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Short Communication

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Severe Preeclampsia and Placental Accreta: the evolution, complications and management

Abstract

Almost 37 weeks pregnant with twins with PROM and preeclampsia operated three times in less than 18 hours, the first one for PROM and transverse twins, the second was a hysterectomy for placenta increta and the third was laparotomy due to hemoperitoneum, the preeclampsia was managed according to current protocols. The patient was medical discharged in good condition together with her babies. The development of the case shows what was done from admission to her discharge in one week. This case show us some lessons.

Keywords: severe preeclampsia, placental accreta, pregnant, twins

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Alejandro Siu Au PhD, MD,[1] Diego Siu Chang MD[2]

[1]PhD, MD, Obstetrician Gynecologist, Former Head of the Department of Gynecology & Obstetrics of the Hospital Nacional Arzobispo Loayza, Principal Professor of the Universidad Peruna Cayetano Heredia, Peru

[2]MD, Surgeon, Resident of Gynecology & Obstetrics of the Universidad Peruna Cayetano Heredia in the Hospital Nacional Arzobispo LoayzaL, Peru

Correspondence: Alejandro Siu-Au, PhD, MD, Obstetrician Gynecologist, Former Head of the Department of Gynecology & Obstetrics of the Hospital Nacional Arzobispo Loayza, Principal Professor of the Universidad Peruna Cayetano Heredia, Peru, Tel +51 999661002, Email alejandro.c.siu@gmail.com

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The case

Very interesting case and with teachings of a patient with Severe Preeclampsia and Placental Accreta, the evolution, complications and management of it. Some time ago I wrote an article "Things that Must Not Be Done in Gynecological and Obstetrics".[1] However, this clinical case shows us correct actions that were taken supported by highly qualified medical staff in a properly equipped Medical Center. Could contribute to discussion.

A 49-year-old patient was admitted to Clínica San Felipe (CSF) Lima-Peru South America on June 21, 2023 with the diagnoses of Primigravida 37 weeks pregnant with twins, severe preeclampsia and PROM.

Pregnancy obtained by treatment with High Complexity Assisted Reproduction with adequate development up to 35 weeks, where she began to present elevations in her systolic blood pressure up to 160 and diastolic up to 95 and eventual headaches. She began to be managed with nifedipine, acetaminophen (allergic to NSAIDs) and low sodium diet. Upon reaching 37 weeks, she presented Premature Rupture of Membranes for which she was admitted to CSF and her blood pressure was found to be 165/100 and edema in the lower limbs. She underwent primary transverse segmental caesarean section during the night of her admission, obtaining two female products of 2,400g and 2,500g. respectively both in transverse situation and adequate apgar. In the manual extraction of the placentas, the first one came out without difficulty, but the second one remained 15% adhered to the surface of the myometrium, which forced a curettage, managing to extract the placenta and leaving the myometrium smooth to later perform the hysterorrhaphy, and close the abdominal wall in layers.

In the immediate postoperative period, she presented profuse vaginal bleeding that did not stop despite uterine massage and intravenous oxytocin. Despite transfusions of 4 red blood cells, 2 plasma and plasma expanders, her heart rate fluctuated between 130 and 148 beats per minute, her blood pressure remained between 140/70 and 100/60. She also administered Magnesium Sulfate 4 grams as a bolus and continuous intravenous infusion. The bleeding was active and did not seem to stop, so it was decided to re-operate with an exploratory laparotomy where a subinvoluted and flaccid uterus was found: a total hysterectomy was performed. While the patient was intubated in the second surgery, the pressure decreased to 80/40, and the uterine arteries were ligated, the heart rate decreased and normalized to 80 beats per minute, the vaginal vault was sutured, peritonized, and closed in layers. She went to the Intensive Care Units where over the course of hours, she developed arterial hypertension and was managed with beta-blockers and calcium channel blockers, however, she began to present tachycardia and abdominal pain. An abdominal ultrasound was taken, these one showed a fluid collection greater than 600cc, possibly blood. She underwent surgery again for the third time in almost 18 hours after the first surgery. Little but continuous bleeding we found from the right angle of the vaginal vault, abundant clots and free blood in the cavity, calculating a total of 800 cc. Transfixing sutures were placed in the bleeding areas, resorbable compresses (Gelfoam) were also applied to that area, peritonization was performed, and the abdominal wall was closed in layers. The Pathological Study reported: Scarce placental remnants adhered to the myometrial surface and some chorionic villi in superficial myometrium compatible with Placenta Increta (grade 2). I must mention that during her prenatal check-ups nothing led to suspicion of the existence of placenta accreta, therefore, the proceedings of the case were not taken.[2,3]

After the third intervention, she was hospitalized for 6 days before she was discharged, four days of which she was in the Intensive Care Unit. In the course of those days, she observed improvement and normalization in liver enzymes, creatinine, hemoglobin, whose minimum value reached 6.1grs, and other blood indicators and biological markers. She was managed with inotropes, Magnesium Sulfate, antihypertensives, antibiotics and what is stipulated in the preeclampsia protocol.[4,5]

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Comments

It is a very illustrative case that leaves us valuable lessons.

Timely managed and treated preeclampsia saves lives and decreases mortality. Placenta increta should not be treated conservatively, the uterus must be removed. When suturing patients with pregnancy-induced hypertension, pay attention to blood pressure, because when arterial hypertension reappears or recovers, the sutures could loosen.

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Conflicts of interest

The authors declare that they have no conflict of interest.

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