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Stick with you: A case of a Type I CS scar pregnancy with concomitant Placenta Previa and Placental Accrete Syndrome

Escarpe, CVF, Bautista, KKP
Dr. Pablo O. Torre Memorial Hospital, Bacolod City, Philippines

Objective

To present a case of a Type I CS scar pregnancy with concomitant Placenta Previa and Accrete Syndrome.

Methods

On initial TVS, a thickened endometrium (1.8 cm) was seen to consider decidualized endometrium. Repeat scan ay 6 4/7 weeks done revealed a single, live pregnancy with a cardiac activity of 148 bpm. Another scan at 8 4/7 weeks showed a low lying gestational sac near the cesarean section scar site in the lower anterior uterine segment. The growth of the fetus was towards the endometrial cavity. Repeat ultrasound at 16 5/7 weeks age of gestation revealed a single, live fetus within the expanded mid portion of the lower uterine segment. The placenta was anterior, totally covering the internal os. Color mapping showed vascularity. The anterior myometrial wall was 0.15 cm thin. Uterine serosal and bladder interface is intact. A high suspicion of CSP was raised. Patient was informed that the pregnancy could develop into a placenta previa or accrete syndrome and that she may be at risk of having major hemorrhage that would require hysterectomy if pregnancy will be allowed to progress. After a thorough discussion with the patient and her family, she decided to continue with the pregnancy due to the desire of having a male offspring. Placental examination at 18 weeks showed loss of retroplacental sonoluscent space with the anterior uterine wall of the uterus markedly thinned out without normal looking myometrium between the serosa and bladder wall. Color mapping showed hypervascularity. CSP with placenta accrete was considered. She was managed expectantly and was advised on strict regular follow up. At 21 3/7 weeks, there was still expansion of the midportion of the lower uterine segment with a single, live fetus. The serosa was intact. The cervical length was 1.2 cm with funneling. Findings were suggestive of preterm labor. Advised admission but opted to be managed on an outpatient basis. At 23 weeks age of gestation, patient complained of vaginal bleeding. Repeat scan still showed short cervix at 1.1 cm with funneling. Oligohydramnios noted with AFI 3.5 cm.

Results

Patient was admitted and subsequently underwent Cesarean Hysterectomy with Bilateral Salpingectomy, Bladder Cystorrhaphy under General Anesthesia for beginning intraamnionic infection manifested by increasing C reactive protein levels. The surgery went well with an estimated blood loss of 4000 cc. Intraoperative transfusion of 2 units of PRBC, 1 unit of Whole blood and 3 units pf FFP. Patient tolerated the procedure. Patient was discharged in a stable state. Surgical pathological report revealed Sections thru the endometrium shows small chorionic villi. These are also noted to infiltrate the myometrium. The umbilical cord shows arteries and one vein. The cervix and both fallopian tubes are unremarkable.

Conclusion

There is no universal management for CSP. Treatment options are individualized and based on the patient's age, number of living children, need for future child bearing, hemodynamic condition and viability of the pregnancy. The expertise of the clinicians and the availability of facilities to manage such cases is also a consideration. The dilemma lies on whether to terminate a live pregnancy or to continue the pregnancy with a possibility of delivering a live offspring, provided that she understands the risk and possible complications, often necessitating hysterectomy. The increasing number pregnancies concluding to cesarean deliveries has been associated with an increased incidence of Cesarean Scar Pregnancies. A high index of suspicion coupled by an accurate sonographic diagnosis must be done to provide optimal management to the patient and thereby reducing overall maternal morbidity and mortality.