CASE REPORT

Successful Pregnancy Outcome Following Conservative Management of Morbidly Adherent Placenta

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Introduction

Adherent placenta is an uncommon but potentially dangerous complication of pregnancy. Hysterectomy remains the “Gold Standard” and lifesaving procedure in the management of adherent placenta. However, with careful selection of cases and meticulous monitoring, successful conservative management is possible with the use of methotrexate.

Here, we report a case of successful pregnancy outcome for a woman who was treated conservatively with methotrexate 1 year ago for morbidly adherent placenta.

Case Report

23-year-old Mrs. K., Gravida IV, para II, abortion 1, and alive nil, attended the antenatal OP in her fourth pregnancy at 20 weeks of gestation. In her past obstetric history, her first pregnancy ended in spontaneous miscarriage at 12 weeks of gestation for which curettage was done. In her second pregnancy, she delivered a dead-born fetus at term.

No obvious cause could be ascertained for the intrauterine death. In her third pregnancy, she attended the hospital at 32 weeks of gestation and the USG showed hydrops fetalis. During the process of investigation, she went into spontaneous labor and delivered a dead fetus weighing 1.5 kg. Following delivery, the placenta was retained and all attempts to deliver the placenta failed. Under anesthesia, the placenta was found to be densely adherent to the right horn of a bicornuate uterus. There was no bleeding per vaginum and her condition was clinically stable. Hysterectomy was discussed with the patient and her relatives, which they refused. As preservation of fertility was a major concern in this case, with the informed consent, it was decided to manage her condition conservatively. The following investigations were done as baseline and were repeated every week: complete hemogram, high vaginal swab, serum beta HCG levels, and USG of the placenta. Special attention was focused on the vascularity of the placenta at USG. Coagulation profile was checked every other day.

She was given an injection of methotrexate 50 mg intramuscularly every week for three doses. She was also given broad-spectrum antibiotics and was observed for evidence of sepsis, heavy bleeding, and anemia. During the course of treatment, she was transfused one unit of blood. There was a gradual decline in the levels of serum beta HCG from 27,270 mIU/ml in the first week to 3,118 mIU/ml in the second week to 96 mIU/ml in the third week. The placental size and vascularity also reduced markedly during the observation period. During the fourth week of observation,

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HCG levels were very low and the Doppler showed a vascularity of the placenta. Therefore, a further dose of methotrexate was not given. Though there was on and off spotting per vaginum, there was no active bleeding or offensive vaginal discharge and she was discharged home at request. Five weeks after the last dose of methotrexate, she expelled a fleshy mass and USG at that time showed a bicornuate uterus with empty cavities. She resumed her menses within 2 months and conceived in the next cycle.

In the current pregnancy, she attended the antenatal OP at 20 weeks of gestation. She was Rhesus positive, her oral GTT was within normal limits, the mid-trimester scan did not show any fetal anomalies, and her VDRL status was normal. She was carefully followed up and the fetal growth and biophysical profile remained normal. In view of the previous morbidly adherent placenta, USG evidence of recurrent adherent placenta was looked for. The placenta was fundal and the hypoechoic retro placental myometrial zone remained normal. At 38 weeks of gestation, she complained of diminished fetal movements, AFI was 7, and the CTG showed unprovoked decelerations. Therefore, an emergency cesarean section was performed and a live healthy male baby weighing 2.6 kg was delivered. The placenta was again located in the right half of the septate uterus and was removed without any difficulty. Her post-operative period was uneventful and she was discharged home well with the baby on the 7th post-operative day.

Discussion

Adherent placenta is a condition where the placenta is abnormally adherent to the uterine myometrium due to

partial or complete absence of decidua basalis and Nita-buch's layers. Depending upon the depth of invasion of trophoblastic tissue, it is histologically classified as placenta accreta, increta, and percreta.

In recent years, there have been reports of medical management of adherent placenta. Hysterectomy is the lifesaving procedure for adherent placenta [1]. However, for a small percentage of women for whom fertility has to be preserved, medical management with methotrexate may be considered. Different dose regimens have been described by various authors [2, 3]. However, a definite dose protocol is not known. Irrespective of dose, duration, and frequency of methotrexate use, careful monitoring for complications and for persistence of trophoblastic activity is important. During the observation period, persistence of vascularity of the placenta noted by USG and the presence of active hemorrhage and sepsis are indications for hysterectomy. The time taken for the expulsion of the placenta varies [2, 3]. In our case, the placenta was expelled within 2 months after completion of chemotherapy and she resumed the menses 2 months later. She conceived in the next cycle and the recent use of methotrexate did not have an adverse effect on the mother or fetus.

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