Une étiologie particulière de perforation utérine spontanée au troisième trimestre de grossesse

Le placenta accreta correspond à une adhérence anormale du placenta au sein du myomètre sans interposition de caduque. La forme percreta est caractérisée par un envahissement de toute la paroi myométriale, de la séreuse et parfois des organes de voisinage comme la vessie et le rectum [1]. Les complications hémorragiques sont les plus redoutables car elles peuvent mettre en danger la vie maternelle [2].
Nous rapportons une nouvelle observation de placenta accreta.

Observation
Une patiente de 41 ans ,quatrième geste, troisième pare, ayant un utérus bi-cicatriciel est reçue aux urgences obstétricales sur un terme de 34 SA en état de choc avec un abdomen distendu. L'activité cardiaque fœtale est négative.pas d'hémorragie extériorisée. L'échographie abdominale montre une grossesse mono-foetale intra-utérine avec activité cardiaque négative, un placenta antérieur et fundique et un épanchement intra –abdominal de grande abondance.
Une laparotomie est pratiquée en urgence. L'exploration de la cavité abdominale retrouve un hémopéritoine de trois litres avec intégrité de l ancienne cicatrice. Après extraction fœtale, l'exploration de l'utérus trouve une zone de perforation fundique due à l'infiltration du placenta au-delà de la séreuse utérine. Le diagnostic de perforation utérine due à un placenta percreta est établi et une hystérectomie d'hémostase est réalisée ainsi qu'une transfusion par sept culots globulaires, quatorze plasma fraic congelé et neuf culots plaquettaire.
La patiente était transférée en service de réanimation intubée, sous noradrénaline. Une reprise chirurgicale est indiquée à J1 post opératoire devant la distension abdominale et l'instabilité hémodynamique malgré les transfusions et les fortes doses d'adrénaline.une hémorragie d'origine annexielle gauche est retrouvée et une annexectomie est réalisée avec ligature des artères hypogastriques. Les suites opératoires étaient simples et la sortie était autorisée après 05 jours d'hospitalisation.
L'examen histologique de la pièce d'hystérectomie confirme le diagnostic de placenta percreta avec des villosités placentaires qui infiltrent toute la paroi jusqu'à la séreuse.

Conclusion
Le placenta accreta est une pathologie à risque de complications hémorragiques graves au cours de la grossesse.il est donc nécessaire d'en faire le dépistage prénatal même chez les patientes qui n'ont aucun facteur de risque apparent.
Le compte rendu échographique, surtout des patientes à risque modéré et à risque élevé, devrait mentionner de façon systématique la présence ou non de critères échographiques de placenta accreta.
Le diagnostic anténatal est très important pour pouvoir adresser les patientes vers des maternités adaptées à ce type de pathologie.

Références
1-Kayem G, Grange D, Goffinet F. Prise en charge du placenta accreta. Gynecol Obstet Fertil 2007; 35:78-92.
2-Kayem G, Anselem O, Schmitz T et al. Comparaison historique de deux type de prise en charge de placenta accreta: radical versus conservatrice. J Gynecol Obstet Biol Reprod 2007; 36:680-7.

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Intramural pregnancy following a salpingectomy

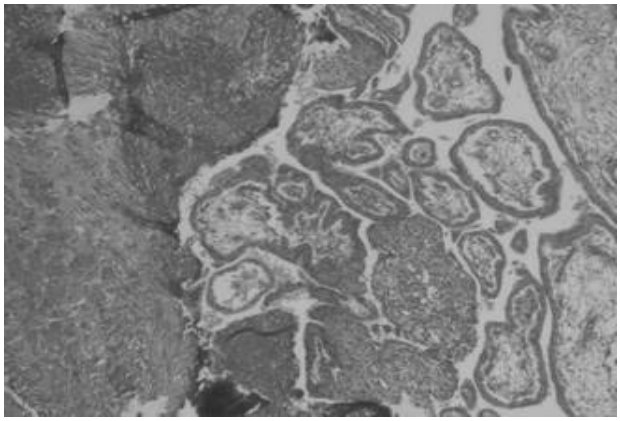
Intramural pregnancy is the rarest type of ectopic pregnancy. It is defined as a gestation occurring outside the uterine cavity and tubes and surrounded by the myometrium. Diagnosis is difficult and often made late. Treatment usually requires an emergency hysterectomy due to massive bleeding and very frequent uterine rupture. However ultrasonography offers the possibility of early preoperative diagnosis allowing conservative management.
We report a case of intramural pregnancy which was diagnosed and treated in our department.

Case report
A 35-year-old woman, gravida 3, para 2 was admitted in our emergency unit at 11 weeks and 4 days of gestation complaining of acute pelvic pain and vaginal bleeding. The patient's medical history was unremarkable. Previous obstetric history included two uneventful full-term vaginal deliveries and a ruptured ectopic pregnancy requiring a left salpingectomy by laparotomy. The patient had never practiced birth control. Physical examination revealed a well preserved general condition; BP 120/80 mmHg. The patient's abdomen was soft and a black bleeding from the cervical bone was noticed on speculum examination.
On pelvic examination, the cervix was soft and posterior; the uterus was at 10 weeks of gestation, and there was a left fornix tenderness. Vaginal ultrasound examination revealed a gestational sac containing an 11 week gestation living embryo distinct from the endometrial cavity with intra-abdominal free fluid. Both the endometrium and gestational sac appeared to be surrounded by the myometrium (figure 1). Based on the ultrasound data, a cornual pregnancy was highly suspected in first place, and intramural pregnancy in second place. The patient underwent laparoscopy which revealed many pelvic adhesions and a left 8-cm bulging adnexal mass on the left side of the uterus. The mass was covered by serosa revealing the gestational sac and seemed to be embedded in the myometrium. The right tube was stubby and adherent to the right ovary. No left tube was found.

216

As injection of methotrexate was to be unsuccessful because of the mass' size and local findings, we decided to perform a laparotomy. Conservative management was carried out with surgical enucleation of the invaded myometrium. Right salpingectomy was performed because of the anatomical lesions. The patient had an unenventful postoperative course. Anatomic pathological findings confirmed the intramural ectopic site of the pregnancy (Figure 1).

Figure 1: Presence of immature placental villi in myometrial tissue.



Conclusion

Intramural pregnancy remains a rare but serious ectopic pregnancy. Diagnosis is often delayed because of its confusing sonographic findings. Prognosis for survival as well as for the patient's fertility depends on early diagnosis based on ultrasound findings revealing intramural ectopic gestational sac completely surrounded by the myometrium and independent from the endometrial complex. Conservative management either surgical or medical can be adopted with an acceptable success rate. This particular ectopic pregnancy can also be revealed by an uterine rupture and the adapted treatment should be hysterectomy.

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Successful pregnancy and delivery in patient with artery bypass grafting for coronary lesion caused by Kawasaki disease

Kawasaki disease or mucocutaneous lymph node syndrome is an acute febrile illness affecting young children characterized by bilateral conjunctival congestion, changes of lips and oral cavity, polymorphous exanthema, changes of peripheral extremities and acute no purulent cervical lymphadenopathy. It is an acute vasculitis syndrome of unknown etiology that primarily affects small and medium sized arteries, particularly coronary artery which is responsible for the illness severity [1, 2]. Some patients who had Kawasaki disease accompanied by cardiac involvement including coronary aneurysm are now adults and of childbearing age. There is no complete guideline in management of pregnancy and delivery in patient with coronary artery disease treated by bypass grafting [3, 4].

We report a successful pregnancy and delivery in patient with artery bypass grafting for coronary lesion caused by Kawasaki disease.

Case report

Ms FL, a 32 years old woman was admitted to obstetric department at 37 weeks gestation in order to plan her delivery. This is her first pregnancy after 5 years of infertility. She had been suffering from coronary insufficiency triggered by acute myocardial infarction in antero-septal territory since January 2002. Coronary angiography performed after this incident showed aneurysm lesions and stenosis affecting the anterior inter-ventricular (AIV) and the right coronary artery (RCA). These lesions evoke Kawasaki disease. In May 2002 the patient was subject to a 2nd acute myocardial infarction crisis; consequently a quadruple bypass grafting was applied using the left internal thoracic artery and the right saphenous vein. Postoperative courses were simple. Excluded aneurysm histopathology examination was in favor of Kawasaki disease. Etiological check-up of Kawasaki disease and thrombosis accident leading to ischemic heart consisting of an immunologic test (ANA, DNA native, and rheumatoid factor), hematological test (Protein S, Protein C, and Antithrombin III), bacterial and virology test were normal. Since she was infertile, she was followed up for five years. Results had showed that hyperprolactinemia was the sterility cause. In order to check her gestation ability, she was sent to cardiovascular department to assess her cardiac performance, and the results were as the following:

At the physical examination, heart rate was 80 beats/min, blood pressure was 110/60 mmHg, and there had been no recent episodes of effort angina. Echocardiography (figure 1) showed neither dilated nor hypertrophic left ventricular. Left ventriculography showed a reserved left ventricular function (ejection fraction = 57%). Electrocardiogram (Figure 2) showed no abnormal Q wave and normal sinus rhythm. A treadmill exercise tolerance test showed no ischemic change on the electrocardiogram. The patient was in New York Heart Association functional class II. As the examination results did not contraindicate pregnancy, therefore, the patient had undergone a Prolactin-inhibitor bromocriptin. After 3 months of treatment the patient was pregnant and she has been under anticoagulant therapy (Aspirin, low molecular weight heparin) since the primary weeks of gestation. The antenatal check up and the course of pregnancy were normal. In the 37 weeks pregnancy and after a multidisciplinary decision (obstetrician, cardiologist and anesthesiologist), elective caesarean section