ПРЕДЛЕЖАНИЕ И ПРИРАЩЕНИЕ ПЛАЦЕНТЫ

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Резюме. В данной работе изложена история болезни женщины с центральным предлежанием и приращением плаценты. При УЗИ диагностике обнаружено по биометрии 30 недель беременности, центральное предлежание плаценты с приращением по ходу рубца. Беременность пролонгирована до доношенного срока и завершена оперативным путем с гистеро эктомией.
Ключевые слова: центральное предлежание, приращение плаценты, ведение акушерских кровотечений, дородовые кровотечения, рубец на матке.

PLACENTA PREVIA, INCREATE

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Summary. This article presents the case report of the pregnant woman with central placenta previa, which covering internal os of the cervix and prior low segment scar with suspicion of placenta increate, also Olygohydramnios, Breech presentation. Pregnancy was prolonged up to gestation age and completed with cesarean section with hysterectomy.
Key words: Placenta previa, increate, management obstetric bleeding, ante partum hemorrhage, scar of the uterus.

Obstetrical hemorrhage refers to have bleeding during pregnancy, labor, or the puerperium [1, 2, 3, 4, 5, 6]. Bleeding may be vaginal and external, or, less commonly but more dangerously, internal, into the abdominal cavity. Typically bleeding is related to the pregnancy itself, but some forms of bleeding are caused by other events. Obstetrical hemorrhage is a major cause of maternal mortality [9, 10, 11.] Antepartum hemorrhage one of the all source of the antepartum hemorrhage is placenta previa. The primary consideration is the presence of placenta previa, a condition that usually needs to be resolved by delivering the baby via cesarean section. In placenta previa, the placenta is implanted in the lower uterine segment within the zone of effacement and dilatation of the cervix, constituting an obstruction to descent of the presenting part. Placenta previa is encountered in approximately 1 in 200 births, but only 20% are complete (placenta over the entire cervix). The incidence of placenta previa is increased by multiparity, advancing age and previous cesarean section. The incidence of placenta previa is slightly higher in multiple gestations. A cesarean section scar triples the incidence of placenta previa.

Bleeding in the placenta previa may be due to any of the following causes: mechanical separation of the placenta from its implantation site, either during the formation of the lower uterine segment or during effacement and dilatation of the cervix in labor.

CASE HISTORY 35 years old woman was admitted to our Perinatal center at 29-30 weeks with following diagnosis: Placenta previa and Olygohydramnios, Anemia 1 st., Breech presentation. Prior History: P 4 L 2, A1: 1 medical abortion; 1 cesarean indication is preterm abruption of the placenta; 1 vaginal birth after cesarean; 1 present. Laboratorial fondues: Hb-105 g/l, Tr- 220,0 WBC - 9.5?10?9/l; ESR - 30 mm/h; Blood analyzes Fibrinogen - 3,10 g/l; prothrombin index - 81%, Biochemical analyses-general protein - 62,4 g/l; rest nitrogen -11,2mmole/l; urea - 3,2 mmole/l; creatinine - 68,74 mkmol/l; bilirubin gen.- 9,0 mkmol/l; thymol test- 2,25un. Ultrasound and Doppler examination gave the following date: 30 weeks of pregnancy by biometry, central placenta previa, covering internal os and prior low segment scar with suspicion of placenta increate, Olygohydramnios, Breech presentation.

After consultation with professor, head of department, and doctors of intensive therapy the

following management was chosen for a woman:

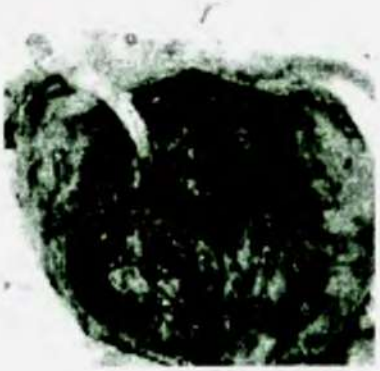
1. Hospital observation (49 days) at the department of anesthesiology and intensive therapy
2. Control to the vaginal discharges
3. Plan: To start the prevention of the respiratory distress syndrome, hem stimulation therapy, observation in dynamic
4. Preparation of the blood bank, FFP
5. Elective Cesarean at 37 weeks

The pregnancy was prolonged up to 37 week at the department of anesthesiology and intensive therapy under 24-hours doctors. But one day before scheduled surgery the vaginal spotting appeared and cesarean section was done emergently with participation of urgent doctor and assistants. First of all clamping by forcipes and bilateral legation of the uterine arteries' and hypogastria artery were done by recommends same authors [1, 2, 3, 4, 5, and 8]. After corporal incision and birth fetus was cut of cord, than without touching of placenta a subtotal hysterectomy was done. The general blood loss was 1,700 cc. Baby weight - 2,914 grams. In assessment of newborn by Apgar score was- 7/7. Before start operation was prepared blood components haw recommended many resources [1, 2, 3, 4, 5, 6, 7 and 11]. During operation the mother developed DIC of sub acute form. Haemostatic and hem transfusion therapy was started with adequate infusion therapy such as: FFP (fresh frozen plasma) - B(III) Rh+; Red blood cells; Refortan (Dextrin); Crystalloids; Tranexamic Acid; Kontricalis; Calcium chloride et another. The level of Hb was increased from 54,3 gr/l up to 82 gr/l, indicators of coagulation systems of blood were improved also and 11 days after operation the women was discharged from our hospital under management local doctor with adequate recommendations.

-Slides №1

After cesarean section, clamping and bilateral legation of the uterine arteries' and hypogastria artery.

-Slides №2



UTERUS AND PLACENTA - GROSS APPEARANCE

-Slides №3

UTERUS AND PLACENTA - CUT SECTION

Postoperative - 11 days in hospital in satisfactory condition the women with babies was discharged under management by local doctor.

Review

Placenta Previa, Prior Cesarean Section, and Placenta Accrete/Increate/Percreta

" Placenta Previa and one prior cesarean: 25% Accrete

" Placenta Previa and two prior cesarean: 50% Accrete

" Placenta Previa and 3 prior cesarean: 75% Accrete

Prognosis:

A. Maternal. With rapid recourse to cesarean section, use of banked blood, and expertly administered anesthesia, the overall maternal mortality has fallen to less than 1 in 1000

B. Fetal. The perinatal mortality rate associated with placenta previa has declined to approximately 1%. Although premature labor, placenta separation, cord accidents, and uncontrolled hemorrhage cannot be avoided, the mortality rate can be greatly reduced if ideal obstetric and newborn care is given.

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