Department of Obstetrics and Gynecology

Chronic Abnormally Adherent Placenta: A Case Report

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Introduction

We present a possible fertility sparing management for chronic abnormally adherent placenta following a vaginal delivery. A 21-year-old presented to us from an outlying facility with chronic retained placenta with imaging concerning for placenta accreta and uterine septum. She was initially evaluated for a fever with vaginal bleeding. Due to her young age, history of two suction dilation and curettages (D&C) and desire for future fertility, the patient was offered conservative medical management with Methotrexate (MTX). Following MTX, the patient passed her remained placental tissue and her HCG was followed to negative. Chronic abnormally adherent placenta is unusual for a primiparous female and could have significant affects on future fertility.

Case Report

A 21-year-old female six weeks postpartum was transferred to us from an outlying facility for vaginal bleeding/fever in the setting of chronic retained placental products. The patient's pregnancy was complicated by PPROM at ~15w gestation followed by delivery at ~27w with a neonatal demise shortly following birth. The umbilical cord was avulsed and manual removal of the placenta was subsequently unsuccessful. The patient was taken back for her first Suction D&C under ultrasound guidance, discharge followed. Two weeks later, she continued to bleed; Cytotec was administered and unsuccessful. She returned the next day which prompted her second Suction D&C; again unsuccessful. Ultrasound prior to her second D&C revealed a possible uterine septum. She was then evaluated a third time for vaginal bleeding and fevers.

On initial admission to the OLF, the patient was found to have a temperature of 38.9C, WBC of 12.6 and tachycardic (140s), normotensive and anemic with Hb of 9.7. Physical exam revealed vaginal bleeding from an open cervical os. She was admitted and started on IV antibiotics (Ertapenem/Metronitazole) for endometritis.

Results

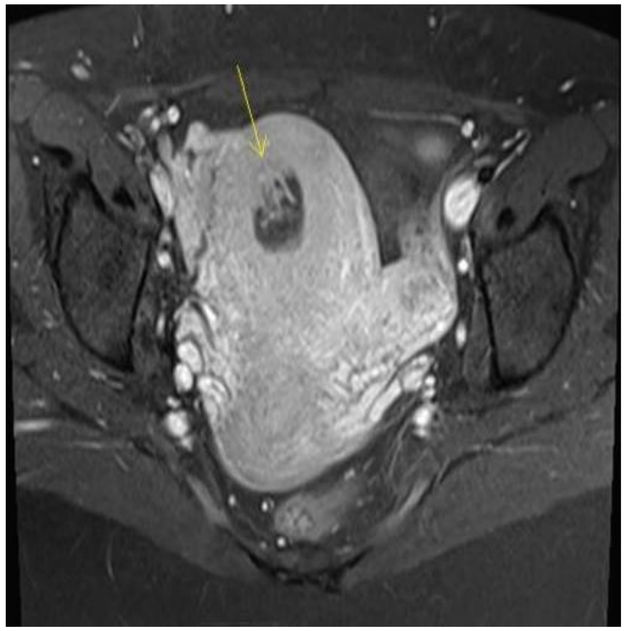

Figure 1: MRI Pelvis: Uterus 10.8 x 5.5 x 6.4cm, reveals small focus of retained products of conception without evidence of uterine invasion

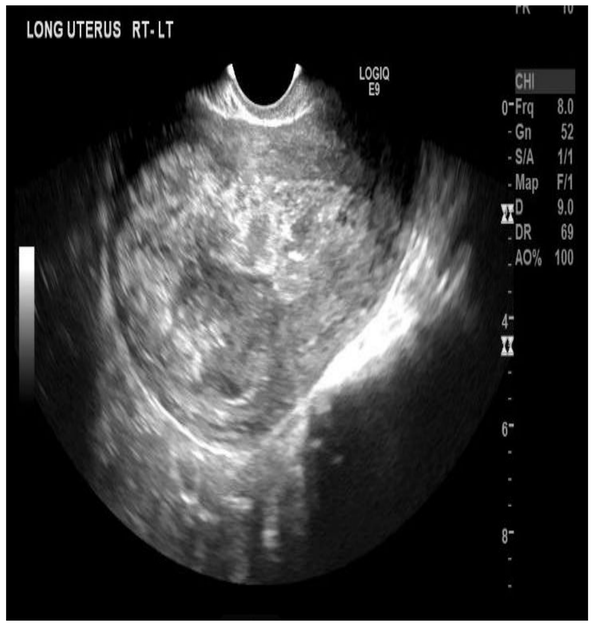

Figure 2: Transvaginal Ultrasound: suggestive of retained products of conception. Vascular flow noted on anterior wall with vascular pedicle like structure extending into the anterior portion of the echogenic endometrium.

Case Report continued

TVUS and CT abdomen and pelvis were completed which both revealed retained placental tissue. MRI was obtained to rule out placental accreta spectrum (PAS) disorders. The MRI revealed: an enlarged uterus, mass within the endometrium and placental invasion cannot be excluded. She was then transferred to our facility for further management.

On arrival and throughout her hospitalization under our care, the patient remained afebrile, VSS, no leukocytosis; however, she did continue to bleed and was noted to be anemic with Hb of 8.4. Repeat TVUS/MRI and labs were completed on admission, retained products can be seen in Figure 1 and 2. Imagining at our facility did not reveal definitive placenta accreta or mention possible uterine septum. HCG trend can be viewed in Table 1.

Care plan was discussed in detail with: primary OBGYN team, the patient and GYN Oncology. Patient was offered: MTX, Ultrasound Guided Suction D&C and hysterectomy was discussed as a last resort. Due to the risk of potential uterine scarring and adhesive disease (Asherman' Syndrome) and strong desire for future fertility, conservative management was the initial treatment option with MTX. MTX was given and the following day and the patient subsequently expelled a large amount of placental tissue. The final pathology on the sample revealed: partially necrotic chorionic villi and foci of acute inflammation. The patients bleeding was monitored and noted to decrease significantly. Following discharge, the patient returned for HCG trend in 7 days which was found to be negative.

Beta HCG Levels	149.47	164.8	IM MTX	73.9	22.4	1.6 (Negative <5)

Table 1: Trending HCG while in our care. IM MTX represents when MTX was given in relation to HCG levels.

Discussion

Chronic abnormally adherent placenta tissue is a rare clinical event especially in the setting of a primiparous female without a history of uterine surgery or trauma. The overall risk of PAS affecting pregnancy is ~0.17% which is largely due to increases in the CS rate in the United States. Although the chance of PAS would be small in a primiparous women in the fundal region of her uterus, it would not be impossible. The other possibility for the retained placenta could have been abnormally adherent an underlying congenital uterine anomaly (CUA, uterine septum) seen on TVUS. Although the exact risk is unclear, it is a known complication in pregnancies with CUA. A uterine septum could also be the reason the two prior suction D&Cs were unsuccessful. Further imaging studies would need to be completed on this patient to confirm any CUA. In the correct patient (failed surgical and medical management), MTX could be considered in an attempted to assist in expelling retained placental products.

Conclusion

Management of chronic, abnormally adherent placental tissue following delivery in a primiparous female is a clinical oddity. The patients clinical picture was clouded by differing imaging modalities, radiology interpretations, unsuccessful management with cytotec and multiple suction D&Cs. It is unclear exactly if the patient had inappropriate invasive growth into her myometrial cavity(PAS) or if the patient had a CUA which could have affected both the suction D&Cs and abnormally adherent placental tissue. The patient would need further workup to evaluate her uterine cavity following this episode. At this time, it could be reasonable to attempt MTX for chronic retained placental products after failed medical and surgical management (D&C) of retained products.