ISSN: 0976-3031

Available Online at http://www.recentscientific.com

CODEN: IJRSFP (USA)

International Journal of Recent Scientific Research
Vol. 8, Issue, 3, pp. 16240-16241, March, 2017

International Journal of Recent Scientific Research

DOI: 10.24327/IJRSR

Case Report

PLACENTA PERCRETA INVOLVING THE BLADDER: A CASE REPORT

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DOI: http://dx.doi.org/10.24327/ijrsr.2017.0803.0108

Article History:

Received 16th December, 2016 Received in revised form 25th January, 2017 Accepted 23rd February, 2017 Published online 28th March, 2017

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INTRODUCTION

Placenta percreta in early pregnancy involving the urinary bladder is a rare condition. It is potentially a life threatening condition because of its propensity for severe haemorrhage. Antenatal diagnosis can be done with USG, MRI and/or cystoscopy. In the management of placenta percreta the primary consideration is to control lethal haemorrhage. We present a case of placenta percreta with bladder involvement necessitating hysterectomy with repair of bladder.

Case Report

A 26 year old 4th Gravida, Para 1+2 presented with hematuria at 16 weeks gestation at our clinic. Her first delivery was by cesarean section for foetal distress. She had two miscarriages at 16-18 week gestation following which curettage was done. She had 3 similar episodes of hematuria before coming to our hospital for which she was admitted and treated conservatively at some nursing home. On admission at our centre her pulse rate was 128/min., BP-130/60 mm of Hg, she had marked pallor and her systemic examination was normal. Uterine size was proportional to gestational age. Her Hb was 6.3 gm/dl, renal and liver function test were normal and her fasting blood sugar was 88 gm/dl. Her USG scan showed complete placenta previa covering the internal os. She was treated conservatively. Indwelling catheterization was done, 2 units of packed cell transfusion were given along with haemostatics.

She remained hemodynamically stable and her hematuria resolved within 72 hours. She was keen to continue her pregnancy. She was kept in hospital for observation. She had a bout of hematuria after 4 days. Cystoscopy was done by urologist- there was vascular fleshy mass in the bladder. Due to recurrent bouts of bleeding laparatomy was decided. A senior anaesthetist, urologist were also present during the operation. On opening the abdomen there was no cleavage between uterus and bladder. Placenta was infiltrating into the bladder wall. Internal iliac ligation on both sides, cystostomy and partial resection of bladder was done. Hysterectomy was performed and bladder was repaired in two layers. 8 units of blood was transfused. A suprapubic catheter and urethral catheter were kept in the bladder and abdomen closed in layers. The post operative period was uneventful and she was discharged on the 12th post operative day in good condition.

DISCUSSION

Placenta percreta invading into the bladder has an incidence of 0.1-1 per 10,000 births. Surgical treatment is extremely difficult with a maternal mortality rate of 5.6-10%, secondary to haemorrhage, infection and damage to adjacent organs. Major risk factors for placenta accreta include placenta previa, prior uterine scarring, advanced maternal age and multiparity. Correct antepartum diagnosis of this serious condition is essential to plan the best line of management. USG and MRI are very good diagnostic tools.

Bilateral internal iliac ligation, uterine incision away from placenta for delivering the baby, leaving the placenta in situ or hysterectomy, excision of bladder and repair are good and important measures to reduce blood loss.

Daniel Frasca[1] and Zachary L Smith[2] had similar observations. In Journal of Pioneering Medical Sciences[3] there was a case report with similar findings and they had performed subtotal hysterectomy and bilateral internal iliac ligation leaving behind whole placenta invading bladder. Post operative methotrexate was given. Post operative excision and bladder repair was done.

Ginekologia Polska[4], reported a giant vesicouterine fistula due to bladder invasion by placenta. The women underwent classical caesarean section at 33 weeks placental was left in situ. Post operatively she was treated with methotrexate. Successful removal of the placenta was done transvaginally 11 weeks post partum.

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CONCLUSION

A high index of suspicion for placenta percreta with bladder invasion is required when evaluating pregnant women with a history of cesarean section and placenta previa presenting with hematuria and lower urinary tract symptoms. USG and MRI assist in establishing the diagnosis. With proper planning, multi disciplinary approach, ICU facilities, availability of blood maternal morbidity and mortality is reduced.

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How to cite this article:

Alka Pandey and Shanti Roy., Placenta Percreta Involving the Bladder: A Case Report. *Int J Recent Sci Res.* 8(3), pp. 16240-16241. DOI: http://dx.doi.org/10.24327/ijrsr.2017.0803.0108

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