INTRODUCTION

In a review of the distribution of Mullerian anomalies, the mean incidence of bicornuate uterus is 46% [1]. This anomaly is associated with both fertility and obstetric complications. Identifying bicornuate uterus can be challenging. Placenta accreta is a general term when part or the entire placenta invades and is inseparable from the uterine wall [2]. Derivation of accrete comes from the Latin ac-+crescere-to grow [3]. The invasion of superficial myometrium is placenta accreta, invasion into deeper myometrial layer is placenta increta, and invasion through the serosa and/or adjacent pelvic organs is placenta percreta [4].

Placenta accreta can lead to considerable maternal morbidity and mortality (upto 9%) due to hemorrhage, infection, or other surgical complications such as those resulting from hysterectomy [5,6]. Retained placenta accreta is usually a rare condition, but its prevalence is increasing due to the rise in the rate of deliveries by Cesarean section [7]. Ultrasonography is sufficient to diagnose placenta accreta with a sensitivity of 77-87% and 96-98% specificity [9,10]. The optimum management strategies include either conservative management of the placenta left in situ, or surgical management which mainly includes hysterectomy [10]. The treatment modalities of conservative approach include use of methotrexate, uterine artery embolization, dilation and curettage, and hysteroscopic loop resection. The decision for choosing conservative management or hysterectomy depends on the extent of placental infiltration, patient’s hemodynamic and infection status, and her desire for retaining fertile. Here, we are presenting a case of 24yrs primiparous with retained placenta accrete in a bicornuate uterus.

CASE REPORT

24yrs old aged Mrs. XYZ, registered G2A1 with 39wks of gestation of pregnancy, was admitted on 12/04/2018 at CSMH with C/O labor pains. She had a spontaneous vaginal delivery of a live baby boy weighing 2.8Kg. However, placenta was not expelled spontaneously. Manual removal of placenta (MRP) under general anesthesia revealed an empty uterine cavity. Attempts to locate the placenta were futile. Patient’s vitals were stable. Her hemoglobin was 6gm% and TLC was 17000. There was no bleeding per vaginum. Uterus was 26 weeks postpartum. 2 Packed Cell Volume were given. Patient was counselled about complications of adherent placenta and also possibility of hysterectomy. As patient’s vitals were stable and there was no fresh bleeding, decision for conservative management was taken. Ultrasonography was suggestive of Bicornuate uterus with heterogenous hyper reflective mass measuring 81 x71 x 55 mm seen extending from the lower uterine cavity into posterior myometrium of left uterine cornua with thickness of myometrium reduced to 4mm, s/o Placenta Accreta in left horn.

ABSTRACT

Placenta accreta is an obstetric complication where the placenta becomes firmly adherent to the uterine wall. Retained placenta accreta may cause post-partum haemorrhage that can lead to peripartum hysterectomy. Here we present a case of retained placenta accreta in an undiagnosed bicornuate uterus, which was managed conservatively using injection methotrexate, systematically, thus, preserving future fertility of the patient.

KEYWORDS

Retained Placenta Accreta, Bicornuate Uterus, Methotrexate, Fertility

Fig.1. Ultrasonography showing placenta accreta in left cornua of a bicornuate uterus.

Beta HCG was 21748mIU/ml. Hemogram, Liver Function Test, Renal Function Test and coagulation profile were within normal limits. MRI was not done as patient was not affording. Injection Methotrexate 1 mg/kg was administered following the regime on 1,3,5,7 days alternating with injection Folinic acid 0.1 mg/kg.

Injection Piperacillin-Tazobactum and Gentamycin were given for 5 days. Patient was discharged on Day 10th and advised to follow up. Patient was monitored on OPD basis with serial beta HCG, CBC and ultrasound. (Table 1)

There was no bleeding per vaginum, fever or foul smelling discharge during the entire period. On 88th postpartum day, patient reported to the hospital with bleeding per vaginum. She spontaneously expelled a fleshy mass measuring 8x6cm. Patient was vitally stable.

In the 12th postpartum week, patient presented to our patient department with Beta HCG of <2.0mIU/ml and histopathology report suggestive of retained products of conception.

Table 1

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Fig.2. Placental mass expelled by the patient. HPE s/o Retained products of conception.

In the 12th postpartum week, patient presented to our patient department with Beta HCG of <2.0mIU/ml and histopathology report suggestive of retained products of conception.
Fig.3. Ultrasonography showing empty bicornate uterus.

**DISCUSSION**

Identifying bicornuate uterus can be challenging. Incidence of placenta accrete has increased from 1/7000 to 1/2500 deliveries due to increase rate of cesarean deliveries\[1\]. In Mullerian anomalies, the mean incidence of bicornuate uterus is 46%. This anomaly is associated with both fertility and obstetric complications\[2\]. In our case, placenta was adherent to left cornua of bicornuate uterus. There are different methods of management, ranging from conservative methods to extirpative management\[13\].

Sentilhis et al, concluded that failure rate of conservative management was 22% which required hysterectomy\[14\].

However, Crespo et al\[15\], Arul Kumaran S et al\[16\] used 4 doses of methotrexate 50 mg/day with folinic acid rescue which was consistent with our management protocol. Peiffer S et al\[17\] also support the conservative management in such cases.

Trimmermans et al\[17\] reviewed that fever and vaginal bleeding, each was seen in 35% of patients on conservative management and had to undergo hysterectomy in majority of the patients.

However, in our case, patient had no complaints of fever, excessive bleeding per vaginum or symptoms of sepsis. Hence decision of conservative management was taken to save the future fertility of this patient.

**CONCLUSION**

Although retained placenta still remains a potentially life threatening condition, we managed our case conservatively by avoiding hysterectomy and preserving the future fertility in a primiparous patient. Thus, a multidisciplinary integrated management strategy at an appropriate tertiary care centre is essential in order to reduce the mortality and morbidity associated with placenta accreta.

**REFERENCES**