UTERINE RUPTURE DUE TO PLACENTA PERCRETA AT 13/40 GESTATION RESULTING IN HYSTERECTOMY

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Background

Placenta percreta affects approximately 1: 7000 pregnancies. Uterine rupture due to placenta percreta is a life threatening complication. It mainly occurs in the second and third trimesters, however, has been reported to occur as early as 9/40 (1). Risk factors for uterine rupture in pregnancy are: previous caesarean, placenta praevia, multiparity and advanced maternal age (1).

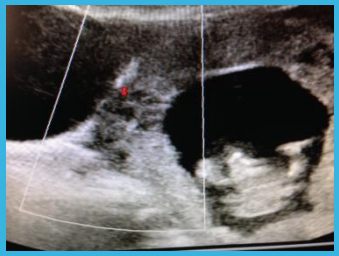
Case reports of conservatively managed uterine rupture describe curettage, packing, methotrexate, bilateral uterine artery occlusion and primary closure (1). However, given the high mortality, hysterectomy is usually the preferred treatment emergently.

Uterine rupture is worse if co-existing with placenta percreta as it is more vascular.

Case

26 y G3P1 at 13+5/40 with sudden right iliac fossa pain radiating to her shoulders. Past hx: emergency lower segment caesarean 1 yr ago – 39/40 fetal distress at 2cm 3.1kg, RPOC & D+C; miscarriage D+C. O/E Looked unwell, normal obs. RIF peritonism. VE: Cx excitation, R adnexal tenderness. Bloods: Hb 115. TVUS: free fluid, live intra-uterine pregnancy. Laparoscopy: haemoperitoneum necessitated conversion to laparotomy. Ruptured uterus with placenta extruding through anterior wall. The fetus was delivered via hysterotomy in an attempt to save the uterus. However, bleeding was profuse and the patient became unstable. A hysterectomy was performed promptly. A Massive Transfusion Protocol was activated. The patient recovered well. Histopathology: placenta percreta.

Case



Conclusion

An acute abdomen in pregnancy should have uterine rupture from placenta percreta considered as a differential diagnosis, even in the first trimester.

References

1. Jang DG et al, Placenta Percreta-Induced Uterine Rupture Diagnosed By Laparoscopy in the First Trimester. *Int J Med Sci* 2011; 8(5):424-427.