



Algorithm of administration of genus in placental attachment anomalies

Rymashevsky AN, Volkov AE, Voloshin VV

Medical University ", Rostov State Medical University" Russian Ministry of Health, Rostov-on-Don, Department of Obstetrics and Gynecology No. 1, Russia

Objective

In recent decades there has been a progressive increase in the frequency of delivery by cesarean section (CS) [1]. One of the actual problems of the operated uterus is the formation, in subsequent pregnancies, of placental attachment anomalies (PAA) (placenta accreta, increta, percreta) [2]. The increase in cases of true ingrowth (placenta accreta) leads to an increased risk of massive bleeding, often life-threatening [2, 3]. Despite numerous studies, there is still no single generally accepted tactic for the management of labor in patients with PAA.

Methods

We analysed 10 clinical observations of patients with prenatally diagnosed PAA, who delivered in the maternity hospital № 5 and the maternity ward of the MLPU № 20 in Rostov-on-Don, between 2012 and 2017. The criterion of selection for the study was the presence in the anamnesis of patients with CS, with PAA diagnosis verified by echography. The echography was performed using the Acuson Antares (Siemens, USA). The mode of triplex scanning in combination with 3D reconstruction (sensitivity of the method - 89%, specificity - 98%) was used. Statistical processing of data was carried out by a package of application programs "STATISTICA 8.0".

Results

The average age of the patients was $32,2 \pm 2,4$ years (27-43 years). The obstetric anamnesis of all patients is aggravated by previous operative labor (a scar on the uterus after CS, from 1 to 4) and by official abortions (from 2 to 4). The diagnosis of PAA in all cases is set with ultrasound from the Color Doppler mapping. The mean time of diagnosis of PAA was $32,5 \pm 1,7$ weeks gestation (18-37 weeks). In most cases, the diagnosis was made before childbirth. All patients were delivered operatively abdominally (8 women at 37 weeks, 2 at 36 weeks). In 4 patients, a corporal CS was performed. In view of the presence of a pronounced vascular pattern ("aneurysm of the uterus"), an operation was performed in the area of placentation and development of massive bleeding in the volume of extirpation of the uterus without appendages in 3 patients, and supravaginal amputation of the uterus in one. Five patients underwent CS in the lower uterine segment followed by metroplasty. The average volume of blood loss was 1900 ± 520 ml. In all cases, the operation was started under epidural anesthesia. In 4 cases after the development of massive bleeding, endotracheal anesthesia was used. In all cases, the diagnosis of PAA was confirmed by a morphological study.

Conclusion

Analyzing the presented clinical observations, we consider it appropriate to use the following algorithm of actions in patients with APP: in the absence of urgent situations (bloody discharge from the genital tract), the optimal term for delivery is 37 weeks gestation. The optimal way of laparotomy is to consider lower-middle access. Optimal method of CS is to consider the corporal modification of the operation. If PAA is detected, do not attempt to remove the placenta in order to avoid massive bleeding. After the extraction of the child, a dressing for the major vessels of the small pelvis (uterine, ovarian, internal iliac arteries) is shown. If there are signs of a "uterine aneurysm", perform a hysterectomy. The operating room must be equipped with a system for blood reinfusion (the Sell Saver system).