

Placenta Increta in First-Trimester of Pregnancy Mimicking Molar Pregnancy: Case Report

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Abstract:The objective of the study was to describe the management of a first trimester vaginal bleeding caused by abnormal placentation. In this paper one case of first trimester of pregnancy with severe vaginal bleeding reported who presented at the Department of Gynecology and Obstetrics in November 2012. A 38-year-old G3L2 (2*C/S) candidate curettage for the reason that she had molar pregnancy (GA=11w+3d) confirmed by Ultrasonography. We placed laminaria in the internal OS for cervical ripening. Immediately severe vaginal bleeding began after that fixed laminaria, she received oxytocin, misoprostole, serum and blood products during curettage. Extremely, uterus expelled because of continued severe vaginal bleeding. Hysterectomy pathology was confirmed placenta increta. Our case suggests that abnormal placenta attachment to myometrium present in through the pregnancy. We must know in a pregnant women with severe or prolonged vaginal bleeding even in the first trimester placenta increta has to be considered as a differential. **Keywords:**placenta increta, molar pregnancy, first trimester vaginal bleeding.

INTRODUCTION

Placenta accrete is an abnormal adherence of the placenta to the uterine wall that can lead to significant maternal morbidity and mortality. Placenta increta occurred when the placenta penetrates the myometrium and is a rare and life-threatening complication of pregnancy. Women at greater risk are those who have myometrial damage caused by a previous cesarean delivery with placenta previa overlying the uterine scar [1]. Placenta increta has been increased because of increasing prevalence of cesarean delivery in recent years. It creates as the result of complete or partial decidua basalis absent. Ideally, first suspicion for placenta accrete stimulate by findings on obstetrical ultrasound while the patient is asymptomatic [2,3]. Manifestation of placenta increta after a dilation and curettage is extremely rare, but it is clinically significant that it can cause severe vaginal bleeding during curettage and management is difficult. One of the differential diagnoses of first-trimester bleeding is abnormal placenta adherence. We present one case of placenta increta who referred to our clinic because of molar pregnancy.

CASE REPORT

A 38-year-old pregnant woman, gravid 3, Para 2, was admitted for pregnancy termination due to molar pregnancy. Her obstetric history was notable for two previous low transverse cesarean section deliveries. After 12 weeks of amenorrhea, serum beta human chorionic gonadotropin (BHCG) was 1035 mIU/ml. She had large uterus about 18 weeks (In bimanual exam), without vaginal bleeding or abdominal pain. Trans abdominal ultrasound was performed, failed to identify a gestational sac in uterus, and showed the presence of echogenic complex mass measuring about 7.5 × 6.5 cm over the uterine cavity that resembled honeycombed pattern. Differential diagnosis included molar pregnancy or uterine tumors. Para clinic data and reminder clinical examination were normal. BHCG level was 1035 mIU/ml. For termination of abnormal pregnancy, we decided placement of laminaria in cervix. After that she began severe vaginal bleeding. For the patient emergent curettage was down but then emergency hysterectomy was performed because of uncontrolled vaginal Bleeding (Fig. 1). The patient received 6 U packed blood cells and 4 U fresh frozen plasma. The patient recovered uneventfully and was discharged 5 days later in a healthy condition. Histological results showed placenta increta (Fig. 2)



Fig. 1: Uterus with placenta increta in lower segment

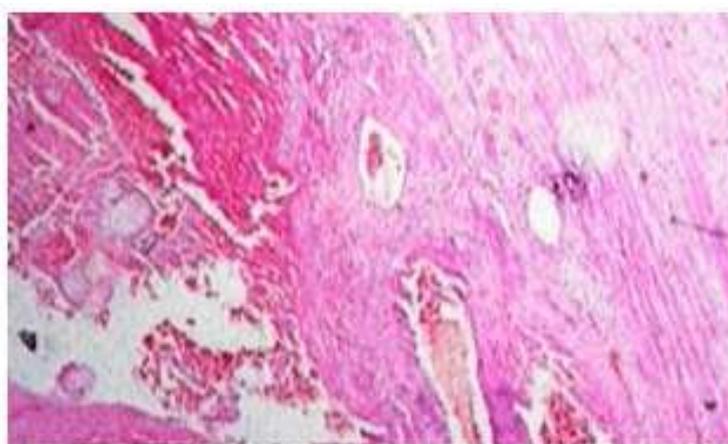


Fig. 2: Histopathologic examination demonstrates trophoblastic invasion into the myometrium

DISCUSSION

Placenta accreta is a life-threatening complication of pregnancy due to complete or partial absence of decidua basalis and imperfect development of the fibrinoid layer. Risk factors are found to be associated with placenta previa, previous cesarean section, previous uterine curettage, multiparity (≥ 6) and older maternal age [4]. It has been subclassified into placenta accretes, placenta increta, placenta percreta on the basis of depth of penetration of placenta to uterine wall [5]. Placenta increta usually manifests with difficult placenta removal and severe vaginal bleeding in the third trimester [4]. It may present after a first trimester pregnancy termination and also may present as a solid uterine mass mimicking endometrial cancer or a uterine myoma [6]. Clinical presentations based on previous reports include uterine rupture [7], massive acute bleeding immediately after dilatation and curettage [8], persistent vaginal bleeding after curettage [9], intraperitoneal bleeding after an uncomplicated dilatation and curettage in the first trimester and uterine mass [10]. It may also manifest with first and second-trimester post curettage hemorrhage. Many patients do not have preceding symptoms. Its early diagnosis is

based on high suspicion and notice to the risk factors [4].

In a similar case, the woman in Korea, two months after uncomplicated curettage in the first trimester, she received hysterectomy due to retroperitoneal bleeding. Post-operative pathology reported placenta accretes [10].

Papadakis *et al.* [11] reported a patient with first trimester fetal demise that had severe vaginal bleeding and coagulopathy after curettage. The patient required an emergency hysterectomy to control the bleeding that was similar to our case.

Komiya *et al.* [8] reported a woman with severe vaginal bleeding after curettage for incomplete miscarriage at 21 weeks of gestation. Cesarean section was immediately performed. After that, she had severe vaginal bleeding, and shock and emergency hysterectomy was done. Pathological findings were placenta accreta.

CONCLUSION

Our patients in the current report had common risk factors, including prior cesarean sections and D&C procedures. Clinical history, radiologic findings and elevated HCG helps the obstetrician to diagnose a retained placenta abnormality. So, we fill the gap junctions of abnormal placenta attachment in the differential diagnosis of first-trimester vaginal bleeding.

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