**Unusual cause of placenta accreta and its management**

Dr. Preeti

Dr. Bela Makhija

Placenta accreta is amongst the commonest morbid adhesions of placenta and the uterine wall and occurs in 1 in 533 pregnancies.

It is usually associated with a scarred uterus i.e. post-myomectomy, post-caesarian, post-hysterotomy.

We report an unusual case of placenta accreta following a large sub-chorionic hematoma in early second trimester of pregnancy.

**Case – history**

A 23 years old primigravida presented at 4 months of gestation with complaint of bleeding per vaginum.

Ultrasound revealed a sub chorionic hematoma of 5.6x 4.6x 2.6 cms along the lateral uterine wall.

Conservative management done and the pregnancy continued up to 33 weeks of gestation uneventfully under constant supervision.

Patient had a preterm vaginal delivery at 33 week of gestation followed by retained placenta.

After the delivery of baby, there were no signs of placental separation even after giving oxytocics and prostaglandins.

Patient was shifted to operation theatre for manual removal of placenta. No plane of cleavage was found between placenta and uterine wall.

A Diagnosis of placenta accreta was made. Cord was clamped and cut as high as possible and conservative management was decided upon.

(A) **Investigations**-

Investigations specific to the retained placenta-

Serum beta HCG-21,490

Ultrasound and Doppler of pelvis revealed well defined echogenic lesion, 15.1 x 7.8 and 10.5 cm in left cornual region suggestive of retained placenta.
(B) **Management**-
Medical management with Injection Methotrexate, 1mg/kg of body weight on days 1,3,5,7 alternating with folinic acid 0.1 mg/kg of body weight on days 2,4,6,8 was given. Response to treatment monitored by serum beta HCG and serial ultrasounds.

**D) Follow-up**
Patient responded well, had no bleeding per vagina. Beta HCG levels came down from 21000 to 4000mIU/ml after one week.

(E) **Conclusion**-
An extensive review of literature was done and we could not find a similar case. Large sub chorionic hemorrhage in early second trimester of pregnancy may later result in placenta accreta. This may be due to fibrosis at hematoma site resulting in firm attachment and invasion of placenta at resorption site.

In conclusion it can be said that patients who have had substantial sub chorionic hemorrhage and have been able to continue the pregnancy **must be treated with caution and possibility of morbid adhesions of placenta must always be kept in mind.**

**Conservative management appears to be a safe alternative** to the surgical management in haemodynamically **stable patients of placenta accreta** desirous of retaining the uterus.

*Ante partum diagnosis with ultrasound and Doppler must always be done* in patients with history of substantial subchorionic haematoma in early pregnancy to rule out morbid adhesions of placenta.

(F) **References**-