

# Undiagnosed Placenta Accreta During an Abortion in Second Trimester: A Case Report

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**Abstract:** Placenta accreta spectrum (PAS) is a dangerous pregnancy condition where the placenta abnormally invades the uterine wall, with three severity levels: accreta, increta, and percreta. It poses a life-threatening risk during evacuation or curettage procedures for pregnancy loss due to potential massive bleeding. Early diagnosis is crucial for at-risk women, but there's limited research and established management protocols specifically for second-trimester pregnancy termination cases involving PAS.

**In this report, we describe a case of placenta accreta in second trimester, diagnosis and management.**

**Keywords:** *Placenta Accreta Spectrum, Diagnosis, Management.*

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## I. INTRODUCTION

Placenta accreta spectrum (PAS) is an abnormal placentation during pregnancy and is categorized into accreta, increta, and percreta in the order of increasing invasion of placental villi through the uterine wall

It can be a life threatening situation when encountered during an evacuation or curettage performed for first or second trimester pregnancy loss, leading to massive hemorrhage.

Women with risk factors for placenta accreta spectrum should be diagnosed early in pregnancy.

There are limited data on pregnancy termination in the second trimester with concurrent PAS disorders in the literature. Specific management strategies for this patient group have seldom been reported, and their efficacy remains unevaluated.

## II. CASE REPORT

A 41-year-old female patient with a history of myomectomy performed 8 years ago. She is G5P4:G1 with vaginal delivery, G2 and G3 by cesarean section, G4 which progressed to early spontaneous abortion for which curettage was performed, G5 corresponding to the current pregnancy, estimated at 21 weeks of amenorrhea. And no significant medical history.

The patient presented to the emergency department in the context of fever occurring two days after a late abortion that occurred at home. The history revealed incomplete expulsion of the fetus, with decapitation at the time of expulsion and retention of the placenta.

On examination, the patient had a temperature of 39°C, blood pressure of 110/80 mmHg, and tachycardia at 120 beats per minute. Speculum examination revealed purulent, fetid, and abundant leukorrhea.

Laboratory tests showed elevated CRP at 269 mg/L and hyperleucocytosis at 22,198 elements/mm<sup>3</sup>. Pelvic ultrasound revealed partial retention of the fetus as well as placental retention.

An attempted evacuation by aspiration and curettage was performed without success. Pelvic MRI was then indicated, showing retention of products of conception with signs of myometrial invasion, suggestive of placenta accreta (figure 1).

During hospitalization, the patient developed a clinical picture of sepsis. Due to strong suspicion of placenta accreta

and after obtaining informed consent, a hysterectomy was performed (figure 2).

Anatomopathological examination of the surgical specimen revealed a morphoologically abnormal placenta, the presence of multiple abscessed collections, as well as retention of fetal skin and bone tissue.

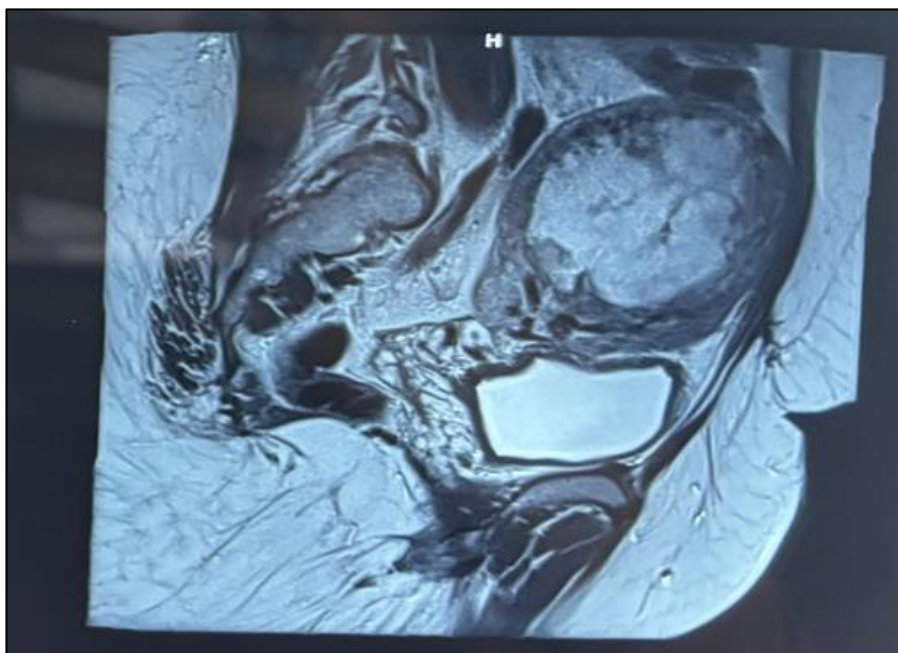


Fig 1 : Myometrial Invasion, Suggestive of Placenta Accreta.

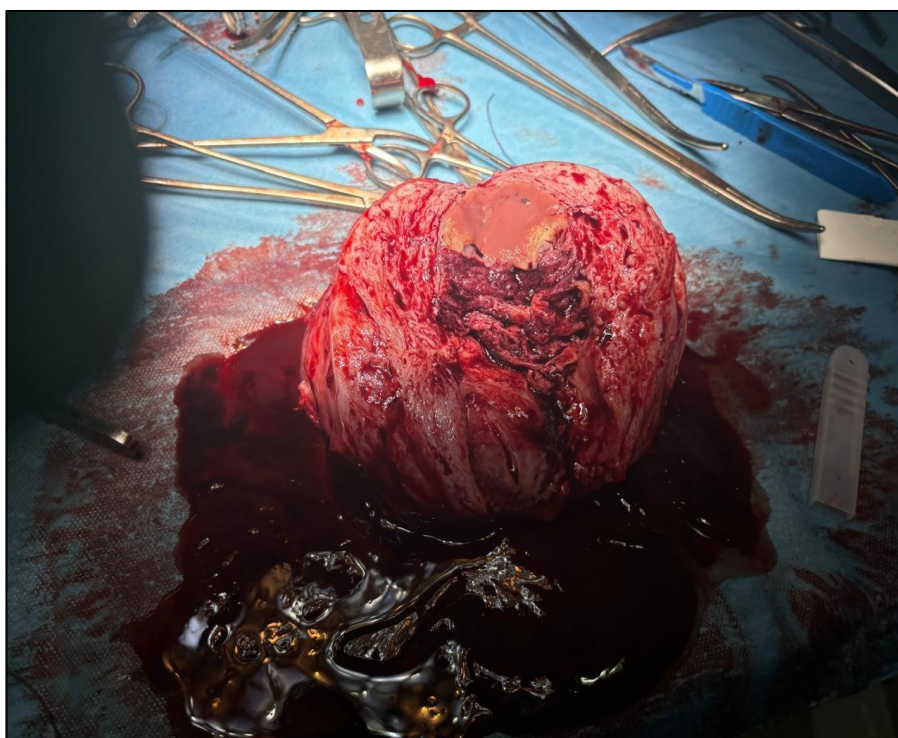


Fig 2 : Uterus Including Placenta and Fetus.

### III. DISCUSSION

Placenta Accreta Spectrum (PAS) refers to abnormal trophoblastic invasion of the placenta beyond the decidua basalis into the myometrium, and in severe cases, beyond the uterine serosa or into adjacent organs (1,2). This abnormal invasion results from defective or absent decidualization, often due to prior damage to the endometrial-myometrial interface. Common risk factors include (3): Previous cesarean sections (especially multiple), Placenta previa, particularly overlying a uterine scar, Prior uterine surgeries, such as myomectomy, Dilatation and curettage (D&C), Endometrial ablation or Asherman's syndrome

PAS is classified into three main types based on the depth of invasion (4):

Placenta accreta: attachment to the myometrium without invasion. Placenta increta: invasion into the myometrium. Placenta percreta: invasion through the myometrium and serosa, possibly affecting adjacent organs (e.g., bladder)

This condition is associated with significant maternal morbidity and mortality due to the risk of massive hemorrhage during delivery.

Early antenatal diagnosis of placenta accreta spectrum (PAS) is essential for improving perinatal outcomes. Although suggestive sonographic features can be detected as early as the first trimester, most cases are identified during the second or third trimesters. In women with known risk factors, systematic screening by an obstetrician-gynecologist is recommended. When suspicion arises, color Doppler ultrasonography should be employed to confirm the diagnosis. Literature reviews suggest that placenta accreta spectrum (PAS) disorders may be detected on early trimester ultrasounds, particularly between 11 and 14 weeks of gestation (5)

Traditionally, hysterectomy has been the standard treatment for placenta accreta diagnosed in the first or second trimester following abortion. However, with the advancement of diagnostic and therapeutic techniques, conservative management has emerged as a feasible option in selected cases—particularly when uterine preservation or future fertility is desired. Methotrexate (MTX) has recently been introduced as a conservative approach in the management of abnormal placentation after abortion or delivery. Uterine artery embolization (UAE) is also commonly employed to achieve rapid hemostasis. Nonetheless, the potential for revascularization of retained placental tissue may lead to persistent or delayed bleeding, which can ultimately result in treatment failure and require hysterectomy (6).

#### ➤ Patient Consent:

A consent for publication of the case was obtained from the patient.

#### ➤ Competing Interests:

The authors declare no competing interests.

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