



Post Cesarean Placenta Increta

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ABSTRAK

Perdarahan post partum masih merupakan penyebab utama mortalitas dan morbiditas persalinan. Angka kejadiannya sekitar 5 % dari persalinan normal. Perdarahan post partum dapat dibagi atas perdarahan post partum dini jika terjadi sebelum 24 jam pasca persalinan ; terutama disebabkan karena laserasi vagina, atonia uterus, retensio plasenta, dan koagulopati. Dan perdarahan post partum lambat jika terjadi setelah 24 jam post partum ; dapat disebabkan oleh retensio plasenta, sub-involusi, dari tempat implantasi, lisis bekuan dan trombus.

Laporan kasus ini mengenai seorang wanita 28 tahun dengan kehamilan 43 – 44 minggu yang menjalani seksio sesarea atas indikasi makrosomia. Meskipun operasi berjalan lancar, pada hari ke lima post seksio sesarea timbul perdarahan dari jalan lahir. Setelah dilakukan kuretase dan tampon utero-vaginal tetap terjadi perdarahan, maka dilakukan histerektomi subtotal. Pemeriksaan histopatologi menemukan suatu plasenta inkreta.

Kata kunci: perdarahan post partum, plasenta inkreta

INTRODUCTION

Post partum bleeding is still a major cause of mortality and morbidity during delivery.^{1,2,3} Post partum bleeding defined as 500 – 1000 ml blood loss after vaginal delivery or more than 1000 ml after cesarean section.¹ The incidence is about 5 % in normal delivery. Post partum hemorrhage can be classified as primary if occurred within the first 24 hour usually caused by vaginal laceration, uterine atony, placenta retention, or coagulopathy; and secondary if occurred after 24 hours, usually within 5 to 14 days with mean at day 7. It can occur after placental retention, sub-involution of placenta implantation site and in incision site, lysis of clot and thrombus. It is occurred more commonly in primipara.^{1,2}

Retained placenta is a common cause of postpartum hemorrhage. The etiology can be functional such as weak contraction, adhesive placenta or abnormal placental site: placental accreta, increta, percreta. These abnormal placental site caused by absence of whole or part of decidual base and improperly developed fibrous tissue, allowing invasion of placental villi into myometrium (accreta) or penetrate through myometrium (percreta).^{1,2,5} The adhesion can be total - all cotyledon invades the myometrium, or partial or focal. The incidence was 1 in about 7000 deliveries.⁵

The problem may occurred at delivery, especially during placenta delivery. Bleeding depends on depth or width or the amount of adhesive cotyledon. In total adhesion, the bleeding is minimal or not occurred until placental manual procedure. Total adhesion can cause uterus inversion after pulling the cord, and also placenta delivery failure.^{2,6} Partial or focal adhesion usually caused more bleeding because of

partial removal in placental implantation site, and residual cotyledon after placental manual. The management consist of hysterectomy and blood transfusion.

Hysterectomy is operative approach to evacuate whole or part of uterus (excluding cervix). Finney (John Hopkins University) indicates that this operation was for life saving, to eliminate symptoms and deformities. Hill and Beischer reported that hysterectomy was done in uncontrolled postpartum hemorrhage.⁷⁻¹⁰ This paper featured a case of hysterectomy done in 5th day after cesarean section because of undiagnosed placenta increta. The proper diagnosis and management, complication, prognosis and social aspect will be discussed.

CASE REPORT

A 28 year-old woman was sent by local midwife with lower abdominal pain. The amnion was already ruptured. She had 5 ANC visits at Kombos PHC and the last one at Manado General Hospital. USG and NST was scheduled three days later, but she failed to come. She married for one and half years; her last menstrual period was November 5th, 2000. Her pregnancy is about 43 to 44 weeks. She never had abortion before. Vital signs were within normal limits. Body height was 156 cm and the body weight was 64 kg. The fundal height was 37 cm with left back cephalic presentation. Estimated fetal weight was about 4000g. Fetal heart sound was decreasing and intrauterine resuscitation was done followed with emergency cesarean section.

A female baby was born, 4080g, 51 cm, with APGAR score 3-5-7; there was slight meconium and 40% infarction of placenta. No bleeding was found. Uterus, both fallopian tube





and both ovaries were normal. After surgery, patient was in good condition. On fifth day post surgery, the patient had vaginal bleeding. The blood pressure was 100/60 mmHg, pulse rate was 96 and her hemoglobin was 6.4 g/dL. Uterus contraction was not good, treated with uterotonic injection; fundal height was 2 fingers below umbilicus. Three bags of whole blood transfusion was given.

There was still bleeding. Blood pressure dropped to 90/60 mmHg and the patient became anemic. Curettage was done, evacuating rest placenta but there was still bleeding even though tamponade had been done. So laparotomy was done : the uterus was as big as baby's head with weak contraction. The bleeding came from placental site at posterior corpus uteri. No bleeding from cavum abdomen or low segment incision. Subtotal hysterectomy was done. The patient condition was good after operation. The histopathology finding on myometrium was normal smooth muscle cells invaded by placental tissue. There was fibrin with focal necrosis and inflammation. No neoplasm was found. Conclusion: placental increta.

DISCUSSION

This case was primipara, 28 years old, 43-44 weeks of pregnancy, first stage of labor; intrauterine fetal, singleton, alive, cephalic presentation, macrosomia, with decreased of fetal heart sound. Macrosomia was diagnosed from fundal height (37 cm - Johnson's rule is 4030g).

The patient had vaginal bleeding 5 days after operation. The conjunctivae were anemic.

This is a late postpartum hemorrhage that could happen between 5th to 14th day postpartum, usually on 7th day, because of clot lysis and thrombosis removal.^{1,3} At inspection, the bleeding was from external os. There was no vaginal laceration and also no incision bleeding. Fundal height was 2 fingers below umbilicus and hemoglobin was 6.2 g/dL. It was uterine atony. Predisposition factor of uterine atony are low nutritional status, uterine muscles' weakness, deliveries under anesthesia and overdistended pregnancy.^{1,2,3}

This patient had overdistended uterus and anemia.

The management of uterine atony is uterus massage, uterotonic (oxytocine 10 IU IM and 40 IU in 500ml normal saline/ RL), intravenous fluid for restoring fluid and drugs delivery. If bleeding still continues and the uterus cannot contract well,

bimanual compression can be done. Misoprostol 400mg can also be given per rectal to induce contraction. If still unsuccessful, ligation of uterine arteries can be done. If the bleeding still continues, hysterectomy is the last choice.³

This patient had cesarean section; so vaginal laceration, trauma, uterine rupture, and uterine inversion can be excluded. Residual placenta is the common cause of late postpartum hemorrhage, especially in primipara; trophoblast invading the myometrium can cause sub-involution and perform thrombus recanalization after delivery.^{1,2}

This case had already have uterine massage and uterotonic also had been given; but there was rebleeding. Evacuation of about 300 ml of clot and placental tissues from cavum uteri has been done digitally; continued by curettage. This patient was prepared for laparotomy, to seek other causes of uncontrolled bleeding.^{7,8} The histopathology finding was placental increta. This condition is difficult to detect on prenatal examination and can only be diagnosed properly by histopathology that showed invading villi chorialis into myometrium. Placental implantation can be totally or just partially invaded. In total condition there will be less or no bleeding until manual placenta procedure. Inversion of uterine can occur during pulling out the umbilical cord, and also at placental removal.⁸ Partial or focal condition usually cause more bleeding.

MANAGEMENT

This case was managed with hysterectomy due to uncontrolled bleeding. Subtotal hysterectomy was chosen to minimize bleeding.^{3,4} The outcome depended on the correct timing of hysterectomy and blood transfusion. Methotrexate can help in focal placental accreta, but its efficacy and safety is uncertain.¹ Hysterectomy was delayed because of misdiagnosis. Since there were no difficulties in placenta delivery during the cesarean section, abnormalities on placental implantation were not considered. Placental increta can be diagnosed only by histopathology examination.^{5,7}

PROGNOSIS

Postpartum hemorrhage is still unpredictable despite careful attention. It is still an important cause of maternal death. This case got a 'dubia ad bonam' prognosis, both for the mother and the baby. ♦

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