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Nutritional Intervention in a High-risk Pregnancy With Placental and Uterine Complications: A Case Report

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Case Report

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Abstract

Pregnancies with complications like ovarian/uterine cysts, uterine myomas, placenta accreta, cervical insufficiency and endometriosis pose significant risk to both mother and the foetus. Conservative management options are limited, and nutritional support is rarely highlighted. This case report presents a 31-year-old primigravida with sonographic findings of cervical funnelling, placental lakes suggestive of PAS, uterine thinning and bilateral ovarian cysts. Standard hormonal therapy was initiated but discontinued at 18 weeks due to cyst progression. A structured nutritional intervention including daily ragi porridge and tender coconut water alongside normal diet advised by NHM and strict be rest was continued. Subsequent monitoring demonstrated progressive regression of placental lakes, normalization of uterine walls, stabilization of haemoglobin levels, enhance cervical integrity indicating the reversal of previously observed high risk conditions. MRI at 25 weeks confirmed cyst persistence but ongoing improvement of uterine and placental complications. The patient achieved a full term spontaneous vaginal delivery at 39 weeks with a healthy neonate of 2.761 kg and uneventful placental separation. Postpartum imaging at three months revealed complete resolution of uterine abnormalities with dermoid cysts remaining. The case highlights the potential role of targeted nutritional therapy in managing high risk pregnancies, emphasizing how diet-based interventions may contribute to the reversal of placental and myometrial complications in an unscarred uterus. These strategies guarantee conventional obstetric care and further exploration of nutritional interventions for safe pregnancy and foetal care.

Introduction

Placenta accreta spectrum (PAS) represents a rare but potentially life-threatening obstetric condition characterized by the abnormal invasion of placenta into myometrium, in some cases extending through uterine wall, placenta increta or extending to adjacent organs, placenta percreta. The failure of placental separation at the respective stage of pregnancy can lead to severe bleeding, coagulation disorders and nee for surgery. The coexistence of adnexal mass during pregnancies is another complication that can cause risk to both mother and foetus. While the cysts are benign, the coexistence with other complications heightens the risk in pregnancy. Neiger (2017) [1] have reported literature mentioning the adverse pregnancy outcomes like placental malfunction called as Placental syndrome that may remain as long term effect in some patients. Cervical incompetency or insufficiency has been a controversy from long years especially in the second trimester of pregnancy causing foetal wastage or preterm birth. The condition is often due to the absence of clinical uterine hypertonocity, prolapse of membranes and dilation of the cervix with loss of tonus [2]. Development of adnexal mass during pregnancy has been a common finding during pregnancy in many patients. Most of them being benign and resolving spontaneously postpartum or removed via surgical methods [3]. Choi-Klier et al., 2025 [4] have reported adverse outcomes of the presence of placental lakes during pregnancy. The major observations were disorders of pregnancy, felt growth restriction and foetal demise. The intensity varies depending on the size and number of lakes and strength of placenta [4].

Complications associated with pregnancy impact the health of both the mother and the foetus contributing to several post pregnancy complications to both [1]. These can be solved by effectively addressing the complications with effective strategies. The key strategies include early identification of complications, early prenatal care and elimination of the risk factors involved during perinatal and inter-conception period [5].

Hormonal therapies such as progesterone supplementation either orally or as injection are routinely prescribed to manage cervical incompetency and threatened miscarriage during early pregnancy period. Ali et al., (2023) [6] have reported the proliferation of Uterine Fibroids because of progesterone signalling certain pathways both genetically and epigenetically. It has been reported to increase cellular heterotrophy, deposition of extracellular matrix and is considered pro-proliferative and carcinogenic in mammary tissues [7]. Similarly, a case reported by Woolrych and Robinson, 1995 have mentioned the increase in uterine fibroids on taking prescribed progesterone therapy and this was dramatically reversed on withdrawing progesterone therapy on patient. The case study strongly gave evidence on the impact of progesterone on fibroid development. Another case report have reported a similar risk factor for malignant transformation of ovarian cyst and endometrioma during progesterone (dienogest) therapy [8]. Another study has reported ovarian cyst development in several women who are under progesterone therapy for different medical reasons [9].

Nutritional interventions for pregnant women have been followed since centuries. World Health Organisation and NHM have prescribed diet plans to be maintained during each trimester and post-partum. Nasmi (2021) [10] have reported ragi products supplemented to pregnant and lactating women to eliminate iron deficiency and neural birth defects. Similarly, the supplementation of Ragi or millet-based food is found to enrich nutrition to both mother and child. Another effective natural supplement that can replenish pregnant mother is the tender coconut water. According to Puspitasari et al., (2024) [11], tender coconut water has the power to reduce Hyperemesis Gravidarum. There are also reports mentioning prevention of early gestational diabetes because of taking coconut water during the first trimester. Similarly, tender coconut water also had the potential to reduce hypertension in pregnant women and replace and enrich several minerals and vitamins in body. Tender coconut water is taken during winters to prevent dehydration, and this is also crucial during pregnancy as the mothers should never go dehydrated during pregnancy period. Tender coconut water contains several nutrients like minerals, vitamins, antioxidants, amino acids and electrolytes that can protect the body from several diseases. Tender coconut water also contains important compounds like magnesium, calcium, potassium, selenium. Boron. Molybdenum, methionine, zinc, iodine and manganese along with phytohormones. These not only replenish the pregnant mother but also enrich the foetus and benefit their development all throughout their growth[12]. Tender coconut water thereby could increase amniotic fluid and prevent placenta previa, abruption and even reduce multiple pregnancies. Fitriana et al., (2024) [13] studied on the positive impact of tender coconut water consumption on early onset of preeclampsia like impairments in rats and have been reported to alter the changes caused hormonally due to high fat diet by pregnant mothers [14].

Case Presentation

Patient Information

A 31-year-old primigravida (G_1P_0) with natural spontaneous conception presented at 12-13 weeks of gestation with mild vaginal bleeding for more than ten days duration with mild pelvic pain and without any discharge or clots. She had no prior complications, surgeries, no previous abortion history, no history of endometriosis, polycystic ovary disease or had any infertility treatment. Her past menstrual history was normal and had no family history of gynaecologic malignancies.

Initial Evaluation/Observation

The ultrasonographical scans showed no abnormalities until the last US scan at 14^{th} week. However, post bleeding, treatment for the same and 20 days bed rest, abnormalities were observed in the 16^{th} week full anomaly scan.

The Level III Ultrasound done at 16^{th} week revealed the following:

- A single live intrauterine foetus, biometrically appropriate for gestational age.

- Minimal fluid in the cervical canal with subtle V shaped funnelling at the internal OS, suggestive of incipient cervical insufficiency.

- Multiple placental lakes and small retroplacental lacunae, raising suspicion of placenta accreta spectrum (PAS)

- A large heterogenous cystic lesion (8-9 cm) along the left uterine/broad ligament region. Differential diagnosis was fibroid degeneration, endometrina or adnexal cyst

- Uterine wall appeared thinned in the anterior segment adjacent to placental bed.

- Fetal Doppler parameters and uterine artery flow were within limits. Laboratory biochemical tests showed an Hb count of 11.2 g/dL.

Initial Management

- Considering the risk of miscarriage and inlaying cervical incompetency, the patient was put on hydroxyprogesterone caproate 500 mg intramuscularly once weekly (Vygest) for luteal support. Tranexamic acid 500mg plus mefenamic acid 200 mg were prescribed 5 days to control bleeding. Supplementation included iron-folate and Calcium D3 daily until delivery. Strict bed rest was administered from 14 weeks, advised to continue from 16^{th} week as per the scan reports and the patient was counselled as a high-risk pregnancy case.

- A structured nutrition plan as advised by NHM with proper hydration for every trimester was followed along with daily supplementation of Ragi malt with pinch of salt and Jaggery to taste every morning as first food and Tender Coconut Water- 500 mL daily until delivery.

Follow Up Scan and Observation

USG full Anomaly 2^{nd} scan at 20^{th} and 23^{rd} week pregnancy

- Normal developing foetus.

- Large heterogeneous cystic lesions typical dermoid cysts on both ovaries- large on left, mild funnelling.

- Reduction in placental lakes, mild uterine thinning and mild cervical incompetence.

MRI scan of the pelvis was done at 25 weeks pregnancy

- A left adnexal cystic lesion measuring 12.8 cm x 6 cm x 10 cm with internal dot-dash pattern and a Rokitansky protuberance- signifying the presence of dermoid cyst or mature cystic teratoma. The presence of small cyst at right ovary which developed within 2-week period.

- Thinned uterine wall approx. 4 mm with small residual placental lakes; no placenta previa

- The cyst had slightly changed size compared to 16-week scan, suggesting progression despite hormonal therapy. The patient was advised to discontinue all hormonal therapy and retain supplement- Iron-folate and Calcium with D3.

Biochemical Examinations

- The patient was tested for CA-125, CA 19-9 and CEA to exclude malignancy. The values for CA 125 were 27.7 and CEA around 1.29 were within the range limit. However, CA 19-9 was beyond permissible range giving a value of 138.9. The inference suggested the high level due to the presence of dermoid cysts.

Follow up Ultrasound findings

The Ultrasound findings of patient at 24 weeks pregnancy showed that placental lakes diminished, cysts stable at a size of 8.3 x 6.2 cm cm at left ovary. The right ovarian cyst was not detectable, but presence was not fully excluded.

At 28 weeks, the ultrasound findings were as follows: Homogeneous placental texture, uterine wall thickened, cyst size of left ovary stable at approx. 8 cm. The right ovarian cyst was not detectable, but presence was not fully excluded.

At 32 weeks, 4 days the findings of the ultrasound is as follows: Single live cephalic fetus, 32 weeks + 2 days (48□□ centile), EFW 1.76 kg; placenta anterior, no accreta/previa; cervical length 3.5 cm; dermoid 8 × 7 cm, intact walls, no vascularity or rupture; AFI 13.9 cm; BPP 8/8. No US observation of right ovary cyst observed. Per Vaginal Examination confirmed palpable cysts on the Left ovary approximately 10 cm size.

On 23rd June 2023, 5 days prior to delivery, a routine Ultrasound (US) scan and per Vaginal examination (PV) were performed to assess the position and condition of known ovarian dermoid cyst. The presence of palpable ovarian dermoid cyst of 7 x 7 cm size extending to cervix region complicating pregnancy was noted. The apparent size reduction compared to previous measurements was attributed to compression by foetus.

Throughout gestation, maternal vitals and laboratory indices remained stable and no preterm contractions occurred. The patient went through the pregnancy well under conserved observation.

Delivery course

At 39 weeks, 1 day (June 29, 2023), labour was induced with oxytocin infusion post the observance of contraction. She delivered vaginally a healthy female neonate weighing 2.761 ka (Apgar >8). The placenta separated spontaneously, normal morphologically and showed no evidence of accreta or haemorrhage. Postpartum recovery was largely uneventful except for the delay in episiotomy wound healing and breast engorgement from the 2nd day of delivery, both resolving with local care and lactation support. No postpartum anaemia, hepatitis or infection observed.

Post Delivery Scan Imaging Observations

Postpartum- 45 days US examination presented the following findings:

- Large bilateral dermoid cysts- Left Ovary- approx. 8.7 x 5.5 cm
- Uterus normal in size, endometrium not thickened.

Per Vaginal Examination

- Uterus normal and well contracted; healthy cervix and no infection
- A firm pelvic mass approx. 10 x 5 cm palpable through posterior fornix likely corresponding to left adnexal dermoid cyst noted in US.

The US scan was done 10 weeks postpartum and following findings were observed:

- Uterus involuted to normal size; endometrium 16mm, homogeneous.
- Persistent left ovarian dermoid cyst 8.3 x 6.2 cm

- Multiple small Nabothian cysts suggesting cervicitis
- Categorized as O-RADS 2 (Benign lesion, no malignancy risk)
- No free fluid or other pelvic abnormalities.
- Laparoscopy was advised.

The patient didn't undergo any surgery as she was breastfeeding until infant was 2 years old.

The US imaging findings post 2 years are as follows:

- Uterus normal in size; no fibroids or lesions; Normal endometrium
- Multiple Nabothian cysts suggesting cervicitis were observed at cervix
- Left Ovary showed a well defined heteroechoic cystic lesion showing internal dot-dash pattern with a Rokitansky protuberance measuring 8.3 x 6.2 cm- signifying a mature cystic teratoma or dermoid cyst.
- Categorized as O-RADS 2 (Benign lesion, no malignancy risk)
- No cysts or lesions observed in right ovary, normal in size
- No free fluids or ascites observed.

At nearly two years postpartum the patient demonstrates stable uterine recovery and persistent benign left ovary dermoid cyst originally identified during mid pregnancy. There have been only reductions in size, and it has retained to an approx. of 8 x 6 cm size. There was no recurrence of placenta-related abnormalities, uterine thinning, structural compromise or endometriosis observed. Nabothian cysts suggested mild inflammation which was normal observation post-delivery. Overall, the patient retained only benign dermoid cysts which advised periodical observation and surgical management at future stage.

Table 1 Chronological Timeline of Imaging and major Laboratory tests during pregnancy and post-partum

Event/Date	GA	Scan/Lab test	Findings	Remarks
LMP			28.09.2022	
1st trimester- November 2022 Hb	4 week	Lab	14.5 gm%	Within range
PCV			41.5%	
Random Glucose Level			98 normal	
RBC			5.13 million/cumm	
TSH			3.17 µIU/mL	
HCG			153.57 mIU/m	Pregnancy positive- predicting around approx.. 4 week
2nd Trimester -28 January, 2023	16-17 week	Level III Scan USG Full Anomaly Scan	Normal developing foetus. Pregnancy Complications observed- placental lakes, endometriomas, cervical funnelling, Large heterogeneous cystic lesions, Uterine wall degeneration, Placental accreta spectrum	Findings categorized as High-Risk Pregnancy. Advised MRI, Strict Bed Rest. Continued hormonal therapy.
2nd trimester- February, 2023	18week	-	-	Nutritional intervention begin- standard NHM south Indian diet along with daily intake of ragi malt and Tender coconut water until 3 months postpartum (February 2023- October 2023)
2nd Trimester -15th February, 2023	20 weeks	USG	Normal developing foetus. Large heterogeneous cystic lesions typical dermoid cysts on both ovaries- large on left, mild funnelling.	Reduced placental lakes observed and uterine wall thinning, no PAS, cervical incompetence was almost reversed. Doctor advised to discontinue hormonal therapy
3rd Trimester- 1 May, 2023	31 week	USG	Normal developing foetus. The growing foetus compressing cyst. Baby position longitudinal.	Pelvic pain at intervals due to cyst compression. Advised bed rest due to baby position. Nutritional intervention continued.

CA 19-9		Lab	138.9	Beyond range- due to cyst
CEA			1.29	Within range
CA 125			27.7	Within range
Random Glucose level			100 normal	
Hb			10.6	Borderline
TSH			3.78	Beyond range. Prescribed thyroxine 12.5 mcg
Postpartum	42 days after delivery	USG	Dermoid cysts- 8.3 x 6.2 cm on left ovary. No placental or uterine abnormalities.	
Hb		Lab	12 gm%	Normal
TSH			3.78	Mild above range. Prescribed to continue 12.5 mcg thyroxine
Random Glucose level			100	Normal range

The TSH level regressed back to normal range within 1.5 years. The prescribed medication was discontinued.

Nutritional and Diet Intervention

The patient followed the South Indian diet as prescribed by NHM along with a daily addition of ragi malt and tender coconut water. The following table summarize the diet plan and components followed by patient from 14th week until delivery and almost throughout lactation period.

Table 2: Nutritional diet plan during Pregnancy period

Time/Meal	Dietary Components	Quantity/Portion	Basic Observations
Initial Weight (28/09/2022) – 57 kg / Height – 169 cm/ Hb count – 14.5gm%; later reduced to 10-11 gm% at later stages of pregnancy; the lowest being 10 gm%			
Diet Plan- South Indian Diet- NHM			
Early Morning (6.30 am)	Ragi Malt- Finger Millet porridge	250-300 mL Prepared with Jaggery and salt to taste	Hb count began to be balanced at 10-12 gm % until delivery
Breakfast (8.00 am)	2 dosas or 3 idlis+ Pulses or Coconut Chutney or Veg curry/ Rice or Wheat Puttu + Green gram boiled, 1 glass milk (200 ml)	Home-made following NHM guidelines	
Mid-Day snack (11.00 am)	Seasonal Fruits (Amla, Custard Apple, Apple, Orange, Watermelon, Sweet melon, Pomegranate, Guava, berries, plums, dates, lichees, rose apples, Jack fruits, grapes, kiwis, dragon fruits, Mangoes) / nuts and dry fruits (soaked fig/apricot, dates, black and white raisins)/ Tender coconut water- fresh	100 g / 30g / 500 ml fresh resp. Amla was consumed all throughout pregnancy in different forms (Murabba, honey amla, Dried Amla/ candy, Chilly Pickle, Chutney, Juice, Brine Amla)	Consumption of fruits and mainly Amla controlled the usual nausea and temptation for sour items. Balanced the Vitamins.
Lunch (1.00 pm)	Steamed Red Rice + dal/sambar/mix veg/leafy vegetables/curd + 1 egg or 50g chicken or meat + pickle	Home-made following NHM guidelines	
Evening Snack (4.30 pm)	Tea- light +toast/wheat or ragi biscuit		
Dinner (8.00 pm)	Red Rice Kanji (porridge) or 2 Roti + Vegetables or Pulses (small cup or 75 g)	Home-made following NHM guidelines	
Bedtime (9.30-10.00 pm)	1 cup milk (100ml)/ Tender coconut water (500 mL)	Tender coconut water is taken as per tendency or heat felt by patient	Electrolytes balanced and body heat reduced
Water Intake per day	2-3 litres		
Outcomes/ Observations	Weight increased by 20 – 25 kg (80+ kg) from initial weight (57 kg) Hb was balanced within range even during 3rd trimester (approx. 11 gm%) Body heat reduced, Hydrated, no nausea, Improved appetite and Fatigue reduced		

	Was able to do basic chores and short walks even during strict bed rest at 3rd trimester

Discussion

The present case report is unique for the following:

- The patient had no uterine scar, no history of abortion, assisted reproduction history or any other issues.
- Placental and Uterine abnormalities resolved under conservative and nutritional based management.
- Even with hormonal therapy, the patient developed cervical incompetency and progressive cystic enlargement, which regressed after treatment withdrawal- showing resolution of Right Ovarian cyst and stability in remaining lesion.
- A full-term vaginal delivery was achieved without haemorrhage or retained placenta.

Placenta Accreta spectrum (PAS) in an unscarred uterus is exceptionally rare [15]. However, in this case the patient developed multiple complications towards the end of 1st trimester. Earlier sonographies were normal showing a single intrauterine foetus, but towards the 14th week full US scan showed – placental lakes, mild myometrial thinning, suspicion of PAS, cervical funnelling raising suspicion of cervical incompetence and large heterogenous cystic lesions with a healthy foetus. There are several reports and cases on development of PAS during pregnancy especially those with caesarean history [16]. However, Pas reported in unscarred uterus were limited to just one case reported by Mlay et al., (2023) [17] where a patient 22-year-old, para 2 living 2 presented a PAS and postpartum haemorrhage during delivery.

Cervical incompetency observed at 16 weeks reflected early softening either due to mechanical stress or progesterone deficiency. However, the patient was on progesterone therapy and further weekly hydroxyprogesterone caproate initially to maintain cervical stability. The progesterone therapy was discontinued post mild observance of cyst enlargement and development. Previous evidence reports cyst development and gynaecological complications developed during progesterone or hormonal therapy [9]. There are also reports of progesterone action on cancer and uterine fibroids mentioning the adverse effects of prolonged progesterone usage [7]. Reis et al., (2016) [18] and Ali et al., (2023) [6] have also reported the development of Uterine fibroids due to the increased availability of progesterone that would activate certain signalling pathways. In this case, the placental abnormalities and cyst progression decreased on discontinuing the progesterone treatment, indicating a self-regulatory uterine recovery once the hormonal balance was restored.

The developed dermoid cysts added a diagnostic complexity even though benign there existed a risk of torsion or uterine structure distortion and complicate the delivery due to its large size. Since the patient has crossed the safe period for laparoscopic removal of cyst the option seemed best was to go through the full term of pregnancy and look for possible solutions. A previous case report on laparoscopic

removal of large dermoid cystectomy in pregnancy was published mentioning the removal of cyst during the second trimester [19]. A case report has reported the management of torsion of a large dermoid cyst and its rupture in left ovary during the second trimester in a patient [20]. A review article published discuss the development of dermoid cysts during pregnancy as observed since 1918 and were discovered if grown beyond 6cm. These were usually removed through laparoscopy preferable in the second trimester [21].

A differentiator in this case was the inclusion of structured NHM guided diet plan with therapeutic supplementation of ragi (finger millet) and tender coconut water. Finger millet is reported to have highest amount of Calcium (344 mg%), Potassium (408 mg%) along with sulphur amino acids, high dietary fibre, minerals and vitamins. Consumption of ragi has been found to lower blood glucose and cholesterol, enhance wound healing and anti-ulcerative [22]. Nazmi (2021) [10] have reported the benefits of ragi malt consumption during pregnancy to provide iron-folate rich diet and protect the baby from neural birth defects and protect mother from gynaecological complications. Similar reports have been published on the benefits of millets including Ragi for their increased nutritional content to support the pregnant mother and support the growth of the foetus, placenta and maternal tissues. Tender coconut water is the water obtained fresh from coconut that is usually at a maturity stage of 5–7 months old. Reports have stated Tender Coconut Water (TCW) to have nutritional and antioxidant properties such as high protein (0.59 mg BSA/ml), total soluble solids, reducing sugar content, several minerals, vitamins and electrolytes [23]. Previous studies have reported TCW to reduce glucose levels and increase Plasma insulin, increase amniotic fluid, reduce hypertension and reduce Hyperemesis Gravidarum [11]. A study has reported the positive effects of TCW on preventing early onset preeclampsia like impairments [13]. The intake of Ragi and TCW ensured macronutrient and micronutrient balance, minimized vascular stress, reduced hypertension, maintained electrolyte balance, reduced body heat and influenced in the regression of placental abnormalities and complications reported in the patient.

The progressive improvement occurred post the progesterone withdrawal and nutritional intervention suggest an interlink between the right diet and therapy for patients with gynaecological complications. The case is aligned with the antenatal guidelines by World Health Organisation (WHO) on the prevention and reducing the risk of preeclampsia and PAS with intake of macronutrients and micronutrients during pregnancy. Mousa et al., (2019) [24] have reported the same stating the reduction and prevention of preeclampsia risk on adequate supply of energy and nutrients during pregnancy period. Kurlak et al., (2023) [25] have also reported alterations in antioxidant micronutrient and macronutrient concentrations in placental tissue, maternal blood, urine and foetal circulation in preeclampsia.

Two years postpartum the imaging reports confirmed normal uterine architecture with stable adnexal cysts and no recurrence of placental pathology. This case give emphasis to the importance of early recognition of complications, restricted hormonal treatments and targeted nutritional therapy on restoring the maternal and foetal health even with high-risk pregnancy complications. Nature establishes an extraordinary synergy between mother and the developing foetus that promotes adaptation, protection and self-repair. The maternal system regulates immune tolerance, vascular modelling and

hormonal balance to sustain pregnancy and the placenta restore equilibrium during any damage or injury.

Conclusion

The case report emphasizes the remarkable role of hormonal and nutritional factors that impact the pregnancy outcomes even during high-risk complications. Despite initial sonography suggesting placenta accreta spectrum, cervical incompetence and a large adnexal cyst, the patient achieved complete recovery and achieved a full-term vaginal delivery. The case suggests that early adoption of right therapy and nutritional interventions can prevent pregnancy risks. Early hormonal therapy targeted to stabilize cervical incompetence but coincided with progressive cystic growth, which was reversed on discontinuing the hormonal therapy, emphasizing that hormonal therapy must be personalized and used in limit. Daily inclusion of ragi malt and tender coconut water with an NHM based diet plan likely improved uterine tone, placental metabolism, foetal growth, maternal health and helped go through a once stated high-risk pregnancy to a full-term normal delivery of healthy female. The case shows that through conservative observation and persistent nutrient modulation the pregnancy complications can be prevented, resolved and stabilized. Ultimately, this case exemplifies the inherent reparative capacity of the maternal-foetal system when physiological balance is restored. With tailored nutrition, limited hormonal exposure and strict observation one can yield a safe, full-term delivery in complex pregnancies affirming that nature's intrinsic design remains the profound therapeutic force.

Declarations

Guarantor of Submission

The corresponding author is guarantor of submission**.**

Consent

Written informed consent was obtained from the patient for publication of this article.

Conflict of Interest

The authors declare no conflict of interest.

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Figures

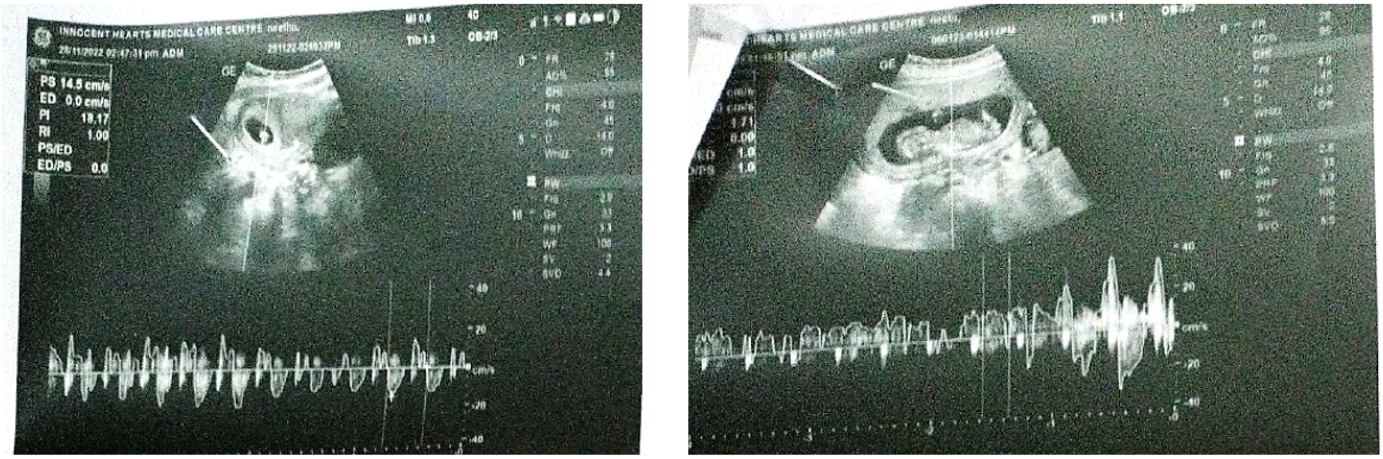


Figure 1

First trimester scan right: 7-week gestation- normal placenta; left: 14-week gestation, mild clot observed near placenta

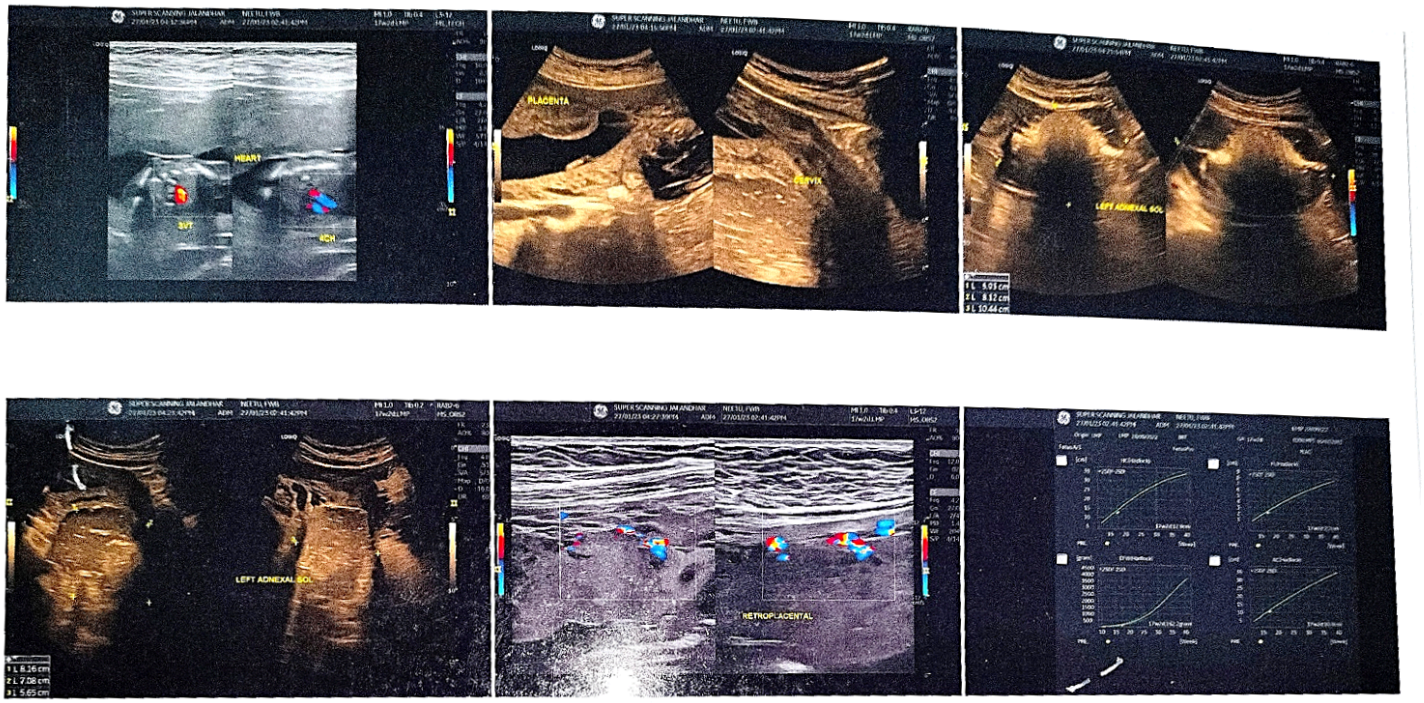


Figure 2

Level II Anomaly full Scan. Showing placental lakes and blood flow (blue and red colour), large heterogeneous lesions, symptoms of placenta accreta spectrum and a developing foetus

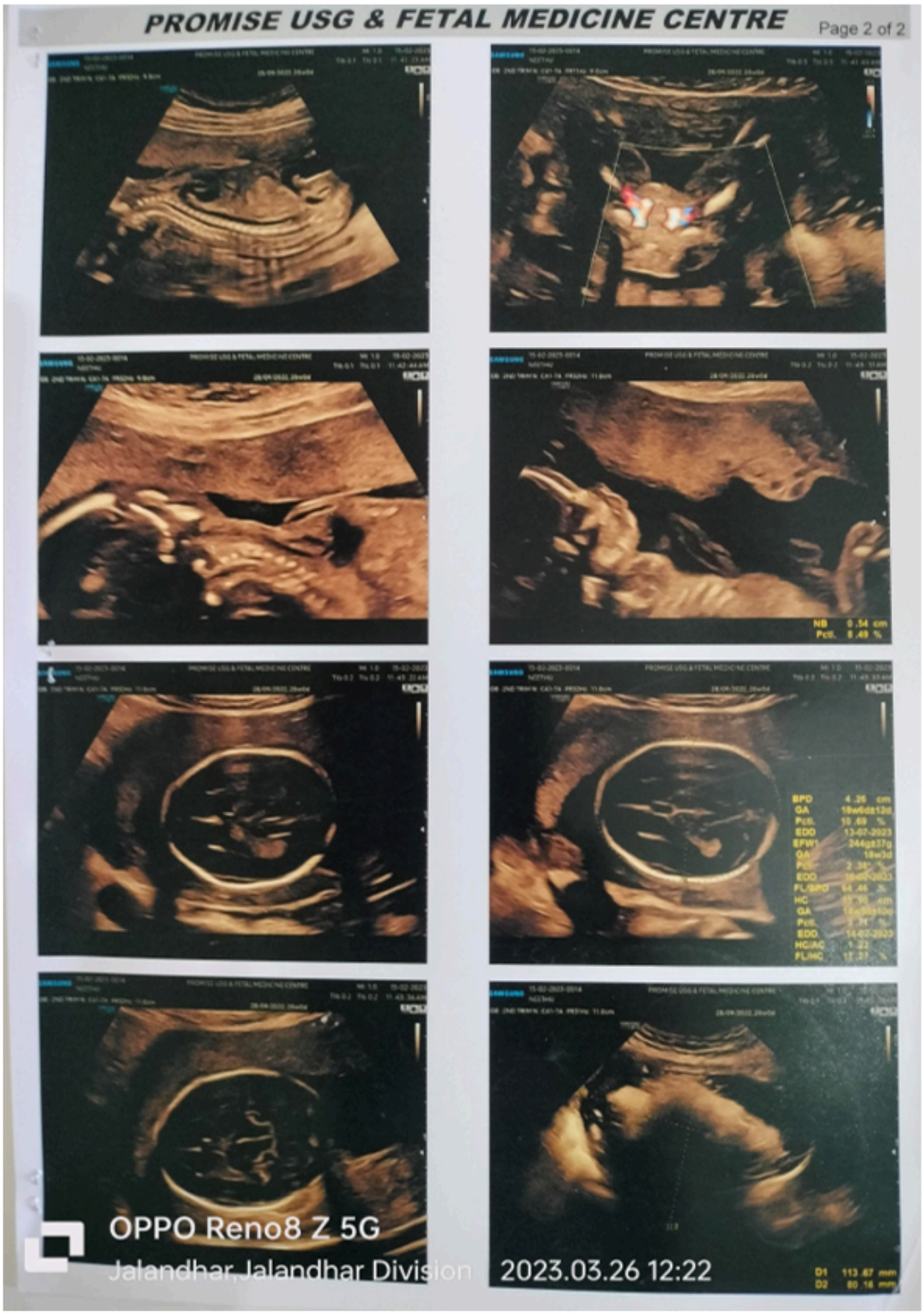


Figure 3

USG Imaging at 2nd Trimester Showing large heterogeneous lesions and developing healthy foetus

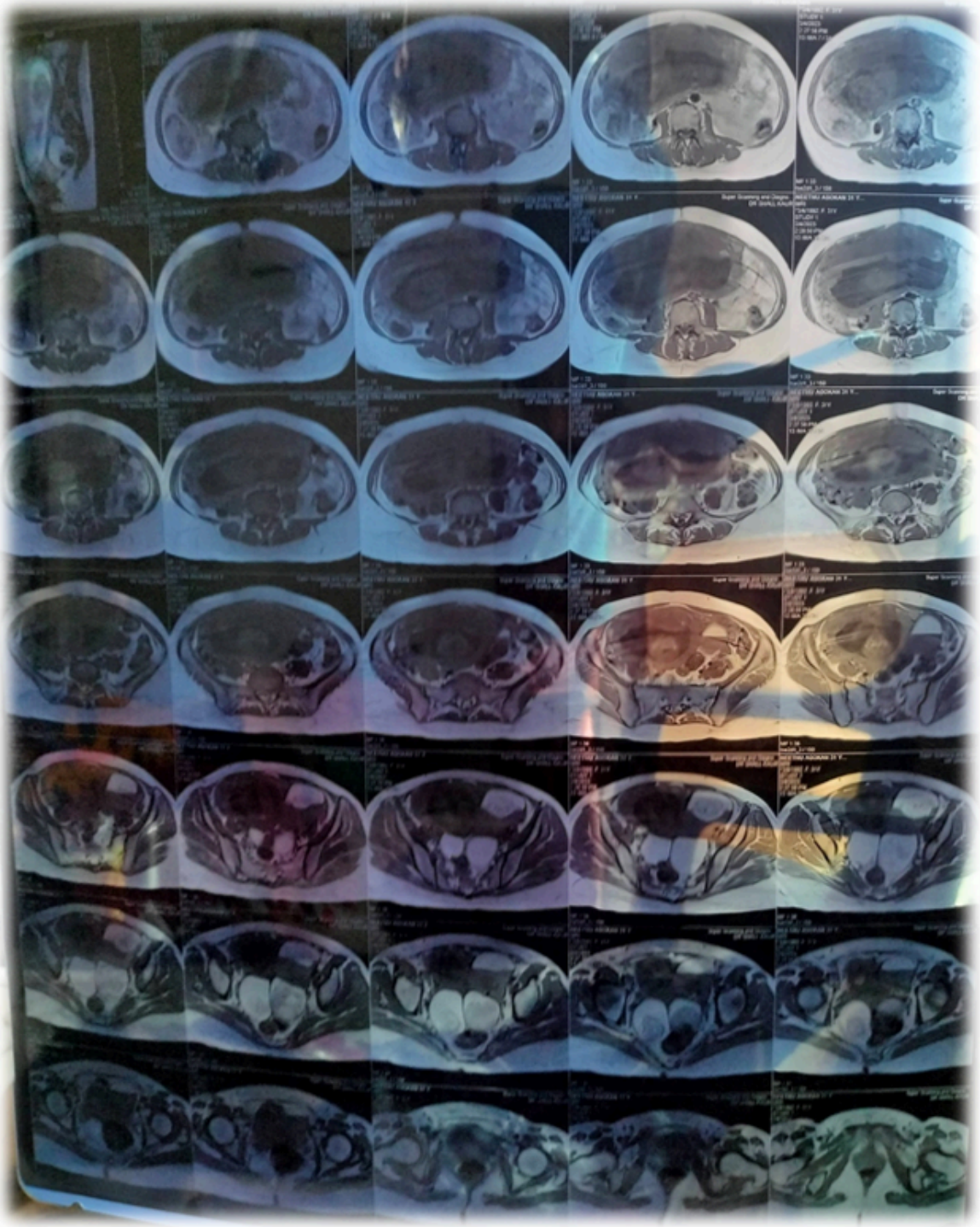


Figure 4

MRI Scan Imaging at 25-week gestation with normal developing foetus. Showing - A left adnexal cystic lesion measuring 12.8 cm x 6 cm x 10 cm with internal dot-dash pattern and a Rokitansky protuberance and cyst development in right ovary with mild placental lakes.