World Academy of Science, Engineering and Technology
International Journal of Medical and Health Sciences
Vol:19, No:01, 2025

Placenta A Classical Caesarean Section with Peripartum Hysterectomy at 27+3 Weeks Gestation For Placnta Accreta

Authors : Huda Abdelrhman Osman Ahmed, Paul Feyi Waboso

Abstract : Introduction: Placenta accreta spectrum (PAS) disorders present a significant challenge in obstetric management due to the high risk of hemorrhage and potential complications at delivery. This case describes a 27+3 weeks gestation in a patient with placenta accreta managed with classical cesarean section and peripartum hysterectomy. Case Description: AGravida 4P3 patient presented at 27+3 weeks gestation with painless, unprovoked vaginal bleeding and an estimated blood loss (EBL) of 300 mL. At the 20+5 week anomaly scan, a placenta previa was identified anterior, covering the os anterior uterus and containing lacunae with signs of myometrial thinning. At a 24+1 week scan conducted at a tertiary center, further imaging indicated placenta increta with invasion into the myometrium and potential areas of placenta percreta. The patient's past obstetric history included three previous cesarean sections, with no significant medical or surgical history. Social history revealed heavy smoking but no alcohol use. No drug allergies were reported. Given the risks associated with PAS, a management plan was formulated, including an MRI at a later stage and cesarean delivery with a possible hysterectomy between 34-36 weeks. However, at 27+3 weeks, the patient experienced another episode of vaginal bleeding EBL 500 ml, necessitating immediate intervention. Management: As the patient was unstable, she was not transferred to the tertiary center. Completed and informed consent was obtained. MDT planning-group and cross-matching 4 units, uterotonics. Tranexamic acid blood products, cryo, cell salvage, 2 obstetric consultants and an anesthetic consultant, blood bank aware and hematologist. HDU bed and ITU availability. This study assisted in performing a classical Caesarean section, Where the urologist inserted JJ ureteric stents. Following this, we also assisted in a total abdominal hysterectomy with the conservation of ovaries. 4 units RBC and 1 unit FFP were transfused. The total blood loss was 2.3 L. Outcome: The procedure successfully achieved hemostasis, and the neonate was delivered with subsequent transfer to a neonatal intensive care unit for management. The patient's postoperative course was monitored closely with no immediate complications. Discussion: This case highlights the complexity and urgency in managing placenta accreta spectrum disorders, particularly with the added challenges posed by remote location and limited tertiary support. The need for rapid decision-making and interdisciplinary coordination is emphasized in such high-risk obstetric cases. The case also underscores the potential for surgical intervention and the importance of family involvement in emergent care decisions. Conclusion: Placenta accreta spectrum disorders demand meticulous planning and timely intervention. This case contributes to understanding PAS management at earlier gestational ages and provides insights into the challenges posed by access to tertiary care, especially in urgent situations.

Keywords : Accreta, Hysterectomy, 3MDT, prematurity
Conference Title : ICGO 2025 : International Conference on Gynecology and Obstetrics
Conference Location : Amsterdam, Netherlands
Conference Dates : January 23-24, 2025