

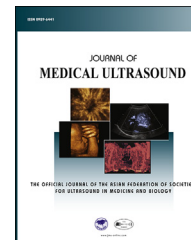


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CASE REPORT

Evolving Cesarean Scar Pregnancy into Morbidity Adherent Placenta—Evidence from Serial Ultrasound Examination

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Abstract Objective: To present the complete history of a case with placenta accreta and demonstrate the special clues of ultrasonography finding during whole trimesters from early pregnancy to delivery.

Case Report: A multiparous 28-year-old female with a history of multiple cesarean deliveries was found with suspected precesarean section scar pregnancy at 6 weeks of gestation. We performed a series of ultrasonography scans, which revealed placenta previa totalis and placenta accreta at 15 and 32 weeks of gestation, respectively. A well-planned cesarean section with hysterectomy was performed at the 35th week of gestation with massive blood transfusion support, and an alive female baby—with a birth body weight of 2485 g, and Apgar score of 9 at the 1st minute and 10 at the 5th minute—was born. The intraoperative blood loss was 7000 mL, and no postoperative hemorrhage or other complication occurred.

Conclusion: Ultrasonography remains the main tool for diagnosis of morbid adherent placenta with several typical clues, including abnormal vasculature, increased size and numbers of vascular sinus, absence of uterovesicle border or retroplacental hypoechoic zone, and invaded placenta insertion on myometrium. Proper planning prior to the operation and detailed counseling may be necessary, as well as hysterectomy; massive bleeding with transfusion remained the most seen complication.

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Conflicts of interest: The authors declare that there are no conflicts of interest.

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Introduction

Morbid adherent placenta, which includes placenta accreta, placenta increta, and placenta percreta, remains a major cause of immediate postpartum hemorrhage and often leads to many complications including hypovolemic shock, disseminated intravascular coagulopathy, postpartum hysterectomy, and even morbidity. Sufficient and detailed delivery planning is necessary if the diagnosis is confirmed, and several preoperative interventions should be considered to avoid massive bleeding, which include therapeutic angiography or prophylactic hysterectomy. The diagnostic tool of this placental insertion disease depends on antepartal ultrasonography, mostly with a sensitivity of 90.7% [95% confidence interval (CI), 87.2–93.6], specificity 96.9% (95% CI, 96.3–97.5), a positive likelihood ratio of 11 (95% CI, 6–20), and a negative likelihood ratio of 0.16 (95% CI, 0.11–0.23) from a meta-analysis in 2013 [1]. We present a patient who was diagnosed to have placenta accreta and was followed with ultrasonography during the three trimesters of her pregnancy.

Case Report

We report a 28-year-old (gravida 8 para 3) multiparous mother with three cesarean deliveries because of cephalopelvic disproportion and previous cesarean delivery. During her fourth parity, serial antepartum ultrasonography scans were checked due to her high risk of morbidly adherent placenta in view of the patient's history of artificial abortion and multiple cesarean deliveries.

At the first trimester, transvaginal ultrasonography was performed at 6 weeks of gestation, which revealed an intrauterine gestational sac (Figure 1). The implanting site of

gestational sac stayed at the anterior lower corpus of the uterus and near the previous cesarean section scar, which was compatible with cesarean scar pregnancy. The lining between the myometrium and deciduas remained smooth. Clinically, no vaginal spotting or massive bleeding was noted during the first trimester.

At the second trimester, transabdominal ultrasonography was performed at the 15th week of gestation, and placenta previa totalis was found with whole internal os covered by the placenta (Figure 2A). Loss of homogeneous appearance, protruding placental base into the myometrium, thinning of the retroplacental myometrium, and interrupted retroplacental anechoic band were noted with multiple lucent vascular lake intraplacentally, which were compatible with placenta accreta (Figures 2B–2E). Color Doppler also showed chaotic vascularity inside and beneath the placenta (Figure 2F). At 24 weeks of gestation, one episode of vaginal bleeding with lower abdominal pain occurred, and the patient was admitted for 4 days and received tocolysis. Otherwise, no fetal distress or gross hematuria was found then.

During the third trimester, transabdominal ultrasonography was checked again at the 32nd week of gestation. Persistent placenta previa totalis was confirmed, and increased heterogeneity with abnormal vasculature was seen in the placenta (Figure 3A). There was obvious progression in number and size of vascular sinus, and color Doppler indicated increased turbulent flow as well (Figure 3B). The uterovesicle border was not seen so clearly during the sonography examination (Figure 3A). Besides, retroplacental hypoechoic banding remained mimic.

The patient underwent cesarean delivery at 35 weeks of gestation after detailed planning and counseling, and the infant's outcome was fine, with birth body weight of 2485 g,



Figure 1 Transvaginal sonography at 6 weeks of gestation with cesarean scar pregnancy. The myometrial border and bladder lining remain smooth.

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