



Placenta Accreata without Placenta Previa. Clinical Conservative Management: Case Report

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Abstract

Conservative treatment and hysterectomy after cesarean section, which is the gold standard, are applied in placenta accreta spectrum (PAS) with a high maternal mortality rate. Two cases with PAS without placenta previa which was successfully treated conservatively were presented. For diagnosis of PAS obstetricians focus on placenta previa or low-lying placenta and previous C-section history, however, 1/3 of all cases are diagnosed with PAS without placenta previa. The gold standard in the treatment of PAS is hysterectomy. In this case, conservative treatment in tertiary centers has been shown to be successful. Obstetricians should not just focus on placenta previa. Conservative treatment modalities should be performed in tertiary centers.

Keywords: Placenta accreta spectrum, conservative treatment of placenta accreta, placenta accreta spectrum without placenta previa

INTRODUCTION

Placenta accreta is a condition resulting from abnormal invasion of the trophoblast into the myometrium (1). Placenta accreta spectrum (PAS) includes three forms: placenta increta, placenta accreta and placenta percreta graded by the invasion of the placenta. Maternal morbidity and mortality can result from severe and sometimes life-threatening hemorrhage, often requiring blood transfusions. Therefore, prenatal diagnosis is very important. Placenta accreta is often associated with factors such as endometrial injury, advanced maternal age, number of pregnancies, and increasing parity. A number of previous cesarean deliveries increase the risk of placenta accreta spectrum. There is a consensus in many literatures that PAS is seen together with placenta previa. However, the incidence of PAS is not uncommon without previa. Cesarean section followed by hysterectomy is the gold standard of PAS treatment. Conservative treatment methods are not widely used. Uterine preservation and expectant management; removal of the placental tissue, leaving uterus in place or leaving partially or totally *in situ* are

the conservative treatment methods described in the literature. Informed consent was obtained from the patients.

CASE PRESENTATIONS

Case 1

The patient was 29 year-old pregnant woman with a history of gravida 2, parity 1 (presented 38 weeks and 4 days by vaginal delivery) and no abortions. During her first pregnancy and delivery, she did not experience any complications. In the second pregnancy, the first trimester combined test aneuploidy screening test was low risk, blood pressure blood sugar, liver and kidney function tests were normal, TORCH and ELISA were negative, body mass index (BMI) was 18. In the 22nd week prenatal ultrasound scan, it was found that the normal hypoechoic region between the placenta and myometrium disappeared, there was a decrease in the retroplacental myometrial thickness (less than 2 mm) and there were a large number of vascular lacunae in the placenta. The placenta was in the anterior wall of the uterus and no previa or low-lying placenta was present Figure 1.



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Cite this article as: Jafarzade A. Placenta Accreta without Placenta Previa. Clinical Conservative Management: Case Report. Eur Arch Med Res 2023;39(2):126-129

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Received: 24.12.2022

Accepted: 25.03.2023

Magnetic resonance imaging (MRI) was performed at 33rd week of pregnancy and the same findings were found in the ultrasound. The patient has no history of cesarean section, *in vitro* fertilization (IVF) and uterine surgery, no signs of placenta previa or low-lying placenta insertion. A 75 mg screening oral glucose tolerance test (OGTT) was performed and the result was normal. The patient had lung maturation with corticosteroids before the operation. Cesarean section performed at 37 weeks and 1 day. After the fetus was removed, the placenta inserted in the anterior surface of the uterus and the fundus was attempted to be removed manually with a halas. Before removal of the placenta, there were 2 areas on the anterior surface of the uterus, approximately 6 cm in diameter, consisting only of serosa (no endometrium and no myometrium). After the placenta was removed, the mentioned areas shrank by 1-2 cm (Figure 2).

Bilateral tubal ligation was performed at the request of the patient. Approximately 600-700 cc of bleeding was observed during cesarean section. No early complications were observed. The patient did not need any blood transfusion. The patient's entry and postoperative 6th hour hemoglobin levels were 11.6 and 10.8, respectively. The patient was discharged 48 hours after surgery.

Case 2

Twenty-nine-year-old pregnant woman with a history of 2 gravida 1 spontaneous abortion. During pregnancy, blood sugar, liver and kidney function tests were normal, TORCH and ELISA were negative, BMI was 19.5, and there is no hypertension. The first trimester combined test aneuploidy screening test was low risk. Placental location was in the fundus-posterior uterus. Prenatal level 2 screening was normal. A 50 mg screening OGTT was performed and the result was normal. Spontaneous vaginal



Figure 1. The placenta in the anterior wall of the uterus and show like placenta accreta spectrum

delivery was performed by lateromedial episiotomy at 39 weeks and 3 days. It was waited for 20 minutes for the spontaneous postpartum separation of the placenta. As spontaneous separation did not occur, ultrasonographic examination was performed and PAS was suspected. MRI was performed which revealed the PAS without placenta previa Figure 3. On MRI, the uterine thickness at the invasion site of the placenta was approximately 5 mm.

In the patient without vaginal bleeding, it was decided to apply the expectant method, which is defined as leaving the placenta completely *in situ*. Amoxicillin and clavulanate potassium 1000 g were started orally. After 5 days of hospitalization, control ultrasound revealed that the placenta size decreased to 5x6 cm and there was no bleeding. The patient was discharged and called for control every 3 days. Infection markers were detected as negative during the controls. Twenty-three days after delivery, the placenta was expelled out spontaneously. Control ultrasound showed no rest after spontan expelled placenta inside the uterus.

DISCUSSION

PAS is a term combining various degrees of abnormal trophoblast invasion into the myometrium of the uterine wall (2). Previous cesarean section, previous uterine surgery, low lying placenta and placenta previa are important risk factors for PAS (3,4). The risk of PAS increased with increasing number of cesarean deliveries (5). In both cases we presented, there was no history



Figure 2. Uterus after removing the placenta. There are no myometrium and endometrium

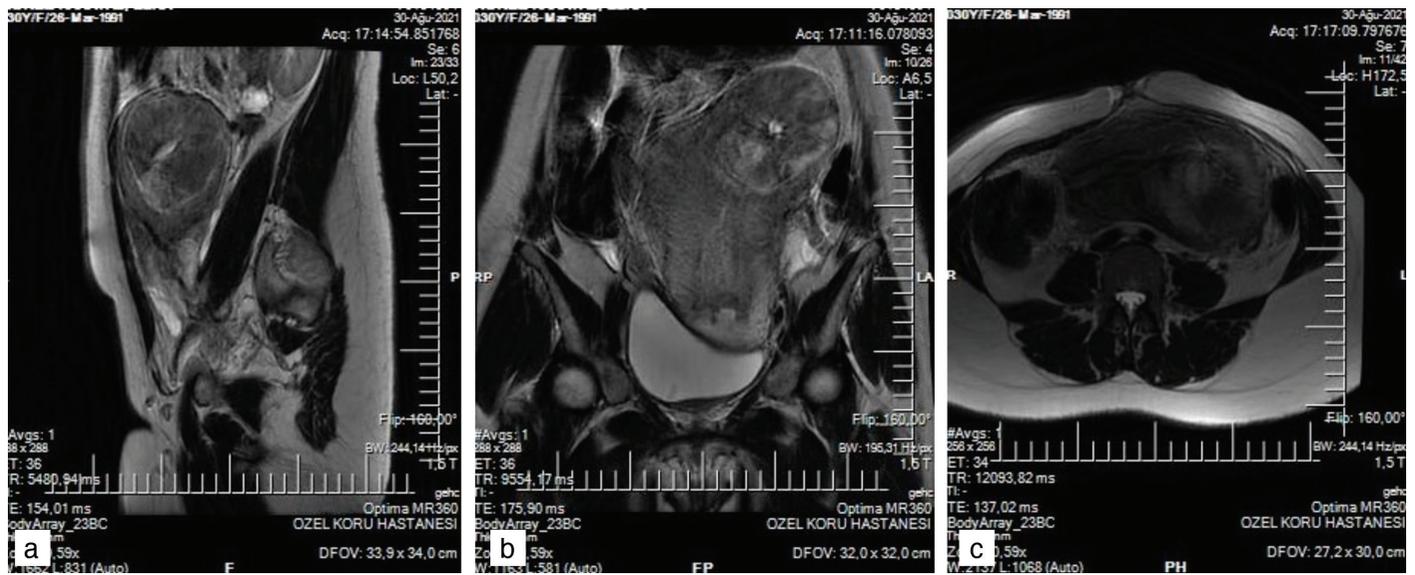


Figure 3. (a-c) Magnetic resonance imaging of the uterus with placenta postpartum 1st hours

of cesarean section, IVF, and uterine surgery, as well as evidence of placenta previa or low-lying placenta insertion. For diagnosis of PAS obstetricians generally focused on placenta previa or low lying placenta and previous C-section history, whereas some authors have shown that there were no any placenta previa in 30% of patients with histologically spectrum of placenta accreata managed by hysterectomy (6). Some studies report that the non-previa PAS group is more likely to conceive via IVF or undergo prior operative hysteroscopy than the previa PAS group, and the incidence of classical hysterectomy is higher than the cystectomy-previa PAS group (6). Hemorrhage and severe morbidity rates were similar to patients with placenta previa. However, these patients should be referred to PAS centers for a multidisciplinary approach. Treatment of PAS is mainly consist of surgery-hysterectomy. Cesarean hysterectomy is considered the gold-standard treatment for invasive accreta (7). However, a high complication rate is observed in this form of treatment (8). Conservative treatment of PAS should be selected and decided individually for the patient. There are four different forms of conservative treatment PAS: the extirpative technique (manual removal of the placenta), the expectant approach (leaving the placenta *in situ*), one-step conservative surgery (removal of the accretal area), and the triple-P procedure (suturing around the accretal area after resection). There is insufficient evidence about the efficacy and safety of methotrexate therapy to recommend its routine use in all PAS (9) cases. Conservative treatment was preferred in both cases we presented. In case 1, as the placenta was located in the anterior fundus of the uterus, the placenta was removed and the invasion sites were sutured if necessary. Bilateral tubal ligation was performed at

the request of the patient. Therefore no sutures were made. In case 2, conservative treatment modalities can be tried in appropriate patients. Since no bleeding was observed in case 2, we preferred the treatment of leaving the placenta *in situ*. Antibiotics were started against the possibility of infection, and the patient was followed closely against the possibility of bleeding. This article presents successful results of conservative treatment modalities in PAS patients. However, we argue that such treatments should only be performed in tertiary centers and that patients should be approached in a multidisciplinary manner.

CONCLUSION

Hysterectomy is one of the PAS treatment options, but only a multidisciplinary approach is performed for good patient outcomes. Conservative treatment modalities of PAS can be applied in tertiary centers and their success rates are high.

Ethics

Informed Consent: Informed consent was obtained from the patients.

Peer-review: Externally peer-reviewed.

Financial Disclosure: The author declared that this study received no financial support.

REFERENCES

1. Usta IM, Hobeika EM, Musa AA, Gabriel GE, Nassar AH. Placenta previa-accreta: risk factors and complications. *Am J Obstet Gynecol* 2005;193:1045-9.

2. Silver RM. Clinical features and diagnosis of placenta accreta spectrum. Up to Date. 2021.
3. Tantbirojn P, Crum CP, Parast MM. Pathophysiology of placenta creta: the role of decidua and extravillous trophoblast. *Placenta* 2008;29:639-45.
4. Khong TY. The pathology of placenta accreta, a worldwide epidemic. *J Clin Pathol* 2008;61:1243-6.
5. Silver RM, Landon MB, Rouse DJ, Leveno KJ, Spong CY, Thom EA, et al. Maternal morbidity associated with multiple repeat cesarean deliveries. *Obstet Gynecol* 2006;107:1226-32.
6. Carusi DA, Fox KA, Lyell DJ, Perlman NC, Aalipour S, Einerson BD, et al. Placenta accreta spectrum without placenta previa. *Obstet Gynecol* 2020;136:458-65.
7. Sentilhes L, Kayem G, Chandraharan E, Palacios-Jaraquemada J, Jauniaux E; FIGO Placenta Accreta Diagnosis and Management Expert Consensus Panel. FIGO consensus guidelines on placenta accreta spectrum disorders: Conservative management. *Int J Gynaecol Obstet* 2018;140:291-8.
8. Einerson BD, Branch DW. Surgical management of placenta accreta spectrum. *Clin Obstet Gynecol* 2018;61:774-82.
9. Farasatinasab M, Moghaddas A, Dashti-Khadvaki S, Raoofi Z, Nasiripour S. Management of abnormal placenta implantation with methotrexate: a review of published data. *Gynecol Obstet Invest* 2016;81:481-96.