

Placenta Accrete Spectrum: About A Case

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Introduction

Placenta accreta, also called placenta accreta Spectrum, is defined by placental invasion that extends beyond the normal boundary between endometrium and myometrium called Nitabuch layer. The risk of developing placenta accreta increases with the number of previous cesareans or Uterine surgeries, advanced age of the mother, multiparity (number of previous pregnancies) or curettage are all risk factors for the development of placenta accreta.

Maternal complications are represented by the risk of hemorrhage, uterine rupture, transfusion, hysterectomy [1].

The objective of showing the benefit of targeted screening for any multiparous patient with a scarred uterus and/or placenta previa by antenatal Doppler ultrasound [2].

Description of the Clinical Case

A 35-year-old woman, blood group O RH positive, with a history of four cesarean sections, the patient consulted our department at 23 weeks of gestation, a Doppler ultrasound showed a localized low placenta with poor insertion, an MRI was requested.

The patient returned at 34 weeks of amenorrhea for minor bleeding, she was hospitalized in the high-risk pregnancy department, the obstetrical Doppler ultrasound had shown biometrics which correspond to the term of pregnancy with fetal well-being, placenta covering percreta aspect, patient refused to have an MRI, the patient subsequently developed 15 days after her admission profuse metrorrhagia requiring admission to the operating room.

Surgical exploration had identified a placenta completely covering anteroposteriorly invading the lower segment and the retrovesical trigone, a hysterotomy allowed the transplacental extraction of a newborn with a good apgar then a hysterorrhaphy done leaving it in place the placenta, staged ligation with uterine plication, and in the face of persistent bleeding, ligation of the hypogastrics was made at her home. View of the non-stabilization of the patient's hemodynamic factors, a subtotal hysterectomy leaving some placental debris in place Inextirpable, highly adherent to the posterior surface of the bladder, and observation of significant bladder disrepair, after identification of the two ureteral meatus, laborious closure of the bladder wall with a probe in place; Patient was transfused with 06 vials of iso rhesus iso group blood.



Figure 1: Doppler Showing

Discussion

The PAS classification is evolving to reflect new understanding of the disease. According to historical patterns based on histopathologic evaluation alone, abnormal localization of

trophoblasts in the myometrium was diagnosed as accreta, increta, or percreta based on the increasing depth of invasion perceived in the myometrium [3,4].



Figure 2: Ultrasound + Doppler



Figure 3: Hysterectomy Surgical Piece

The utility of historical classification has recently been questioned because its focus on progressive trophoblast invasion appears contrary to prenatal imaging observations, intraoperative findings, and focused pathologic evaluation. In 2019, the International Federation of Gynecology and Obstetrics (FIGO) proposed a classification system for the clinical diagnosis of PAS disorders. In 2020, a group of experts came together and published a document on the classification and reporting of a pathological diagnosis of PAS disorders that roughly resembles the FIGO guidelines [5]. Regardless of the underlying pathophysiology, the end result is clear: severe PAS is characterized by significant distortion of uterine and pelvic anatomy and an impressive transformation of the placenta and pelvis into a potential source of massive hemorrhage [6].

Diagnostic tools for SAP are imperfect and many patients are only diagnosed at the time of delivery. When the diagnosis is not made before delivery, management may occur in a hospital setting where the necessary resources are not needed, which can lead to more serious outcomes [7]. Studies of promising biomarkers for SAP are ongoing, but there are currently no widely available and clinically useful blood or urine tests to predict PAS. It is important to note that a patient's a priori risk should not be discounted on the basis of a reassuring ultrasound

study. Therefore, risk factor assessment and ultrasound should be the basis of PAS screening and diagnosis. Magnetic resonance imaging (MRI) may be preferred for diagnosis in some institutions, but its routine use is limited by its higher cost and limited availability of MRI interpretation expertise for PAS.

The incidence of placenta accreta is increasing and this can be explained by the increase in cesarean section rates, which highlights the importance of targeted screening (2).

In patients at risk, ultrasound is the main screening and diagnostic modality. The most important sign of SAP is placenta previa, as it strikingly alters the risk of disease and morbidity. When previa is present in patients with a previous cesarean section [8], the risk of SAP is considerable and increases with the number of previous cesarean deliveries (3%, 11%, 40%, 61% and 67%, for the first, second, third, fourth and fifth or more cesarean sections, respectively). the most important ultrasound signs linked to SAP; loss of the normal hypoechoic zone between the placenta and the myometrium or "zone clear," myometrial thinning (less than 1 mm), placental lacunae, subplacental hypervascularization, and bridging vessels, although these and other "signs of SAP" are surprisingly common in unaffected pregnancies [9,10]. Other signs include placental bulge, bladder wall disruption, exophytic mass, and uterovesical hypervascularization. Investigations continue in search of new, potentially more useful signs. Transvaginal scan with lower uterine segment scanning can be invaluable in assessing the lower uterine segment at higher resolution. 46 No individual sign is highly predictive of PAS, so a combination of findings and a patient's a priori risk helps determine overall suspicion [10].

Conclusion

Placenta accreta is a condition that puts patients at high risk of hemorrhage, surgical complications, and even death. As such, their care is best achieved in centers with sufficient experience and resources to manage the full range of physical and psychosocial needs associated with a diagnosis of SAP. Clinical risk assessment, primarily history of uterine surgery, in addition to detailed ultrasound assessment of the placenta in at-risk patients, is the first-line diagnostic approach. In prenatally diagnosed cases, cesarean hysterectomy is the most common and definitive approach. The adoption of conservative or alternative management approaches depends on institutional expertise and resources, severity of PAS, and patient preferences. All A facility providing obstetric care must anticipate the risk of encountering undiagnosed PAS and have an escalation pathway to a higher level of care.

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