ISSN 2598-3180 (Online)
JOURNAL OF MIDWIFERY
Research and Practice
Accredited by SINTA 4th

Article

Placenta Percreta with Massive Hematuria

Yevri Zulfiqar[1]

[1]Urology Division, Department of Surgical, Faculty of Medicine, Andalas University– Andalas University Hospital Padang, Indonesia

SUBMISSION TRACK

Recieved: May 28, 2024
Final Revision: June 03, 2024
Available Online: June 30, 2024

KEYWORDS

Placenta Accreta Spectrum
Placenta Percreta
Hematuria

CORRESPONDENCE

Yevri Zulfiqar
Phone: 08126613078
E-mail: yevri_zulfiqar@yahoocom

A B S T R A C T

Placenta accreta spectrum disorder (PAS) is diagnosed clinically when the placenta cannot be separated from the uterus after delivery. Abnormal placentas can be classified into three different entities such as placenta accreta, increta, and percreta. Placenta percreta is rare. Bladder bleeding due to placenta percreta has a poor prognosis. The main peculiarities of our case were a history of previous cesarean section, uterine curettage for miscarriage, and multiparity. Hematuria occurred in only 5% of patients. Early detection and appropriate treatment can save the patient's life.

I. INTRODUCTION

Placenta accreta spectrum disorder (PAS) is diagnosed clinically when the placenta cannot be separated from the uterus after delivery.[1] Abnormal placentas can be classified into three different entities such as placenta accreta, increta, and percreta.[2] In placenta percreta, invasion of trophoblastic tissue involves the serosa and adjacent pelvic organs such as the bladder, ureters, fallopian tubes, or abdominal cavity. Placenta percreta only accounts for 5% of all cases because it is rare.[3] The incidence of bladder bleeding caused by placenta percreta is very low (0.36%).[4] Bladder bleeding due to placenta percreta has a poor prognosis because maternal and fetal mortality rates can increase to 9.5% and 2.4%, respectively. Bladder invasion causes life-threatening hematuria at delivery in most cases.[5] Therefore, early diagnosis and timely planned management are essential.

II. CASE ILLUSTRATION

A 31-year-old woman came to Maternal Fetal Medicine Polyclinic with G3P2A0L2 38-39 weeksof term pregnancy + total placenta previa suspected accreta + once previous CS, and a one-step conservative surgery was planned. On ultrasound examination, 38-39 weeks of pregnancy according to biometry. Fetal alive, singleton, intrauterine, head presentation. The placenta is implanted in the anterior corpus, covered by OUI, maturation grade III. They are bridging vessel (+), rail sign (+), lacuna (+), large swiss sign (-), halozone (-), and uterovesical hypervascularization (+). Early urology consultation and surgical assistance will decrease the incidence and/or rate of urinary tract complications during surgical management. Therefore, we will consult the urology department for preoperative ureteral catheter placement.

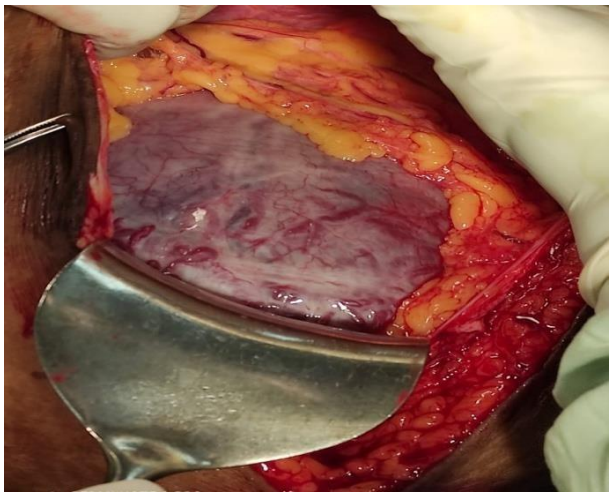


Figure 1. Documentation Intra Operation

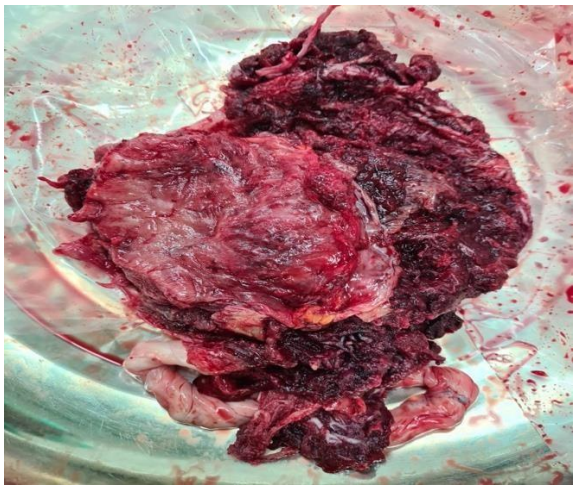
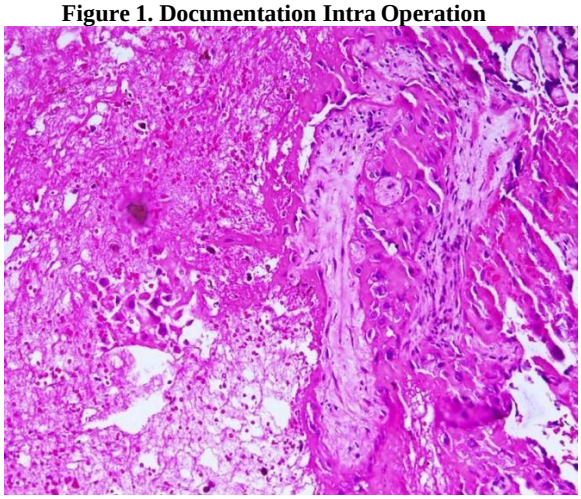


Figure 2. Documentation Post Operation



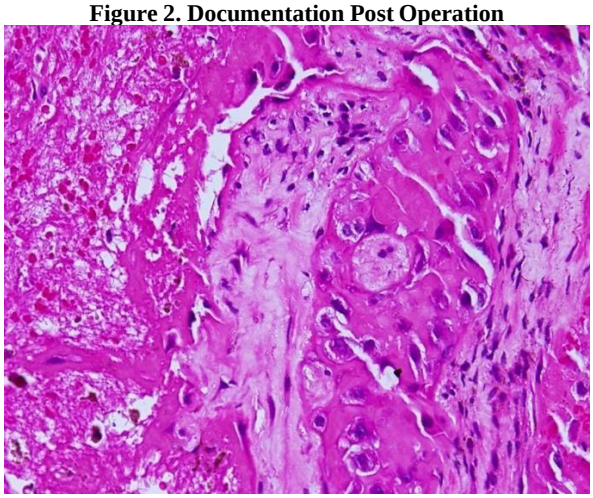


Figure 3. Necrotic Gravidative Decidual Tissue (20x10)

Figure 4. Necrotic Gravidative Decidual Tissue (40x10)

III. DISCUSSION

Placenta percreta is the most severe and very rare form of PAS.[6] Placenta percreta is the most severe form of abnormal trophoblastic attachment outside the decidua basalis, which is a rare condition with a reported incidence of 1/500 to ½/500 pregnancies.[7] A history of previous cesarean section is an important causative factor for placenta percreta, in addition to uterine curettage, grandmultiparity, and myomectomy scars, which pose a risk for developing placenta percreta.[3] The main peculiarities of our case were a history of previous cesarean section, uterine curettage for miscarriage, and multiparity. Meanwhile, hematuria occurred in only 5% of patients. Therefore, it is recommended that placenta percreta with bladder invasion should be suspected in every pregnant woman who presents with severe hematuria and has a history of previous cesarean section. There are two main treatment options for placenta percreta with bladder invasion, namely cesarean hysterotomy with conservative management and cesarean hysterectomy.[3]

IV. CONCLUSION

Although rare, bladder bleeding due to placenta percreta should be suspected in pregnant women who have hematuria, previous cesarean delivery, and specific ultrasonographic findings, especially in primary care. Early detection and appropriate treatment can save the patient's life.

REFERENCES

Pain, Flore-Anne et al. “Percreta score to differentiate between placenta accreta and placenta percreta with ultrasound and MR imaging.” Acta obstetricia et gynecologica Scandinavica vol. 101,10 (2022): 1135-1145. doi:10.1111/aogs.14420

Dutta, Satya et al. “A Retrospective Study of Placenta Accreta, Percreta, and Increta in Peripartum Hysterectomies in a Tertiary Care Institute in Northeast India.” Cureus vol. 12,11 e11399. 9 Nov. 2020, doi:10.7759/cureus.11399

Suhaimi N, Ishak A, Mohammad N. A near miss case of placenta percreta at primary care:A case report. Electron J Gen Med. 2023;20(1):em438. https://doi.org/10.29333/ejgm/12691

Zhao H, Zhao X, Liu C, Tao Y, Zhou Y. Bladder bleeding due to placenta percreta: Reportof four cases and management discussion. Matern-Fetal Med. 2021;3(4):285- 91. https://doi.org/10.1097/FM9.0000000000000120

Tillu N, Savalia A, Patwardhan S, Patil B. Placenta percreta with bladder invasion: The armamentarium available in its management. Urol Ann. 2019;11(3):324-7. https://doi.org/10.4103/UA.UA_84_18 PMid:31413516 PMCid:PMC6676855

Chavan N, Mirza H, Venkateswaran S, Changede P. Placenta percreta: A rare presentationof obstetric emergency in second trimester. Int J Reprod Contracept Obstet Gynecol. 2020;9(10):4295-9. https://doi.org/10.18203/2320-1770. ijrcog20204327

Balan, Raluca et al. “A Rare Cause of Massive Hematuria: Placenta Percreta With Bladder Invasion.” *In vivo (Athens, Greece)* vol. 35,6 (2021): 3633-3639. doi:10.21873/invivo.12670