Akhila Sangeetha Bhat U. / Vol 2 / Issue 2 / 2012 / 115-118.

International Journal of
Innovative Drug Discovery
e ISSN 2249 - 7609
Print ISSN 2249 - 7617
www.ijidd.com

A DIAGNOSIS AND MANAGEMENT OF PLACENTA PRAEVIA AND ACCRETA

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ABSTRACT

Placenta accreta spectrum, erstwhile referred to as morbidly adherent placenta, refers to the vary of pathologic adherence of the placenta, as well as placenta increta, placenta percreta, and placenta accreta. The foremost favored hypothesis relating to the etiology of placenta accreta spectrum is that a defect of the endometrial–myometrial interface ends up in a failure of traditional decidualization within the space of a female internal reproductive organ scar that permits abnormally deep placental anchoring villi and membrane infiltration. Maternal morbidity and mortality will occur due to severe and typically grievous hemorrhage, which immediately require intervention. Ultrasound analysis is vital, ultrasound findings are crucial in diagnosing placenta accreta. There are many risk factors for placenta accreta spectrum. The foremost common could be a previous delivery, with the incidence of placenta accreta spectrum increasing with the quantity of previous cesarean deliveries. prenatal diagnosing of placenta accreta spectrum is extremely fascinating as a result of outcomes are optimized once delivery happens at grade III or IV maternal care facility before the onset of labor or hemorrhage and with dodging of placental disruption. The foremost typically accepted approach to placenta accreta spectrum is cesarean cutting out with the placenta left in place. Optimum management involves a consistent approach with a comprehensive multidisciplinary care team aware of management of placenta accreta spectrum. Additionally, established infrastructure and robust nursing leadership aware of managing high-level postpartum hemorrhage ought to be in situ, and access to a blood bank capable of using huge transfusion protocols ought to facilitate guide selections concerning delivery location. Placenta praevia and placenta accreta are related to high maternal and baby morbidity and mortality. The rates of placenta praevia and accreta have exaggerated and can still do thus as a results of rising rates of caesarean deliveries, exaggerated maternal age and use of assisted reproductive technology (ART), inserting larger demands on maternity-related resources. The very best rates of complication for each mother and newborn are determined once these conditions are solely diagnosed at delivery.

KEY WORDS: Peripartum, placenta accreta, placenta increta, placenta percreta, pre-eclampsia.

INTRODUCTION

Placenta accreta is characterized as irregular trophoblast intrusion of section or the entirety of the placenta into the myometrium of the uterine divider.[1] Placenta accreta / pathologic adherence of the placenta, together with placenta increta, placenta percreta, and placenta accreta.[2] Maternal bleakness and mortality can show up in view of severe and now and then hazardous drain, which often requires blood transfusion.

Patients with placenta accreta vary are sure to require hysterectomy at the hour of conveyance or at some stage and longer medical institution stays too. In 2007 the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal–Fetal Medicine constructed up a normalized danger appropriate maternal romanticized care framework for offices, in view of region

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and aptitude of the medical staff, to reduce typically maternal horribleness and mortality in the United States three This project is alluded to as "levels of maternal consideration," and exists for conditions, for example, placenta accreta range.[3] Placenta accreta vary is considered as a high-chance circumstance with true associated morbidities; consequently, ACOG and the Society for Maternal–Fetal Medicine advocate these cases as stage III (subspecialty) or greater consideration.[4] This stage accommodates continuously available scientific team of workers with perfect making ready and involvement with overseeing complicated maternal and obstetric confusions, which include placenta accreta range, simply as dependable admittance to interdisciplinary personnel with mastery in simple consideration (ie, fundamental consideration subspecialists, hematologists, cardiologists, and neonatologists).[5] The basic property ought to have been prepared to accomplish multiplied wellness consequences in the putting of a recognised or suspected placenta accreta contain getting prepared for conveyance with ideal subspecialists and drawing close a blood donation core with conventions set up for tremendous bleeding. [6]

In this research section 2 work focuses the related research work for this study. In section 3 focuses the Materials and methods, in section 4 presents the results and discussions and finally, section 5 represents the conclusion of this study.

LITERATURE SURVEY

In this section presents the related works of this work. Paces of placenta accreta range square measure expanding. Exact investigations from the Seventies and Nineteen Eighties depict the commonness of placenta accrete.[7,8]There square measure many hazard factors for placenta accreta range. The principal basic could be a past cesarean, with the occurrence of placenta accreta range expanding with the measure of past cesarean conveyances. during a methodical audit, the speed of placenta accreta range hyperbolic from 0.3% in women with one past cesarean to 6.74% for young ladies with 5 or a ton of cesarean conveyances.[9,10] additional hazard factors grasp progressed maternal age, multiparity, past female organ medical procedures or curettement, and Asherman condition. Placenta previa is another significant hazard issue.[11,12] Placenta accreta range occurs in three-dimensional of young ladies determined to have maternity and no past cesarean conveyances.[13] inside the setting of a maternity and one or a ton of past cesarean conveyances, the possibility of placenta accreta range is significantly hyperbolic. For young pregnant ladies, the possibility of placenta accreta is three-dimensional, 11%, 40%, 61%, and 67%, for the essential, second, third, fourth, and fifth or a great deal of cesarean, severally .[14,15]

MATERIALS AND METHODS

This is a prospective data-based study allotted at Department of OB and gynecology in Kerala region between Gregorian calendar month first 2008 to 2010. Total seventy two emergency peripartum ablation specimens thanks to abnormal placentation were received throughout study amount. Age bracket of patients in our study was between thirty and thirty six years.

Inclusion criteria

- Pregnant ladies with abnormal placentation diagnosed by ultrasound
- Multiparity
- Previous caesarean delivery
- Advanced maternal age
- Pregnant ladies with late complications like pre-eclampsia, preterm labour.

Specimen reception and grossing

- We received contemporary specimen in formalin-filled instrumentation labeled with patients' names, information science numbers at the side of proforma containing clinical details of patient and relevant history from OB and gynecology department.
- Specimen varieties embody peripartum womb with cervix at the side of placenta unchanged or in some cases.
- fragmented items of placenta when tried removal.

Grossing technique focus on:

- Proximity of invasion of placenta in uterus and its distance from cervix
- Implantation whether or not anterior or posterior
- Depth of invasion
- Involvement of any close structure like bladder.
- Bread loaf sections of posterior female internal reproductive organ wall to assess myometrial invasion just in case of placenta increta and placenta percreta is completed.
- These findings were confirmed on histopathological examination.

Slide review and reportage

After staining the slide with haemotoxylin and bromeosin stain, microscopic examination of section is completed if there's lack of epithelium between placental villi and myometrium; it indicates placenta accreta. Assessment of myometrial invasion by membrane is completed just in case of placenta increta and percreta.

RESULTS AND DISCUSSIONS

Retrospective cross-sectional study drained patients with abnormal placentation resulting in emergency peripartum ablation throughout a course of 2 year amount.

deciding placental location is one in every of the primary aims of routine midpregnancy (18+6 to 21+6 weeks of gestation) transabdominal medicine ultrasound examination. A recent multidisciplinary workshop of the yank Institute of Ultrasound in drugs suggests that the term 'placenta praevia' is employed once the placenta lies directly over the interior os. The calculable incidence of placenta praevia at term is one in two hundred pregnancies. The purpose of this guideline is to explain the diagnostic modalities and review the evidence-based approach to the clinical management of pregnancies difficult by placenta praevia and placenta accreta. we tend to received total of seventy two emergency ablation specimens throughout eight-year amount of that placenta accreta accounts fifty five.5 p.c (40/72), placenta increta upto thirty eight.8 p.c (28/72) and placenta percreta five. 5 p.c (4/72). Analysis of result with parity shows uniparous ladies up to twenty two.2 p.c (16/72), and multiparous ladies seventy seven.7 p.c (56/72). Risk correlational analysis shows previous caesarean in fifty five. 5 p.c (40/72), gestation in thirty three.3 p.c (24/72) and pre-eclampsia in eleven.1 p.c (8/72). Antenatal identification of placenta accreta spectrum is very fascinating as a result of outcomes area unit optimized once delivery happens at grade III or IV maternal care facility before the onset of labor or trauma and with shunning of placental disruption twenty four twenty five twenty six twenty seven. 3 ladies had been making an attempt physiological state for roughly one year, and twenty four ladies had thirty four pregnancies. Of the thirty two continued pregnancies, ten were miscarriages, one was AN eccyesis, and twenty one gave birth once thirty four weeks of gestation. Of the trimester deliveries, 6 out of twenty one ladies (28.6%) had continual placenta accreta spectrum. alternative series according similar rates of physiological state success and conjointly represented enlarged placenta accreta spectrum repetition rates starting from thirteen.3% to 22.8%.

CONCLUSIONS

In our examination, among unusual placentation, frequency of placenta accreta represents 55.5 percent and it is more normal in multiparous ladies than primigravidas. Among hazard factors in our investigation, past cesarean section is usually connected with strange placentation followed by a placenta previa and PIH. Placenta accreta range is getting progressively normal and is related with critical horribleness and mortality. Taking these restricted distributed information together, and the acknowledged methodology of caesarean hysterectomy to treat placenta accreta range, traditionalist administration or hopeful administration ought to be viewed as just for deliberately chose instances of placenta accreta range after itemized guiding about the dangers, dubious advantages, and adequacy and ought to be considered investigational.

CONFLICT OF INTEREST

Author declared no conflict of interest.

FUNDING SUPPORT

None

ACKNOWLEDGEMENT

The authors are thankful to all who have extended their constant support for the completion of the work.

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