



Case report

Placenta Percreta in a Normally Implanted Placenta on an Unscarred Uterus with Uterine Perforation at 30 Weeks of Gestation: A Case Report

Placenta percreta normo-inséré sur utérus non cicatriciel avec perforation utérine
à 30 semaines d'aménorrhée : à propos d'un cas

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Résumé

Introduction : Le placenta percreta est une forme rare mais grave du placenta accreta spectrum, habituellement associée à des antécédents de chirurgie utérine. Sa survenue avec un placenta normo-inséré sur un utérus non cicatriciel est exceptionnelle et peut se révéler par des complications mettant en jeu le pronostic vital.

Cas clinique : Nous rapportons le cas d'une patiente de 37 ans, sixième geste, mère de quatre enfants vivants, tous nés par voie basse. Elle avait un antécédent de fausse couche traitée par curetage hémostatique non compliqué. À 30 semaines d'aménorrhée, alors qu'elle était suivie pour une hypertension artérielle gravidique équilibrée sous traitement, elle a été admise en état de

choc avec des douleurs abdominopelviennes aiguës et intenses. L'échographie a révélé un hémopéritoine massif, une mort fœtale in utero, un placenta fundique et une perte de continuité de la paroi utérine dans la région cornéofundique. La laparotomie en urgence a mis en évidence un placenta percreta avec perforation utérine cornéale droite. Une césarienne suivie d'une hystérectomie d'hémostase a été réalisée.

Évolution : Malgré une réanimation intensive et une transfusion massive, la patiente est décédée en peropératoire.

Conclusion : Ce cas illustre le potentiel catastrophique du placenta percreta, même en l'absence de cicatrice utérine majeure, et souligne l'importance ainsi que la difficulté du diagnostic anténatal précoce et d'une

prise en charge multidisciplinaire adaptée.

Mots-clés : Placenta percreta ; perforation utérine ; hystérectomie ; mortalité maternelle.

Abstract

Background: Placenta percreta is a rare but severe form of placenta accreta spectrum, usually associated with previous uterine surgery. Its occurrence in a normally implanted placenta on an otherwise unscarred uterus is exceptional and may present with life-threatening complications.

Clinical case: We report the case of a 37-year-old woman in her sixth pregnancy, with four living children, all delivered vaginally. Her history included a miscarriage managed by uncomplicated haemostatic curettage. At 30 weeks of gestation, while receiving treatment for gestational hypertension, she was admitted in shock with acute, severe abdominopelvic pain. Ultrasonography showed massive haemoperitoneum, intrauterine fetal death, a fundal placenta and loss of uterine wall continuity in the cornual fundal region. Emergency laparotomy revealed placenta percreta with right cornual uterine perforation. Caesarean delivery followed by haemostatic hysterectomy was performed.

Outcome: Despite intensive resuscitation and massive transfusion, the patient died intraoperatively.

Conclusion: This case illustrates the catastrophic potential of placenta percreta even in the absence of a major uterine scar and highlights the difficulty and importance of early antenatal diagnosis and appropriate multidisciplinary management.

Keywords: Placenta percreta; uterine perforation; hysterectomy; maternal mortality.

Introduction

Placenta accreta spectrum (PAS) comprises placental invasion disorders characterized by abnormal trophoblastic attachment to and invasion of the myometrium [1]. These disorders are usually associated with a history of uterine surgery [1,2].

Their occurrence in a normally implanted placenta on an otherwise unscarred uterus is exceptional and may lead to severe complications. Placenta percreta, the most severe form of PAS, may cause uterine perforation and catastrophic haemorrhage. Its prevalence is increasing in parallel with the rising frequency of previous uterine procedures, including caesarean delivery, myomectomy and curettage [1,3]. Maternal mortality remains high, particularly in settings where diagnosis is delayed and resources are limited.

Clinical case

A 37-year-old woman in her sixth pregnancy, with four living children, all delivered vaginally, had a history of miscarriage managed by uncomplicated haemostatic curettage.

The current pregnancy had reached 30 weeks of gestation, and previous examinations described the placenta as normally implanted. Gestational hypertension had been diagnosed at 26 weeks during her first, late antenatal consultation and was controlled with antihypertensive treatment.

She was admitted in shock with acute abdominopelvic pain and absent fetal heart sounds. Ultrasonography showed a large-volume haemoperitoneum, intrauterine fetal death with biometric measurements consistent with 30 weeks of gestation, a fundal placenta and loss of uterine wall continuity in the cornual fundal region. The patient was transferred directly to the operating theatre for resuscitation and emergency laparotomy under general anaesthesia. A massive haemoperitoneum and placenta percreta perforating the right cornual fundal uterine wall were found. After evacuation of the haemoperitoneum, caesarean delivery followed by haemostatic hysterectomy was performed while resuscitation continued.

Cardiocirculatory arrest occurred intraoperatively. Despite massive transfusion, surgical haemostasis and advanced resuscitation measures, spontaneous circulation could not be restored, and maternal death was declared in the operating theatre.



Figure 1: Intraoperative appearance of cornual fundal placenta percreta with uterine perforation.

Discussion

Placenta percreta is a rare but dramatic condition. Placenta accreta spectrum is strongly associated with previous uterine surgery, particularly caesarean delivery [1,4]. In this patient, the only identified uterine risk factor was previous curettage, supporting the view that even relatively minor intrauterine procedures may impair decidualization and promote abnormal implantation.

Spontaneous uterine perforation caused by placenta percreta is exceptional. It may produce massive intraperitoneal haemorrhage, commonly presenting as haemorrhagic shock and intrauterine fetal death [5]. Antenatal diagnosis relies mainly on ultrasonography and magnetic resonance imaging [1,6,7], but may be difficult when placental implantation appears normal. In the present case, the usual sonographic markers were not specifically sought because the placenta appeared normally implanted and typical PAS risk factors were absent. Typical ultrasound findings include loss of the retroplacental clear zone, subplacental hypervascularity, and thinning or interruption of the uterine wall [6,7]. Failure to investigate these signs contributed to the delayed diagnosis.

In many low-resource settings, screening is delayed and maternal mortality remains high because of late presentation and limited access to blood products.

Hypertension was diagnosed at 26 weeks; however, previously unrecognized chronic hypertension cannot be excluded because the first antenatal consultation occurred late. This illustrates the difficulty of distinguishing gestational from chronic hypertension when antenatal care begins late. Hypertensive disorders of pregnancy are associated with insufficient trophoblastic invasion [8-10], whereas placenta percreta results from excessive local trophoblastic invasion [7,11]. Their coexistence in this patient illustrates the complexity of disorders at the maternal-fetal interface: placental hypoperfusion on one hand and excessive local invasion on the other. Gestational hypertension may have contributed to placental hypoperfusion, while placenta percreta was more plausibly related to previous curettage and localized defective decidualization. These different trophoblastic phenotypes may coexist and compound maternal and fetal risk.

Optimal management requires multidisciplinary preparation involving obstetricians, anaesthetists, radiologists and surgeons, together with substantial transfusion capacity [8,10,11]. Conservative options include vascular ligation, embolization and expectant management [8,11], but these were not feasible because of the patient's rapid clinical deterioration. Hysterectomy often remains the life-saving procedure, although mortality is high when diagnosis is delayed and massive haemorrhage has already occurred. In this case, the outcome was fatal despite caesarean delivery, haemostatic hysterectomy and massive transfusion.

This case emphasizes the importance of targeted antenatal ultrasonography, emergency massive-transfusion protocols and continuing professional training to recognize atypical presentations. Strengthening the diagnostic and emergency-care capacity of secondary-level facilities is essential to improve maternal outcomes.

Conclusion

Placenta percreta may occur in a normally implanted placenta even without a major uterine scar. Antenatal sonographic diagnosis can be difficult when the placenta appears normal and conventional risk factors are absent. Less typical risk factors, including advanced maternal age, multiparity and previous curettage, should therefore be considered during risk assessment. Late-diagnosed hypertension may also represent previously unrecognized chronic hypertension, highlighting the complexity of coexisting disorders of trophoblastic invasion. Multidisciplinary management and immediate access to adequate blood products are critical. In secondary-level facilities, improved screening capacity and preparedness for catastrophic obstetric haemorrhage should be priorities.

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References

- [1] Jauniaux E, Bhide A. Placenta accreta spectrum: epidemiology and risk factors. Clin Obstet Gynecol. 2018;61(4):733-742.
- [2] Silver RM, Barbour KD. Placenta accreta spectrum. N Engl J Med. 2019;380(16):1529-1536.

- [3] Eller AG, Porter TF, Soisson P, Silver RM. Optimal management strategies for placenta accreta. BJOG. 2009;116(5):648-654.
- [4] Fitzpatrick KE, Sellers S, Spark P, Kurinczuk JJ, Brocklehurst P, Knight M. Incidence and risk factors for placenta accreta/increta/percreta in the UK: a national case-control study. PLoS One. 2012;7(12):e52893.
- [5] Ghosh SK, Ramdev B, Sidhu N. Anaesthetic management of placenta percreta: case report. Int J Res Rev. 2022;9(1):39-44.
- [6] Allen L, Jauniaux E, Hobson S, Papillon-Smith J, Belfort MA. FIGO classification for the clinical diagnosis of placenta accreta spectrum disorders. Int J Gynaecol Obstet. 2019;146(1):20-24.
- [7] Jauniaux E, Collins SL, Burton GJ. Placenta accreta spectrum: pathophysiology and evidence-based anatomy for prenatal ultrasound imaging. Am J Obstet Gynecol. 2018;218(1):75-87.
- [8] Sentilhes L, Ambroselli C, Kayem G, et al. Maternal outcome after conservative treatment of placenta accreta. Obstet Gynecol. 2010;115(3):526-534.
- [9] Sorout S. Comprehensive management of placenta increta and percreta: a case report. Int J Sci Res Publ. 2024;14(8):208.
- [10] Wu S, Kocherginsky M, Hibbard JU. Abnormal placentation: twenty-year analysis. Am J Obstet Gynecol. 2005;192(5):1458-1466.
- [11] Timmermans S, van Hof AC, Duvekot JJ. Conservative management of placenta percreta: a systematic review. Obstet Gynecol Surv. 2007;62(8):529-539.

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