

Case Report

Laparoscopic Management of Placenta Increta after Late First-Trimester Dilation and Evacuation Manifesting as an Unusual Uterine Mass

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ABSTRACT Placenta increta is a rare and potentially life-threatening complication of pregnancy. The initial symptoms are generally vaginal bleeding during difficult placental removal in the third trimester. However, placenta increta may complicate first- and early second-trimester pregnancy loss. The diagnosis may be difficult during early pregnancy because the lesion is difficult to identify. Herein is reported the case of a woman with a diagnosis of placenta increta that caused prolonged bleeding after a late first-trimester abortion and manifested as an unusual lower segment uterine mass. Management included laparoscopy, and the placental tissue was completely removed successfully and uneventfully. *Journal of Minimally Invasive Gynecology* (2011) 18, 250–253 © 2011 AAGL. All rights reserved.

Keywords: First-trimester abortion; Laparoscopy; Placenta increta; Uterine mass

Abnormal adherence of the placenta to the uterus is defined as placenta accreta. This condition is subclassified into placenta accreta vera, placenta increta, and placenta percreta based on the depth of penetration of the placental tissue into the uterine wall. Although manifestation of placenta increta after a dilation and evacuation procedure is extremely rare, it is clinically significant because it can cause postevacuation bleeding, making clinical management difficult. Furthermore, the retained trophoblastic tissue and an accompanying hematoma can become entrapped in the myometrium and mimic an unusual uterine mass lesion. Herein is reported a case of placenta increta after a late first-trimester abortion that caused prolonged bleeding and an unusual lower segment uterine mass. Management was via laparoscopy, with complete removal of the placental tissue successfully and uneventfully.

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Case Report

A 38-year-old woman, gravida 3, para 2, had undergone dilation and evacuation (D&E) for elective termination of pregnancy at 12 weeks of gestational age at a local clinic. Her obstetric history was notable for 2 previous low transverse cesarean section deliveries at a local clinic without any complications. At D&E, profuse hemorrhage occurred. However, the bleeding subsided after intramuscular administration of methylergonovine, vigorous uterine massage, and blood transfusion. The patient reported vaginal bleeding and dull intermittent lower abdominal pain for about 2 months after D&E. Serial transvaginal ultrasound revealed a complex mass in the anterior lower uterine segment. The patient was transferred to our hospital for further evaluation and management.

Transvaginal ultrasound was performed, which revealed an echogenic complex mass measuring about 6.6×6.5 cm over the anterior lower uterine segment (Fig. 1). Differential diagnosis included placental site trophoblastic tumor, persistent placental tissue, or other uterine tumors including degenerating myoma. The β -human chorionic gonadotropin concentration was 3.2 mIU/mL. Surgical intervention was suggested and arranged to confirm the diagnosis and to remove the lower uterine segment mass.

Surgery was performed with the patient under general anesthesia and in the 15-degree Trendelenburg position.

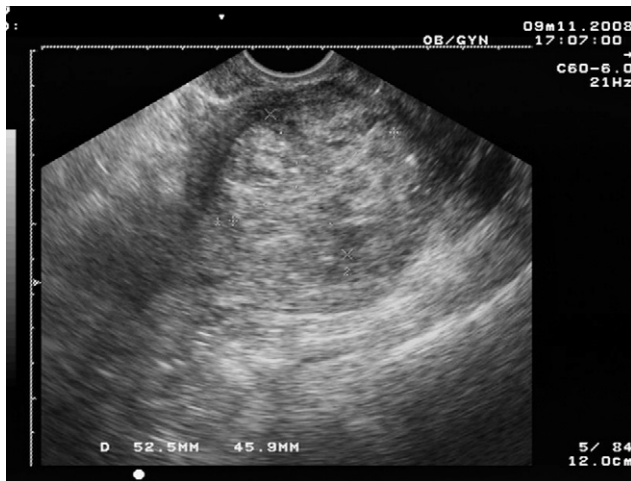


Fig. 1. An echogenic complex mass measuring about 5.3×4.6 cm over the anterior lower uterine segment.

A Foley catheter was inserted preoperatively to empty the bladder and enable continuous monitoring of urine output. Diagnostic hysteroscopy was performed smoothly. Placental tissue that had invaded the lower uterine segment was observed at hysteroscopy (Fig. 2). A Verres needle was inserted through a small incision just inferior to the umbilicus, and pneumoperitoneum was created by insufflating carbon dioxide to a maximal pressure of 20 mm Hg. A 10-mm operative trocar was inserted into the abdominal cavity. A laparoscope with attached video camera was passed through the cannula to visualize the intraabdominal organs. A 5-mm trocar was inserted into the pelvic cavity in the midline suprapubically, and 2 additional 5-mm trocars were inserted at the level of the anterior superior iliac spine, lateral to the epigastric blood vessels. After placement of the trocars, the intra-abdominal pressure was decreased to 15 mm Hg. The uterus was found to be anteverted and of normal size; however, a 6-cm mass was observed over the lower uterine segment (Fig. 3). Although the intent was to manage the condition

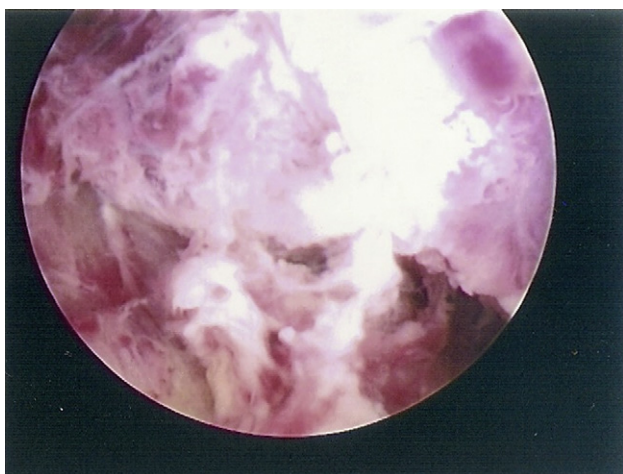


Fig. 2. Diagnostic hysteroscopy revealed that the placental tissue had invaded the myometrium of the lower uterine segment.

laparoscopically, we were prepared to perform immediate laparoscopic/vaginal hysterectomy or to convert to open laparotomy if serious bleeding developed.

The serosa was incised, and the bladder was pushed down to enable access to the lower uterine segment. A mass with a thin wall of myometrium was observed. Dilute vasopressin, 1 U/mL, was used for hemostasis. Five to 10 mL of vasopressin solution was injected into the myometrium at 1 or more sites with an 18-gauge spinal needle placed directly through the abdominal wall until blanching occurred. A transverse incision was made over the most prominent area of the mass, revealing dark red placental tissue, which was removed using Allis grasping forceps with hydrodissection via irrigation probe for facilitation of the separation between the myometrium and placental tissue. The resulting space in the myometrium was cleaned using suction irrigation, and hemostasis was achieved using bipolar forceps at 20 W. One layer of interrupted 2-0 polyglactin 910 sutures was placed in the uterine wall using extracorporeal ties. The placental tissue (Fig. 4) was removed using an Endobag. Total operative time was 140 minutes. Blood loss was 300 mL, and no blood transfusion was needed. Pathologic analysis revealed necrotic and hemorrhagic placental tissue, consistent with placenta accreta. The patient was discharged on the second postoperative day, after an uneventful recovery.

Discussion

Placenta accreta is a life-threatening complication of pregnancy characterized by complete or partial absence of the decidua basalis and imperfect development of the fibrinoid layer (Nitabuch layer). The condition can be subclassified into placenta accreta vera, placenta increta, and placenta percreta based on the depth of penetration of the placental tissue into the uterine wall [1]. The reported incidence of placenta accreta/increta/percreta is 1 in 2500 to 7000 pregnancies; however, this abnormal adherent placental condition assumes considerable significance clinically because of

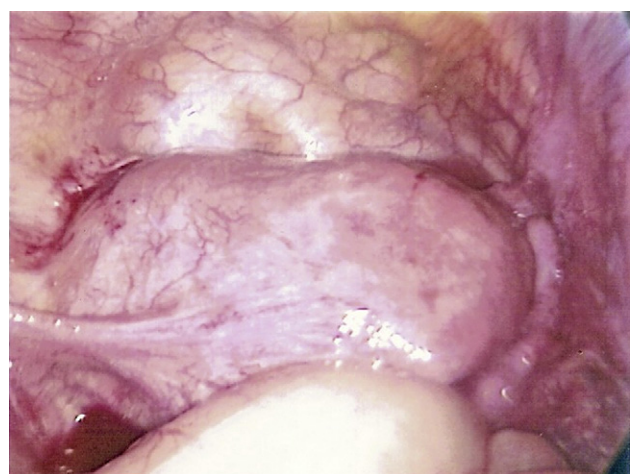


Fig. 3. At videolaparoscopy, a bulging mass measuring about 6 cm in diameter was noted over the lower uterine segment.

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