



Original Article

Maternal outcome after conservative management of abnormally invasive placenta



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ABSTRACT

Objective: The purpose of this study was to describe our preliminary experience of the efficacy and safety of a conservative strategy for abnormally invasive placenta.

Materials and Methods: A retrospective review of eight pregnant women with abnormally invasive placenta (one with placenta previa accrete, three with placenta previa increta, and four with previa percreta) was performed. The diagnosis was made by prenatal ultrasonography, and was confirmed by operative and histopathological findings. Patients who desired future fertility or who had extensive diseases were selected as candidates after panel meeting. Conservative management after obtaining informed consent was defined by a primary cesarean delivery before 35 weeks of gestation with the abnormally adherent placenta left in situ, partially or totally. The primary outcome was successful uterine preservation. The secondary outcome was severe maternal morbidity including sepsis, coagulopathy, immediate or delayed hemorrhage bladder injury, and fistula.

Results: Among the eight patients, the mean age was 34 ± 3 years (range, 30–40 years). All women had risk factors, such as placental previa, previous cesarean delivery and/or dilation & curettage, for abnormally invasive placenta. Seven women underwent planned cesarean delivery at the mean gestation age of 34 weeks (range, 31–37 weeks). One woman received hysterotomy at 18 weeks. In our series, the uterus was preserved in only two cases (25%), one who received hysterotomy at a relatively young gestational age and another who had mild disease. Mean maternal blood loss during primary cesarean delivery was 528 ± 499 ml (range, 100 ml–1,500 ml). Severe maternal morbidity was recorded in seven out of eight patients (87.5%).

Conclusion: In this small series, we observed a low successful uterine preservation rate and a high maternal complication rate. We recommend that primary cesarean hysterectomy should be used as the treatment of choice for mild to severe abnormally invasive placenta. Conservative management should be reserved for women with a strong fertility desire and women with extensive disease that precludes primary hysterectomy due to surgical difficulty.

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Introduction

Abnormally invasive placenta, also known as morbidly adherent placenta, is a broad term that describes abnormal adherence of placenta to the underlying myometrium. Depending on the depth

of invasion, it is further defined as placenta accreta, placenta increta, and placenta percreta. The term “accreta” is the umbrella term most commonly used to refer to all of these conditions. The term “abnormally invasive placenta” (AIP) was introduced in 2013 and defined as: “A placenta that cannot be removed spontaneously or manually without causing severe bleeding” [1].

The management strategy for AIP is a challenging problem in obstetric practice. Prenatal diagnosis of AIP and a planned cesarean delivery have been proven to improve maternal outcome [2–4]. Scheduled preterm delivery before 35 weeks has been proposed in order to avoid bleeding or labor signs that necessitate emergent

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operation [5,6]. Delivery in a tertiary medical center using a multidisciplinary approach is also mandatory [7,8].

A conservative management with the abnormally adherent placenta left in situ is sometimes indicated because cesarean hysterectomy may be difficult for patients with severe AIP, especially with bladder or parametrium invasion. It is also indicated when fertility preservation is considered. Successful conservative treatment with spontaneous placental resorption has been reported [9–12]. Some women can subsequently achieve pregnancy, with or without recurrent AIP. Maternal complications including adjacent organ injuries, excessive blood loss with transfusion of blood products, immediate or delayed vaginal bleeding, infection, disseminated intravascular coagulation, and even death have been reported.

In Taiwan, the rate of cesarean sections increased from 33.1% in 2004 to 36.6% in 2013 [13]. Outcomes after conservative management for AIP were reported in case reports [14–20] and one case series [21]. The aim of this study was to investigate the safety and efficacy of conservative management in cases with AIP.

Materials and methods

This was a retrospective and descriptive study performed at Taichung Veterans General Hospital, Taiwan, from January 2014 to May 2015. Women with a diagnosis of AIP who received conservative treatment in the hospital were included.

The diagnosis of AIP was made based on findings obtained by color Doppler mapping and 3D ultrasonography, according to previously published protocols [22–24]. All cases of suspected AIP were reviewed in a panel meeting, and individualized management was discussed. We favored a planned preterm cesarean delivery preferably before 35 weeks with concomitant hysterectomy as the first-choice treatment [6,25]. The decision to apply conservative management was made if the patient strongly hoped to preserve her uterus or if primary hysterectomy was deemed to be a difficult and bloody procedure because of extensive invasion.

For patients who were managed conservatively, the operations were performed by collaborating maternal-fetal medicine specialists. Bilateral ureteral stenting was performed by the urologist on the day of operation. A midline longitudinal incision was made in the lower abdomen, and a vertical incision was made on the uterine fundus. After delivery of the newborn, the cord was transected near the placental insertion site and the uterus was closed. The abnormally adherent placenta was left in situ after adequate hemostasis. The patients were transferred to the radiology department after operation. Embolization of uterine arteries and other pelvic collateral vessels was performed by an interventional radiologist using gelfoam cubes. We gave broad-spectrum antibiotics prophylactically. Outpatient visits were arranged weekly or biweekly. We avoided methotrexate injection because it is no longer considered a standard adjuvant therapy [9].

The primary outcome for this study was the rate of successful uterine preservation. The secondary outcome was severe maternal morbidity, including sepsis, coagulopathy, immediate or delayed hemorrhage, bladder injury, and fistula.

Results

A total of eight women (mean age 34 ± 3 years, range 30–40 years) received conservative management of AIP during the study period. All eight cases had been referred from other hospitals or obstetric clinics in the second and third trimesters with a mean gestation of 28 ± 7 weeks (range, 18–37 weeks). All eight cases had documented risk factors for AIP, including previous cesarean delivery and/or dilation & curettage. Antepartum hemorrhage was reported in six cases (75%), but none of the patients received emergent operation due to active bleeding. One case requested termination of the pregnancy at 18th weeks because of bladder invasion. The other seven cases received planned cesarean delivery at a mean gestation of 34 ± 2 weeks (range 31–37 weeks). Maternal demographic characteristics are summarized in Table 1.

Table 1
Demographic characteristic, outcome, and pathology.

Case no	Age (y)	Gravidity/Parity/Abortion	Risk factors	GA at diagnosis (weeks)	GA at delivery (weeks)	Surgery and interventional procedures	Complications	EBL (ml) Primary surgery/secondary procedure	Pathology
1	35	G3P1A1	PL previa CS x1	32	34	CS and UAE/ Delayed SAH	Coagulopathy (63 days after CS) ICU admission	100/4580	Percreta
2	40	G4P2A1	PL previa CS x2	37	37	CS and UAE. Delayed SAH	Coagulopathy (60 days after CS) Bladder perforation	300/2350	Increta
3	30	G3P0A2	PL previa D&C x2	29	34	CS and UAE Delayed D&C	Endometritis (92 days after CS)	1500/250	Increta ^a
4	33	G3P2	PL previa CS x1	18	18	UAE and hysterotomy	Nil	100/minimal	Percreta
5	36	G5P2A2	PL previa CS x2	20	34	CS and UAE Delayed SAH	Coagulopathy (36 days after CS) Bladder perforation	300/1200	Percreta
6	32	G5P2A2	PL previa CS x4	36	36	CS and UAE Delayed TAH	Endometritis (86 days after CS) Bladder perforation	800/800	Increta
7	34	G5P4	PL previa CS x2	23	31	CH + IIAL + cervical suture	IAI immediately ICU admission.	13500/N/A	Percreta
8	33	G4P2A1	PL previa CS x2 D&Cx1	27	34	CS and UAE Delayed SAH	Delayed VAG bleeding (16 days after CS) Multiple organ failure V-V fistula ICU admission	600/about 70000	Increta

CH = cesarean hysterectomy; CS = cesarean section; D&C = dilation and curettage; EBL = estimated blood loss; GA = gestational age; IAI = intra-abdominal infection; ICU = intensive care unit; IIAL = internal iliac artery ligation; N/A = not applicable; PL: placental; SAH = subtotal abdominal hysterectomy; TAH = total abdominal hysterectomy; UAE = uterine artery embolization; USG = ultrasonography; VAG = vaginal; V-V = vesico-vaginal.

^a This was the sole case in which diagnosis was made by preoperative color doppler ultrasound. Diagnosis in all the other cases was based on pathology findings.

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