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Extended Abstract

The clinical analysis of 156 cases of placenta increta

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Abstract:

Objective: Morbidly adherent placentation (MAP), which includes placenta accreta, increta, and percreta, is a serious complication of pregnancy associated with perinatal massive hemorrhage, intensive care unit admission, and cesarean hysterectomy. MAP complicates approximately 1 in 500 to 1,000 pregnancies. This rate has increased up to 10-fold in the past 20 years, attributed largely to rising rates of cesarean deliveries. The reported incidence in the United States increased from 0.08% in 1985 to 0.3% in 2005.Domestic incidence of MAP has increased by 10 times nearly 30 years, with the increasing of abortion, hysteroscopy surgery, cesarean section rate。The steadily increasing rate of placenta previa and caesarean section may result in an increased number of patients with abnormal placentation. Additional risk factors for MAP include uterine operation, caesarean delivery, advanced maternal age (≥35 years), multiparity, and a history of endometrial ablation. The occurrence of placenta percreta will significantly affect the outcome of pregnancy, causing postpartum haemorrhaging, uterine perforation, and other serious complications; additionally, it can even endanger the lives of pregnant women and their foetuses. This study is to discuss the risk factors, etiology, diagnosis, treatment of placenta increta. To improve the quality of obstetrics.

Method: Retrospective analysis was made on the date of 156 cases of maternal age, parity, and gestational age, mode of delivery, type of placenta implantation, risk factors, postpartum treatment, and bleeding after placental implantation, postoperative complications and maternal outcomes in our hospital in 3 years.

Result: There were 156 cases of placenta accreta in 3 years. Of which ＜28 weeks in 5 cases, ≥28 weeks in 151 cases. There were 14 cases of prenatal diagnosis of placenta, 136 cases were implanted in the placenta, and 6 cases were implanted in the placenta after a late diagnosis (24 hours after birth). There were 147 cases of abortion in patients with a history of miscarriage, combination of placenta previa in 11 cases, has a history of progesterone spuc conception, assisted reproduction and caused by intrauterine adhesions surgery patients with a history of 37 cases of placenta increta, 21 cases respectively and 21 cases. There were 69 cases of severe postpartum haemorrhage, 54 cases of severe secondary anaemia, and 29 cases of haemorrhagic shock.

Conclusion: History of abortion and placenta previa is the main risk factors for placental adhesions, but in recent years, intrauterine surgery has become an important cause of placenta accreta, such as uterine adhesions, uterine septal resection, cesarean section, endoscopic uterine myoma resection. In summary, it is clear that the steadily increasing rate of deliveries may result in an increased number of abnormal placentation cases. Abnormal placentation is one of the most important risk factors of severe obstetric complications, including perinatal massive haemorrhage. Therefore, prenatal diagnosis and identification of abnormal placentation are vital in order to plan appropriately the date, place, and mode of delivery as well as to ensure the availability of highly qualified specialists in the

field of obstetrics and anaesthesia and ensure availability of a sufficient amount of blood products and blood substitutes. Traditionally, placenta percreta is treated by removing the uterus, as it is effective for reducing maternal mortality and stopping bleeding rapidly and completely. Decisive hysterectomy should be performed in patients with serious intraoperative bleeding, shock, a coagulation dysfunction or blood shortage, a large area of placenta percreta, a thin uterine wall, and poor uterine contractions. Kohn et al reported the case of a pregnant woman in whom hysterectomy was performed because of placenta percreta and incomplete uterine rupture after endometrial ablation was performed at 18 weeks of pregnancy.

However, removal of the uterus would cause the patient to lose fertility, resulting in physical and psychological damage, and some patients cannot accept this outcome. Thus, conservative treatment should be considered if the patient's condition is relatively stable. However, this depends on an accurate prenatal diagnosis, adequate pre-operative preparation, and a skilled surgical operation.

The key to conservative treatment is effective haemostasis. If the area of placenta percreta is small, local resection and suturing may be appropriate during caesarean section (e.g. wedge resection or excision and a partial figure-of-8 suture or ring suture). Ligation of the uterine muscle can facilitate haemostasis. The B-Lynch suture can also be used, and the uterus can be sutured at the anterior and posterior walls. In clinical practice, surgeons can combine several surgical procedures to stop bleeding. For pregnant women at high risk for uterine rupture, such as scarring of the uterus and placenta percreta, it is necessary to provide detailed and prudent prenatal counselling, evaluate the relationship of the uterine muscle and placenta with ultrasonography regularly, and recommend caesarean section as soon as possible. If uterine rupture is suspected, a timely caesarean section to terminate the pregnancy may be necessary, or laparotomy can be performed to make a clear diagnosis in an attempt to keep the uterus.The treatment for placenta percreta should be selected according to the patient's condition, blood loss, and rate of blood loss, taking into consideration the type and location of the placenta percreta, surgeon's skills, rescue capacity of the medical institution, and the patient's reproductive requirements.

A comprehensive analysis must be conducted to make the right decision. A prenatal diagnosis and identification of abnormal placentation are vital for the following reasons: 1) to plan the date, place, and mode of delivery; 2) to ensure the availability of highly qualified specialists in the field of obstetrics and anaesthesia, and 3) to ensure the availability of a sufficient amount of blood and blood substitutes. If the MRI scan or ultra-sonogram findings are suggestive of placenta percreta pre-operatively or prenatally, sufficient preparations should be made, including adequate blood preparation, a detailed, reasonable surgical program, and treatment methods to control bleeding and avoid unnecessary hysterectomy. An adequate prenatal assessment, accurate diagnosis, and timely treatment are essential to reduce maternal and child mortality and complications. Prenatal preparation was adequate to prevent intraoperative bleeding and to ensure a good postoperative recovery and preservation of the uterus.