal mortality [1], in a sample of 72.000 deliveries were found 1.200 fetal deaths. The average of prenatal control among the cases of fetal death was zero. No deaths neither in labor nor at entry to the Hospital. All the cases came to the Hospital with the fetus dead. This study underscore the importance of good and timely prenatal control.

Take in account that also in this case, the international guidelines about optimal finalization of pregnancies with abnormal placental implantation confirmed or suspected, is a scheduled cesarean section between 34 and 36 weeks of gestational age with a several precautions that are not the focus of this report [2,3]. This patient obligated to the medical team to suspect the probability of abnormal placental implantation as one of the probably diagnosis and perform an emergency cesarean section without any previous preparation because of the intense bleeding presented at emergency room.

Another problem in this case, is the probably difficulties to make a diagnosis of abnormal placentation when the placental insertion is posterior. It could be the reason by which a non expertise imagenologist could not to make the diagnosis of accrete.

The second problem and not less important was the decision of the anesthesiologist to perform the cesarean section under spinal anesthesia. This decision allowed to perform the surgery under a good anesthesia and mainly to keep the patient awake avoiding the probably complications of a general anesthesia in a non prepared patient and without a previous Mallampatti score [4,5].

Again, we think that it is a good example about things that should not happen at the present time. Luckily, all the procedure ended well because the skill of the practitioners and the smart criteria of the anesthesiologist. But, regrettably, not always is like this.

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