Acute abdomen and massive hemorrhage due to placenta percreta leading to spontaneous uterine rupture in the second trimester

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ABSTRACT

An abnormal placenta is a rare obstetric complication that can cause severe third trimester hemorrhage, severe postpartum bleeding, and maternal morbidity and mortality unless it is diagnosed antenatally. We present a rare case of placenta percreta leading to spontaneous uterine rupture during the second trimester with acute abdomen and hypovolemia.

Case Report.

A 25-year-old gravida 2, parity one pregnant woman was referred to our clinic due to sudden onset of severe abdominal pain. The pain had started approximately 8-10 hours before referral. She was admitted to a town hospital's general surgery department and then referred to a tertiary center due to her pregnancy. The pain had been getting worse over time. She could not describe any factors modifying the pain in terms of aggravation or reduction. There were no uterine contractions. She reported having a cesarean operation 2 years before this incident. The current pregnancy was uneventful. She was followed up in a peripheral hospital in her hometown. Her pregnancy comprised 24 gestational weeks so far. The placenta was lying through the anterior uterine wall without covering the cervical os. There was a moderate amount of free fluid in the abdomen. She had rebound, especially at the right lower quadrant. Her blood pressure was 100/60 mm Hg; heart rate was 92 beats/min; and body temperature was 36.4°C. Her hemoglobin (Hb) level was 8.8 g/L, her white blood cells (WBC) were 20,000/mm$^3$ (normal range: 11.7-15.5 g/L), and her platelet level was 220,000/mm$^3$ (normal range: 4500-11000/mm$^3$). An emergent laparotomy was performed. Approximately 2 L of blood was removed from the abdomen. Perioperative Hb level was 5.0 g/L.

Placental invasion anomalies refer to the abnormal adherence of the placenta to the uterine wall, resulting in detachment failure after delivery. They are classified according to invasion depth. Placenta accreta occurs if the villi penetrate the decidua but not myometrium, placenta increta occurs if the villi penetrate the myometrium, and placenta percreta occurs if these villi perforate the serosa and also sometimes into adjacent organs such as the bladder. The prevalence is approximately one in 2,500 pregnancies. However, the exact incidence is not known, because there are only a few isolated case reports in the literature. In this paper, we present this unusual case, followed by a brief review of the published data.

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Received 5th March 2014. Accepted 27th May 2014.

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Saudi Med J 2014; Vol. 35 (9): 1131-1132

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Perioperatively, her blood pressure was diminished to 70/40 mm Hg with prominent tachycardia of 140 beats/min. There was uterine rupture at the isthmic level, and the placenta was protruding from the ruptured area. A vertical fundal incision was performed to avoid the placenta, and thus prevent further bleeding. The fetus, 730 g, was delivered; the cord was clamped and the placenta was left in the uterus. Due to severe bleeding from the ruptured uterine area, hysterectomy was performed. A total of 6 U erythrocyte suspension and 3 U of fresh frozen plasma were used. After the surgery, the Hb level was 8.2 g/L. She was discharged on the postoperative sixth day. The newborn died due to respiratory failure on the third day of life. The uterus (Figure 1) was sent for pathologic evaluation. The pathology report revealed placenta percreta.

Discussion.

1/5,000

5%

3,4

6

(Figure 1)