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Case Report

RARE CASE OF PLACENTA PREVIA ISTHMICOCERVICALIS, DIAGNOSED 40 HOURS AFTER CESAREAN SECTION. CASE REPORT

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ABSTRACT

Placenta previa is characterized by the abnormal placenta overlying the endocervical os. It is one of the most feared adverse maternal and fetal-neonatal complications in obstetrics.

The condition is frequently complicated by placenta accreta or increta. Women with placenta previa have often an increased risk of postpartum hemorrhage. The risk factors for placenta accreta are previous uterine surgery, as cesarean sections (CS)., dilatation, curettage, the advanced maternal age, multiparity etc.

A 31-year-old woman, P.T.S., who went in for delivery with moderate bleeding from the genitals and regular labor. Childbirth with cesarean section was performed (C.S), because of intrapartum asphyxia of the fetus. A female fetus was born, weighing 3270 g. Finding that the placenta is located on the posterior uterine wall and descends to the cervical canal. Immediately after CS, profuse bleeding from the uterus begins. After a control revision of the uterine cavity, cervical placenta was established. An emergency total hysterectomy without the adnexa was performed. It must be known that any bleeding during the third trimester of pregnancy, low blood counts and worsening general conditions of the woman should be considered as a warning of possible placenta previa isthmicocervicalis.

Key words: Placenta previa isthmicocervicalis, placenta accreta, placenta increta, postpartum hemorrhages

INTRODUCTION

Placenta previa (PP) is characterized by the abnormal placenta overlying the endocervical os, and it is known as one of the most feared adverse maternal and fetal-neonatal complications in obstetrics (1, 2).

The condition is frequently complicated by the invasion of placental villi beyond the decidua basalis causing placenta accreta or increta (3). Placenta increta can unexpectedly lead to catastrophic blood loss, multiple complications for the mother and the baby, and even death (4). Thus, women with placenta previa have often increased the risk of postpartum hemorrhage (PPH).

The risk factors for placenta accreta are previous uterine surgery, as cesarean sections (CS)., dilatation and curettage. Multiple cesarean sections may be present in over 60% of placenta accreta cases. Placenta accreta consists around 10 % of all cases of PP. The advanced maternal age, multiparity, Asherman syndrome can be a leading risk factors for PP. (5-7). A thin decidua can also be a risk factor for trophoblastic invasion. Some studies suggest that the rate of incidence is higher when the fetus is female. (8) The early and accurate diagnosis and the appropriate management is very important for reduction the complications for the mother and the baby. Bleeding during the third trimester can be a warning sign for placenta accreta existence.

Premature delivery is the primary concerns for the baby.

As for the mother, the primary concern usually is bleeding during manual removal of the placenta, which can cause massive obstetric hemorrhage and be life threating. It occurs after delivery, when manual removal of the placenta is difficult or fails.

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Data from 15-year analysis of peripartum hysterectomy was associated with mortality rate of 12,5% and urinary tract injury rate of 7,5% (9).

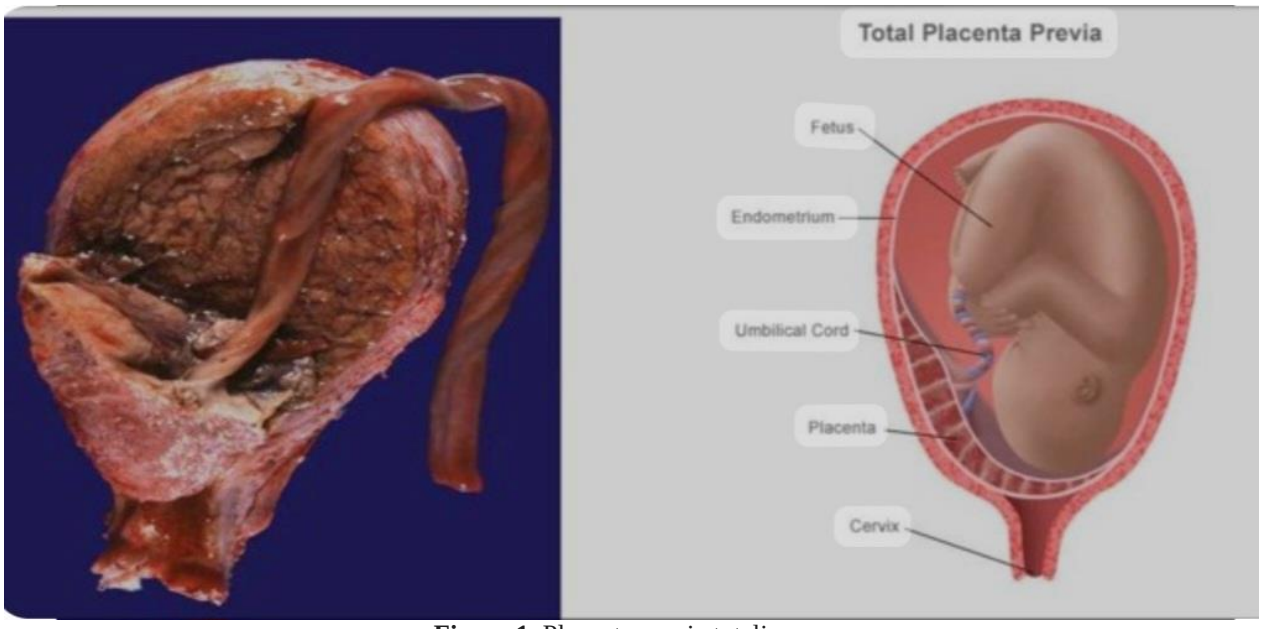

Figure 1. Placenta previa totalis

CASE REPORT

A 31-year-old woman, P.T.S., disease history (DH) N 2062/2023, who went in for delivery at 10:50 a.m. on 8/03/2023, with moderate bleeding from the genitals and regular labour.

From the examination: Opening of the cervical canal -6-7 cm, preserved amniotic sac.

Childbirth with cesarean section was performed (C.S), because of intrapartum asphyxia of the fetus. A female fetus was born, weighing 3270g. Finding that, the placenta is located on the posterior uterine wall and descends to the cervical canal. Immediately after CS, profuse bleeding from the uterus begins.

Laboratory results upon admission at the hospital : WBC: 12.0, RBC: 3.37, HGB : 0.35., HCT: 0,305. HGB values are 110 g/l, with a gradual decrease to 66g/l.

A consultant was summoned by republican emergency. After a control revision of the uterine cavity with a large obstetric curette, it was established that it is a cervical placenta.

HGB : 66 g/l. Performed hemotransfusion of 4 blood banks. Emergency LHT was performed without the adnexa. In parallel, resuscitation measures were taken. On the second day after the operation, the patient regained her peristalsis and began to breastfeed the new-born on her own. Blood parameters are still in the lower limits of the norm.

Figure 2. Placenta previa isthmicocervicalis intra operacionem

At 7- the day after the operation, the patient was discharged in good general condition, together with the child.

Laboratory results upon discharge: WBC: 8.81, RBC: 3.8, HGB: 112, HTC: 0.345.

Histological examination N 138-151:
Endocervix - blood stasis with perivascular hemorrhages. Placenta with scars for involution and degenerative changes, diffuse fibrinoid deposits, hemorrhages. Placenta and uterine wall with data of placenta accreta and placenta increta

DISCUSSION:
This case ends favourably for the mother and the child but raises many questions about the risk factors and groups, the possible complications, the behaviour in emergency conditions and, above all, about the early diagnosis (prenatal). It should be known that women with multiple previous CSs, dilatations and curettage, dead fetus, myomectomy are main risk groups for placenta previa. The thin decidua is a major factor in trophoblastic invasion.

Any bleeding during the third trimester of pregnancy, low blood counts and worsening general condition of the woman should be considered as a warning of possible placenta previa isthmicocervicalis. In the presence of these symptoms and risk factors, CS should be performed immediately, in the interest of the mother and the fetus.

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