

SUCCESSFUL CONSERVATIVE SURGICAL MANAGEMENT OF SUSPECTED PLACENTA INCRETA IN A PRIMIGRAVIDA: A CASE REPORT

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ABSTRACT

Placenta accreta spectrum (PAS) disorders complicate approximately 0.19% (1 in 533) of pregnancies and are associated with significant maternal morbidity and mortality. More than 90% of cases occur in women with prior cesarean delivery, placenta previa, or previous uterine surgery. Occurrence of placenta increta in a primigravida without identifiable risk factors is therefore exceptionally rare and largely limited to isolated case reports. We report a case of a primigravida at 40+1 weeks of gestation with breech presentation and posterior placenta who underwent elective cesarean section. Intraoperatively, the placenta was found to be abnormally adherent to the posterior uterine wall, and a clinical diagnosis of placenta increta was made. The patient developed massive postpartum hemorrhage requiring multidisciplinary intervention. Conservative surgical measures, including bilateral uterine artery ligation, intrauterine packing, and B-Lynch compression suturing, successfully achieved hemostasis and preserved the uterus. The patient recovered well and resumed normal menstrual cycles on follow-up.

Keywords: Placenta Accreta Spectrum, Placenta Increta, Cesarean Section, Postpartum Hemorrhage, Uterine Artery Ligation

INTRODUCTION

Placenta accreta spectrum (PAS) disorders encompass placenta accreta, increta, and percreta and are characterized by abnormal adherence or invasion of chorionic villi into the myometrium. The global incidence of PAS is approximately 0.19% (1 in 533 pregnancies) and has increased over recent decades, parallel to rising cesarean section rates. More than 90% of PAS cases are associated with prior cesarean delivery or placenta previa. In women without prior cesarean delivery, the estimated risk of PAS is approximately 0.03%, compared with 3-7% in women with placenta previa and previous cesarean section. Placenta increta in a primigravida without prior uterine instrumentation is, therefore, exceedingly rare. Posterior placental implantation further reduces antenatal suspicion due to lower ultrasound detection rates (1-5).

CASE PRESENTATION

A primigravida with no history of uterine surgery presented at 40+1 weeks of gestation. The antenatal course was unremarkable, with no history of surgery or instrumentation. Ultrasound showed a singleton fetus in breech presentation with fundo-posterior placenta. Elective cesarean section was planned. After delivery of a live neonate under spinal anesthesia, placental separation was difficult. The placenta was densely adherent to the posterior uterine wall with brisk hemorrhage. The senior registrar and on-call consultant were called, and a clinical diagnosis of placenta increta was made. Partial placental removal resulted in massive postpartum hemorrhage. Spinal anesthesia was converted to general anesthesia, and attendants were counselled about the possibility of hysterectomy. Conservative surgical management was attempted. Bilateral uterine artery ligation was performed, followed by placement of seven intrauterine packs and application of a B-Lynch compression suture. Hemostasis was achieved, and the uterus was preserved. The patient received 2 units of packed red blood cells and 4 units of fresh-frozen plasma. A surgical drain was placed.

POSTOPERATIVE COURSE AND FOLLOW-UP

The patient was monitored in the surgical intensive care unit for three days. Intrauterine packs were removed sequentially without recurrent bleeding. She was discharged in stable condition. Two weeks later, she presented with vaginal bleeding. Ultrasound revealed approximately 12 mL of retained products of conception, which were managed conservatively. She subsequently resumed normal menstrual cycles.

DISCUSSION

PAS disorders represent a significant obstetric challenge due to their relationship with severe postpartum haemorrhage and maternal morbidity. The present case is remarkable because suspected placenta increta occurred in a primigravida woman without classical predisposing factors such as a previous cesarean section, placenta previa, or uterine curettage. Contemporary literature consistently recognizes prior cesarean delivery as the strongest risk factor for PAS, with the risk increasing with the number of prior cesarean sections. The occurrence of suspected placenta increta in a previously unscarred uterus, as in this case, represents the exceptionally rare clinical scenario (1, 6).

This case represents an exceptionally rare presentation of suspected placenta increta in a primigravida without classical risk factors. PAS disorders overwhelmingly occur in women with prior uterine surgery. FIGO and ACOG guidelines recognize that clinical diagnosis based on intraoperative findings is acceptable in emergencies when histopathology is unavailable. Conservative surgical techniques, including uterine artery ligation, compression sutures, and intrauterine packing, can avoid hysterectomy in selected cases but require close follow-up.

This case, in summary, contributes to the limited body of literature recording the suspected placenta increta among the primigravida with posterior placentation. It strengthens the significance of intraoperative recognition and the potential role of conservative surgical techniques in selected patients. Whereas cesarean hysterectomy remains the gold standard for confirmed PAS, uterine-preserving management may be considered in prudently selected cases with available expertise and close follow-up. Further prospective data are required to refine

patient selection criteria and optimise management strategies for atypical presentations of PAS.



Intraoperative view showing suspected posterior placenta increta with abnormal placental adherence to the posterior uterine wall during cesarean section, resulting in massive postpartum hemorrhage managed by conservative uterine-preserving surgical techniques.

CONCLUSION

Placenta increta in a primigravida is extremely rare. This case demonstrates that conservative surgical management can successfully preserve the uterus in selected patients when timely multidisciplinary intervention is available.

DECLARATIONS

Data Availability Statement

All data generated or analysed during the study are included in the manuscript.

Ethics approval and consent to participate

Approved by the department Concerned.

Consent for publication

Approved

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTION

ROSHNI MUMTAZ (Trainee Medical Officer)

Conceived the case report, participated in patient management, collected clinical data, and drafted the case report

ASMA KHAN (Trainee Medical Officer)

Coordinated data collection, and assisted in drafting the case report

FAIZA ALI (Trainee Medical Officer)

Assisted in literature review, compilation of clinical findings, and manuscript editing

SAIMA KHAN MAHSOOD (Trainee Medical Officer)

Contributed to the documentation of the case, interpretation of findings, and preparation of figures

SOPHIA TAHIR KHAN (Trainee Medical Officer)

Assisted in literature search, proofreading, and final revision of the manuscript

All authors read and approved the final version of the manuscript.

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