IJBCS
ISSN: 2147-1428

Original Article

International Journal of Basic and Clinical Studies (IJBCS)
2013;2(2): 105-107 Arslan Z et al.

The Anestesia Managemant of a Case Plasenta Perkreata Diagnosed During Caesarean Operation

Zakir Arslan[1], Fesih Kara[2], Mustafa Kutuk[1], Urfettin Huseyinoglu[1]

[1] MD, Kafkas University, Anesthesiology Clinic, [2] MD, Special Sifa Hospital, Erzurum

Anesthesia is known to be a risky field. Intraoperative period is usually black despite the anesthesia preoperative risk assessment. Anesthesia risks usually calculate by using ASA and Goldman Cardiac Risk Indexs. However, it is not possible to predict the intraoperative surgical variables with two indexes (1). Risk of anaesthesia could be showed as follows; in later years, high ASA, a major emergency surgery, preoperative problems, as the male sex and the use of opioids (2). In addition to the risks associated with an anesthesiologist, adequate equipment, facilities and trained staff, related thereto (3). Perioperative most causes of death are as follows; bronchopneumonia, congestive heart failure, myocardial infarction, pulmonary embolism, and respiratory failure (4). Mortality is greater than one operations, cardiovascular surgery, emergency surgery, extended unanticipated surgical, bleeding and the liquid sift are the main causes to increase the risk of anesthesia. Placenta abnormalities are one of the major causes of maternal deaths and bleeding related to birth. Because of the placenta perkreata to invade the neighboring to the pelvic organs, attached the placenta is the most severe form of anomalies. Usually the case results with hysterectomy (5-6).

The aim of this study is to present the treatment the administration of anesthesia for the case with ASA-1 class was diagnosed with placenta perkreata during the cesarean operation.

Case

The case was a 24-year-old, 3. pregnancy is a living child (G3), she had repeated cesarean birth and learned that the previous cesarean had been made three years ago. Day 2-3 packs of cigarettes smoked. Pereop examination was normal. She is pregnant since 38 week hemogram and blood biochemistry values were in normal range, the blood type and blood pressure were as follows; A rh (+), 125/75mmHg.

Spinal anaesthesia was planned. The vain was opened. After providing an infusion of 500cc isotonic NaCl (0.09%) iv. and sterilization conditions with sitting position, from the range L3-4 spinal anesthesia was applied by using G:26 (Atrokan) and the hidroclorur Bupivacaine 0.5% Heavy 3.5 cc (17.5 mg). Full block produced, operation was started.

Acute widespread bleeding started after getting a live baby girl. Two vain were opened with 18 g and 16 g branul, it has been started to replacement of I. V liquid (of crystalloid and colloid). Blood pressure started to fall (70/35mmHg). In spite of Ephedrine HCL (total: 300mcg) has been given a shock was developed after acute hypotension table. Blood pressure was not measured. Consciousness is closed. Without any anesthetic drug, orotrakeal was intubated. A rh (+) blood immediately found in her closet, and from personnel received was started to infusion regardless of suitability of cross. Infusion was started with fluid replacement (of crystalloid: 2000cc,

Colloid: 1000cc), whole blood, packed red blood cells (ES), and fresh frozen plasma (TDP) replacement, as well as (the) inotropic agent, Dopamine 10mcg/kg/min, the dose of Adrenaline 1mcg/kg/min. It was applied to the tissues compression. Clamp was set to the uterine arteries.

It has been replaced a total of four full-blood, 8 U ES, TDP (2 U ES and 1 U TDP were given in intensive care unit). During the operation, it was determined that from the placenta invasion starts down the over vaginal, bladder and retzius range were invaded. Subtotal hysterectomy was made. The operation lasted three and a half hours. At the end of the operation, although with intubation's and with blood pressure 105/50mmHg, heart rate 97/min was taken to the intensive care unit and on the same day patient was extubated. Any complication was not developed depending on the Massif blood transfusion. A day later, the patient transferred to the normal service. She was discharged from hospital after the sixth day admission.

Discussion

It is well known that in 1941, ASA; Anesthesia has used the preoperative risk evaluation (7). The location and size of the surgery increases the risk independently from ASA. Due to excessive blood loss, hypovolemic shock, the patient has required emergency replacement of liquid-electrolyte, blood and blood products.The goal here is primarily to protect the vital organs from hipoksy needs to increase the oxygen carrying capacity, and as well as intravascular volume. The general opinion for hypovolemic shock, emergency volume restoration has been done by crystalloid or colloid solutions. If the volume does not provide clinical stabilization, it needs emergency replacement of blood and blood products transfusion. Emergency transfusion, in the case of patient delay risk without completed the standard pretransfusion tests it needs emergency transfusion the red blood cells. In an emergency situation, it is recommended that if there is not a type-specific whole blood or red blood cells it needs to used red blood cells that carry (zero) group. Cross-match has not been exist however blood type-specific or type compatible red blood cells transfusion in terms of non-compliance is not a very large risk (8).

In our patient, there is an indication for emergency transfusion as well as massive transfusion. Blood Massif transfusion could be defined as; blood transfusions within 24 hours until the recipient's blood volume, transfusion more than 20 U erythrocyte suspensions within 24 hours or transfusion recipient's blood volume within 3 hours more than 50% blood volume.

The Massif is an urgent issue, and if the status of transfusion and follow-up is an appropriate way, it is life saving. However, there are also significant complications that affect the patient's prognosis.

Whole blood, erythrocyte suspension, packed red blood cells, fresh frozen plasma and liquid use in the Massif transfusion. The basic purpose of the treatment of the massif hemorrhages with the shock together, is to correct the oxygen perfusion and its distribution into the tissues. To continue sufficient circulation more amount of liquid volume must be placed rather than lost blood. One cannot be successful only to make blood transfusions. Replacement liquid with lost blood fluid must be given. So the more successful the result will be taken (9-11).

There are case reports in the literature dealing with bladder invasion placenta (12). In our case, during operation it has been determined that the placenta were found to be attached to the wall of the bladder and the vagina through seroza. There was a life-threatening of mother because of bleeding. Due to the importance of clinical condition, hysterectomy and subtotal hysterectomy was done.

As a result; even a looks simple caesarean case with ASA-I section can be difficult, urgent and risky for anesthesia. Intraoperative risks cannot be previously account, ASA-1case can carry the risk of ASA-4 and 5. Therefore, each case in terms of Anesthesia and requires a multidisciplinary approach. Trained auxiliary staff is very important. Quick and accurate treatment management during operation can save lives.

References

1- S.Ramani Moonesinghe Current Opinion Critical Care 2009
2- Cohenmm:JAMA 1988
3- Silber JH: Anesthesiology 96:1044.2002
4- Buck N: Report of a Confidental Enquiry into Perioperative Dealths, Nuffield Provintial Hospitals Trust. London The King's Pup,House
5- Rahman MH, Akhter HH, Khan Chowdury ME, et al. Obstetric deaths in Bengladesh. Int J Gynaecol Obstet 2002;77:161.
6- Henrich W, Fuchs I, Ehrenstein T, Kjos S, Schmider A, Dudenhausen JW. Antenatal diagnosis of placenta percreta with planned in situ retention and methotrexate therapy in a woman infected with HIV. Ultrasound Obstet Gynecol 2002;20:90-3.
7- Şaklad M. Grading of patients for surgical procedures Anesthesiology 1941:2 :281-84
8- Menitove JE, ed. Standards for blood banks and transfusion services, 19th ed.Bethesda, MD: Amerikan Association of Blood Banks. 1999.
9- Andeson KC, Ness PM Scientific Basis of Clinical Practice, İmplications for Clinical Practice, Philadelphia Saunders, 1999
10- Hiippala S. Replacement of massive blood loss. Vox Sang 1998.2,
11- Anesthesiology,V:105,No:1, Jul 2006
12- Chou MM, Tseng JJ, Ho ES, Hwang JI. Three-dimensional color power Doppler imaging in the assessment of uteroplacental neovascularization in placenta previa increta/ percreta. Am J Obstet Gynecol 2002; 187: 515- 6.