Early second trimester incomplete abortion with undiagnosed placenta accreta encountered as an acute gynecological emergency: a case report

Abstract

Placenta accreta spectrum (PAS) are life-threatening obstetrical conditions, which may have catastrophic outcomes when encountered in the emergency setting. We present a case of a 36 yo G4P3003 at 14 weeks 4 days who received prenatal care at outside facility who had passage of incomplete abortion at home and brought in hypotensive shock with active vaginal bleeding. Massive transfusion protocol was started and patient was brought to operating room and proceeded with suction dilation and curettage. Despite removal of products of conception confirmed with US guidance; brisk heavy bleeding continued with use of multiple uterotonic. The decision was made to proceed with abdominal hysterectomy with removal of anatomic uterus that was bivalved in OR showing abnormal placentation later confirmed with pathology. Patient postoperative course was uneventful; extubated from surgical ICU and discharged 3 days later. We wish to highlight the importance of astute clinical practice and timely decision making by the Ob/Gyn team in the presentation of a critical patient with placenta accreta encountered in the early second trimester.

Keywords: placenta accreta, abortion, vaginal bleeding, dilatation

Background

PAS are a range of abnormal placentation with disruption of the decidua basalis enabling invasion of chorionic villi into or past the myometrium; leading to incomplete placental separation and hemorrhage. Planned cesarean section with hysterecstomy is mainstay of management when encountered in term patients of which diagnosis is elicited. The correct diagnosis of accreta spectrum by ultrasound and MRI remain speculative but has shown greater accuracy in later 2nd trimester imaging between 18-24 weeks with close to 90% accuracy based on population-based studies. Clinical guideline management of this condition are limited to term or near term deliveries; with no clearly defined process for PAS if encountered in spontaneous abortion or early term loss. For these atypical patients who present with risk factors and signs of PAS; high suspicion and prompt response by the obstetric and gynecological team is key to prevent morbidity and mortality of parturienty.

Case summary

A 36 yo G4P3003 at 14 weeks 4 days by reported EDD is evaluated within 1 hour of fetus and other passage of products of conception (POC) in her home with presenting symptoms of heavy vaginal bleeding and hypotension with noted vital signs of 80mmHg/40mmHg. Patient was from an outside prenatal facility and did not present with collateral. Past medical and obstetric history was significant for previous three cesarean sections. Upon evaluation the patient received 1000mcg of Misoprostol rectal and the massive transfusion protocol was started with multiple peripheral lines and 3 units of PRBC. Lab work was significant for hemoglobin of 10.9(g/dL) and hematocrit of 30.7%. Coagulation profile of PT/PTT and INR were normal. Once stabilization of patient vital signs with blood and crystalloid; Patient was consented for dilatation and curettage; possible laparotomy and possible hysterectomy. Patient was noted to still be continuously bleeding on passage to OR and while being prepped intra-operatively. During the procedure remaining POC were evacuated and empty endometrial strip was noted on bedside ultrasound, with minimal improvement to brisk and heavy bleeding; prompting the use of additional uterotonic 0.25mg Methergine and 250mcg Carboprost. Despite the continued resuscitation with ongoing blood transfusion, fresh frozen plasma, platelets, and empty uterine cavity, copious bleeding was noted to be pouring from the vagina and patient vital signs again became hypotensive. The decision was made to proceed with abdominal laparotomy with hysterecstomy in order to control hemorrhage. Extensive adhesions were noted from the abdominal rectus to the anterior uterine serosa and bladder. Supracervical hysterectomy was performed and the uterus was found to be atonic; bivalve of gross specimen revealed adherent placenta pathology (Figure 1). Patient was brought to surgical intensive care unit, extubated the following day, with no complications in post-operative course with discharge on POD#3. Patient received in total 7 units of PRBC, 4 units of platelets and 1 unit of fresh frozen plasma. Histological evaluation revealed disruption of decidua basalis with invasion of chorionic villi into myometrium confirming diagnosis of placenta accreta (Figure 2).

Figure 1 Demonstrates the gross specimen of uterus showing no separation and clear plane between placental bed and endometrium as designated by instrument in figure. Tagging of suture to morbidly adhered placental bed was used to aid pathologist in diagnosis.
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Upon diagnosis in antepartum in patients with high liklihood of PAS, development of preoperative plan is paramount. The goal of this is to provide information and plan interventions that will reduce the risk of massive hemorrhage, as well as its substantial morbidity and potential mortality with delivery modality of cesarean hysterectomy. One case from literature details a placenta percreta encountered at 14 weeks with intra-abdominal bleeding, which was managed conservatively with continuation of pregnancy until 35th week where elective cesarean with hysterectomy performed. Although limited to case reports, management of these conditions from late first to early second trimester to the third trimester may become more pronounced as earlier diagnosis of these conditions improve.

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Conflicts of interest

The author declares there are no conflicts of interest.

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References