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Original Research Paper

Anaesthesiology

PERIOPERTIVE ANESTHETIC CHALLENGES ENCOUNTERED IN PLACENTA PERCRETA PREGNANCIES A CASE SERIES.

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ABSTRACT Placenta Percreta is the least common and most severe type of abnormal placental presentation in which the villi penetrate the entire myometrial wall thickness and reach or traverse the serosa to encroach the adjacent organs. Our Aim in the study is Early prenatal diagnosis of Percreta and timely interventions like bilateral uterine artery embolization and intraoperative abdominal aorta clamping along with adequate perioperative anesthetic preparations to deal with anticipated massive intraoperative hemorrhage can reduce the maternal mortality and morbidity with the help of multidisciplinary approach. Objective is to reduce anticipated massive intraoperative hemorrhage and to reduce the maternal mortality and morbidity with the help of multidisciplinary approach. Placenta Percreta is life threatening condition causing high risk for perioperative hemorrhage which could endanger the lives of both the mother and the baby. Early prenatal diagnosis of Percreta, timely intervention, adequate perioperative anesthetic preparations to deal with anticipated massive intraoperative hemorrhage can reduce the maternal mortality and morbidity with the help of multidisciplinary approach. Our patients were managed effectively and successfully throughout perioperative period.

KEYWORDS : Placenta Percreta, Anaesthesia, Obstetrics, Gynaecology, Multidisciplinary approach.

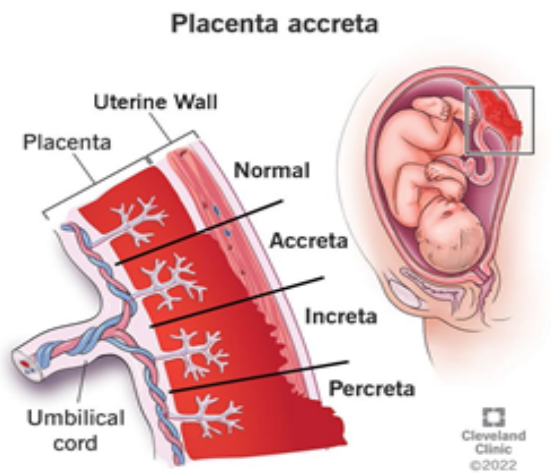
INTRODUCTION

Placenta Percreta is the least common and most severe type of abnormal placental presentation in which the villi penetrate the entire myometrial wall thickness and reach or traverse the serosa to encroach the adjacent organs.

The incidence of abnormal placental presentations (Acreta, Increta and Percreta) is increased with increasing incidence of cesarean section i.e. 1.7 per 10000 pregnant females.

Other risk factors include placenta previa, other uterine surgeries, advanced maternal age, multiparity, and curettage.

The treatment in such adherent placenta includes hysterectomy following cesarean section.



Case Series

Case 1: 22 year old female, G2P1L1 37 weeks of gestation with previous LSCS with placenta Percreta with Placenta Previa. 1 year ago Patient had underwent hysteroscopic septal resection i/v/o bicornuate sub septate uterus.

Case 2: 34 year old female, G4P1L1A2 38 weeks of gestation with 2 previous D and C done with placenta Percreta.

Case 3: 27 year old female, G3P2L2 36 weeks of gestation with 2 previous LSCS, with Placenta Percreta with placenta Previa.

Case 4: 21 year old female, G2P1L1 38 weeks of gestation with pervious 1 D and C done, and previous 1 LSCS done , now presenting with placenta percreta with placenta previa.

Case 5: 30 years old female, G4P3L3 36 weeks of gestation with previous 3 LSCS done, now presenting with placenta percreta.

Case 6: 27 year old female G2P1L1 operated for Hysteroscopic septal resection i/v/o septate uterus, had one normal delivery, now presented with placenta percreta.

Case 7: 26 year old female G3P2L2 with pervious two LSCS done and one D and C done now presented with placenta percreta.

USG of all 7 patients showed findings suggestive of placenta percreta and three with placenta previa accompanying. All of which was supported with MRI findings consistent with the above, and suggestive of abnormal placental presentation.

Anaesthetic Management

Preoperatively all 7 patients were posted for bilateral uterine artery embolization where monitored anesthesia care (MAC) was provided.

Patients were shifted to Operation theatre and they were connected to multipara monitors with pulse rate, Non invasive blood pressure, Saturation and ECG monitoring.

Triple lumen Central venous line and arterial line was secured for resuscitation purposes and hemodynamic monitoring.

Patients were resuscitated with colloids and crystalloids and blood and blood products were transfused as per requirement During surgery urine output and random blood sugar charting were done hourly. ABGA was sent intraoperatively and near extubation.

Patients hemodynamic stability was maintained throughout the procedure Postoperatively all 7 patients were

hemodynamically stable, hence reversed and extubated and shifted to ICU for postoperative observation

DISCUSSION

Placenta Percreta is life threatening condition causing high risk for perioperative hemorrhage which could endanger the lives of both the mother and the baby.

Early prenatal diagnosis of Percreta and timely interventions like bilateral uterine artery embolization and intraoperative abdominal aorta clamping along with adequate perioperative anesthetic preparations to deal with anticipated massive intraoperative hemorrhage can reduce the maternal mortality and morbidity with the help of multidisciplinary approach.

CONCLUSIONS

We conclude that proper preoperative planning and with the multidisciplinary approach will make a better outcome in these types of cases.

Our patients were managed effectively and successfully through out perioperative period.

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