Original Resear	Volume - 13 Issue - 03 March - 2023 PRINT ISSN No. 2249 - 555X DOI : 10.36106/ijar Gynaecology STUDY ON FETOMATERNAL OUTCOME IN LOW LYING PLACENTA DIAGNOSED IN SECOND TRIMESTER IN PREGNANCY IN IPGME&R- SSKM HOSPITAL,KOLKATA
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(ABSTRACT) Introduction: Low-lying placenta is a term used at our institution to describe a placenta whose inferior edge extends close to but does not cover the internal cervical os. Some institutions use the term marginal placenta previa to describe the same situation, when the placental edge ends within 2 cm of the internal os without covering it. At the time of second-trimester sonography, it is important to assess the location of the placenta with respect to the cervix to identify those placentas that end close to the internal os, as this location may increase the risk of third-trimester bleeding. Aims: To determine any complications during pregnancy and after birth in pregnant mother with low lying placenta, to describe socio demographic profile of study subjects and placenta diagnosed in pregnant women on patient herself and their newborn in tertiary care unit along with maternal mortality rate in this pregnant women. Result: It was found that patients had low-lying placental location in third trimester [9(12.9%)] and we also found that, 11 patients had PPH. Only 6 patients had Active bleeding per vagina.

KEYWORDS: Low-lying placenta, pregnancy, vaginal bleeding.

INTRODUCTION

Low-lying placenta is a term used at our institution to describe a placenta whose inferior edge extends close to but does not cover the internal cervical os. Some institutions use the term marginal placenta previa to describe the same situation, when the placental edge ends within 2 cm of the internal os without covering it. At the time of second-trimester sonography, it is important to assess the location of the placenta with respect to the cervix to identify those placentas that end close to the internal os, as this location may increase the risk of third-trimester bleeding. However, as cause no problems for the pregnancy because the placental edge moves away from the cervix before cervical effacement or shortening occurs. In only a small number of cases does the placental edge persist close enough to the internal cervical os to cause bleeding or necessitate cesarean delivery.

Because a diagnosis of placenta previa can cause alarm and concern for the patient, we use the term low-lying for those placentas that end within 2 cm of the internal os but do not cover it before 24 weeks' gestation. From 24 weeks' gestation onward, we differentiate those placentas that end within 1 cm of the internal os by reporting our study illustrates, most low-lying placentas identified before the third trimester them as marginal previa, from those ending 1 to 2 cm from the internal os, which we report as low lying. Placentas that end more than 2 cm from the internal os are reported as "no previa."

Low-lying placentas diagnosed in the second trimester that persist to or near term have been implicated in cases of antepartum hemorrhage, postpartum hemorrhage, and small- for-dates neonates. Many advocate repeated sonographic evaluations later in pregnancy to reassess the placental location, although at least one group does not. Cephalad migration of the lower placental edge has been well documented, and some postulate that the degree of migration may be dependent on whether the placenta is situated anteriorly or posteriorly. No specific recommendations have been made regarding the timing of a follow-up examination.

Our study of second-trimester low-lying placentas, will likelihood of migration of the placenta away from the cervix (>2 cm from the internal os) by the time of delivery. These results agree with those of others and can be used to counsel patients and reduce their level of anxiety regarding peripartum complications or the need for cesarean delivery as a result of the second-trimester finding. Since only 66% of low-lying placentas resolve by the end of 27 weeks' gestation, whereas almost 90% of cases will be clear of the cervix by 32 weeks, it would be cost effective to delay reassessment of the placental location until after 28 to 30 weeks in those pregnancies uncomplicated by bleding or preterm labor. That our rate of clearance was not dependent on the gestational age at initial diagnosis of a low-lying placenta differs somewhat from the results of at least one other study.

The importance of third-trimester follow-up of low-lying second-

trimester placentas is illustrated by the occurrence of placenta previa and cases of vasa previa in this cohort. It is important to note cases of low-lying placenta in the second trimester may became vasa previa with velamentous cord insertion by the time of delivery. A low-lying placenta is a known risk factor for the development of vasa previa, and this factor must be kept in mind when following up on an earlier diagnosis of a low-lying placenta. Color Doppler imaging is recommended to assess the internal surface of the cervix to diagnose or exclude vasa previa, as well as to identify the umbilical cord insertion to the placenta.

Our study was based largely on transabdominal sonographic evaluation of the placenta in the second trimester, with few patients undergoing transvaginal evaluation of the cervix and placenta at that time. There are studies that advocate transvaginal sonography as a superior method for evaluating the placental location, and we agree. However, because the cervix is rarely obscured by fetal parts in the second trimester, and most placentas that are low lying before 24 weeks clear the cervix later, we think that a transvaginal scan is not warranted at an early gestational age solely to assess the placental location with respect to the cervix unless vasa previa is suspected. The safety of this practice is confirmed by the absence of urgent cesarean deliveries for vaginal bleeding before the late third trimester in our cohort. Some authors do suggest that many women with a placenta-toos distance of greater than 1.0 cm at term can deliver vaginally without an increased risk of hemorrhage. This can reduce morbidity and mortality of mother and fetus.

In summary, when a low-lying placenta is diagnosed in the second trimester from 16 to 24 weeks Careful scanning at follow-up is essential for determining whether part of the placenta or a fetal vessel crosses the internal surface of the cervix to plan appropriately for delivery.

AIMS AND OBJECTIVE OBJECTIVE

To describe socio demographic profile of study subjects

To determine any complications during pregnancy and after birth in pregnant mother with low lying placenta

To find out any complications of newborn baby born to a mother with low lying placenta.

SPECIFIC

To determine outcome of low lying placenta diagnosed in pregnant women on patient herself and their newborn in tertiary care unit along with maternal mortality rate in this pregnant women.

MATERIALS AND METHODS

Materials, method and logical plan to be followed for currant research

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INDIAN JOURNAL OF APPLIED RESEARCH

STUDY SETTINGS - Department of obstetrics and gynaecology, IPGMER AND SSKM ,Kolkata

STUDY TYPE -Observational Prospective TIMELINE- 1st JAN 2021 to 30 JUNE 2022

STUDY POPULATION - All pregnant women **INCLUSION CRITERIA-**

All pregnant women with low lying placenta diagnosed in second trimesterSingleton pregnancy Uncomplicated pregnancy

EXCLUSION CRITERIA

Patient who could not be contacted even after 3 attempt Patient with multiple pregnancy

DIAGNOSTIC CRITERIA

Ultrasonography

SAMPLE SIZE- All pregnancies women lying placenta diagnosed in second trimester was included during my data collection phase (total enumeration)

Statistical Software

Sample size has been calculated with help of Epi Info (TM) 3.5.3. EPI INFO which is a trademark of the Centers for Disease Control and Prevention (CDC). For statistical analysis data were entered into a Microsoft excel spreadsheet and then analyzed by SPSS 27.0. and Graph Pad Prism version 5. Data had been summarized as mean and standard deviation for numerical variables and count and percentages for categorical variables. Unpaired proportions were compared by Chi-square test or Fischer's exact test, as appropriate. Two-sample ttests for a difference in mean involved independent samples or unpaired samples. p-value ≤ 0.05 was considered for statistically significant.

SAMPLING DESIGN-Consecutive sampling

Table1. showing frequency of placental location in third trimester of pregnancy

Placental location in third trimester	Frequency	Percent
Anterior	21	30.0%
Completely covering internal OS	1	1.4%
Fundal	12	17.1%
Fund anterior	3	4.3%
Fundo-anterior	1	1.4%
Fund posterior	5	7.1%
Low lying	9	12.9%
Placenta Previa	2	2.9%
Posterior	15	21.4%
Posterior, lower margin touching internal OS	1	1.4%
Total	70	100.0%



SUMMARY AND CONCLUSION In our study, out of 70 patients, most of the patients were 21-

- 30years of age. The mean Age of patients was [25.3857±5.5932]. We found that, most of the patients are primigravida.
- It was found that, more number of patients had Anterior Placental location in third trimester and we also found that, more number of placenta did not remain low lying. Only 6 patients had Active bleeding per vagina.
- Our study showed that, higher number of patients had vaginal delivery. And higher number of patients had Local anesthesia.
- We showed that, majority number of patients had no PPH. Majority number of patients had Good 6 Week follow up.
- We observed that, lower number of patients had IUFD as baby outcome. Most of the baby had no NICU/SNCU. In our study, most of the patients had low birth weight,
- We found that, the mean ANC of patients was [5.2571±1.3480.], the mean Week of Termination of patients was [36.6000±1.9664] and the mean birth weight of patients was [2.5579±.4626]. We concluded that poor fetomaternal outcome was observed in low lying placenta diagnosed in second trimester if placenta remain on lower segment of uterus.

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