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INCIDENCE OF OBSTERTIC HYSTERECTOMY IN CASES OF PLACENTA ACCRETA WITH PREVIOUS CAESAERAN SECTION

Dr Prajakta Wadadare* Junior Resident Dept of OBGY DR PDMMC Amravati*Corresponding Author

Dr Smita Bijwe Associate professor Dept of OBGY DR PDMMC Amravati

ABSTRACT This is observational study in patients who are admitted in hospital .It is valuable to know the increasing number of placenta accreta cases due to increase in number of caesarean section which lead to postpartum haemorrhage finally landing up in obstetric hysterectomy .So that these cases of placenta accrete are managed well at tertiary care centre and will help in reducing maternal morbidity and mortality. **AIM:** To study incidence of obstetric hysterectomy in cases of placenta accreta with previous caesarean section . **MATERIAL AND METHODS :**This study is conducted on patients admitted in OBGY department of DR PDMMC Hospital Amravati from June 2021 to January 2022 over 100 ANC patients with previous caesarean section . **RESULT :** Increase in number of obstetric hysterectomy in patients with placenta accreta having previous caesarean section. **CONCLUSION** : Predict every case of previous caesarean section as placenta accreta and manage at tertiary care centre.

KEYWORDS : Placenta accreta, caesarean section,hysterctomy,haemorrhage

INTRODUCTION:

Placenta accreta occurs when the placenta—the organ that provides nutrients and other support to a developing fetus—attaches too deeply to the uterine wall. This often leads to two major complications: the placenta cannot normally deliver after the baby's birth, and attempts to remove the placenta can lead to heavy bleeding. Women with a placenta previa overlying a uterine scar should be evaluated for the potential diagnosis of placenta accreta.

Placenta previa or "low-lying placenta" overlying a uterine scar early in pregnancy should be reevaluated in the third trimester with attention to the potential presence of placenta accreta. When the diagnosis of placenta accreta is made remote from delivery, the need for hysterectomy should be anticipated and arrangements made for delivery in a centre with adequate resources, including those for massive transfusion. Intraoperatively, attention should be paid to abdominal and vaginal blood loss. Early blood product replacement, with consideration of volume, oxygen-carrying capacity, and coagulation factors, can reduce perioperative complications.(1)

The risk of placenta previa was 0.26% with an unscarred uterus and increased almost linearly with the number of prior cesarean sections to 10% in patients with four or more. Patients presenting with a placenta previa and an unscarred uterus had a 5% risk of clinical placenta accreta. With a placenta previa and one previous cesarean section, the risk of placenta accreta was 24%; this risk continued to increase to 67% (two of three) with a placenta previa and four or more caesarean sections. (2)

Scheduled caesarean hysterectomy without attempting placental removal was associated with a significantly reduced rate of early morbidity compared with cases in which placental removal was attempted. (3)

Aim and objectives:

To study incidence of obstetric hysterectomy in patients with placenta accrete having previous caesarean section to manage cases well at tertiary care centre.

To decrease maternal morbidity and mortality in cases of placenta accreta.

No of cases:

100 ANC patients with previous caesarean section.

Result:

3 patients landed up in obstetric hysterectomy having diagnosed with placenta accrete with previous caesarean section.

CONCLUSION:

Rising number of caesarean sections is alarm for increasing number of placenta accreta. Every patient with previous scar now to be evaluated in her third trimester for placenta accreta. Help of imaging studies like USG should be taken for evaluation. Attempts for manual removal should be avoided in such cases which might predispose patient for emergency hysterectomy. When placenta accreta is diagnosed preparation for caesarean hysterectomy should be available in same ot with adequate availability of blood and blood products.

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