

Emergency Management of Anterior Placenta Accrete with Uterine Wall Excision

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My name is Anas Alojyali, I am specialist registrar at Queen's hospital in Romford in the United Kingdom. At our hospital, we manage women with placenta accrete using a multidisciplinary approach and have done so for the last 8 years.

We will show you a short video to explain how to manage an unexpected presentation of morbid adherent placenta at the time of either routine or emergency caesarean section.

The management in this feature refers to a low-lying anterior placenta which is amenable to excision and reconstruction of the uterus.

It may not be suitable if the placenta is posterior, a complete or if the placenta invading the cervix. However, the preliminary management on how to identify morbidly adherent placenta at the time of surgery and the avoidance of the affected area was simple homeostatic techniques of being applied may be invaluable and reducing blood loss until appropriate support is available and a hysterectomy required can be performed safely.

On entry of the uterus. The lowest segment will be seen to be bulge with a massive a central tissue. This a thin serosa a layer of the lower segment, called **blueberry appearance** of the lower segment.

Often there are dilated vessels on the surface which increase in number; the thickest closest to the bladder fundus and where the previous incision on the uterus was made; Once this is visualized, every effort must be made to avoid this area.

The incision must be extended, even if it requires that the rectus muscles are transected.

Usually this is not necessary if a woman has had previous pregnancies, as the abdominal wall is often quite lax.

A **vertical incision is made** as high and closer to the fundus as possible again, if the woman has lacks abdomen Usually, the uterus can be **completely exteriorized**, as shown in the video.

Once the baby's delivered and handed to the midwife, **the umbilical cord is clamped and cut close to the placenta on the foetal surface.**

Any membrane present is trimmed prior to closing the uterine cavity.

No attempt is ever made to try to remove at the placenta if the finding is described above are seen. The lower aspect of the uterus is most vascular and where bleeding is likely to occur.

This is between the fundus of the bladder and the lower uterine interface. It is also where the bladder wall maybe adherent to the uterine wall or where the placenta invades the bladder wall.

Often the surface of the lower segment is thin and occasionally the placenta may be seen extruding from the surface, usually with many dilated veins and arteries. It is for this reason a flexible ligature, usually a **Jacque catheter** is applied to help secure haemostasis.

Any flexible catheter can be applied. We use the jacque catheter because it is easy to see and can take on a significant amount of tension.

In this video we have used two catheters: first, 1 displaced by passing through a hole in both the right and left broad ligaments, starting anteriorly passing behind the uterus back to the front through the posterior aspect of the other broad ligament and not in the catheter bladder anteriorly to in this instance include the bladder for a brief time.

Once sufficient tension is applied. The single thrown knot is secured with a pair of forceps. Occasionally more attention is required. So, a second forceps is clumped across the 2 ends of the ligature between the knot and the surface of the uterus to further increased tension. The ligature is placed as low as possible, ensuring no Bowl is trapped within the ligature. this is left until the large vessels between the uterus and the fundus of the bladder have been successfully ligated in prolong surgery it is removed as soon as this step is complete. **The uterus is closed in two layers** as when preparing a classical uterine incision or closing a myomectomy incision.

To secure haemostasis of the vessels on the fundus of the bladder. **Liga titanium clips** are applied, and the vessels are cut between them.

Before trying to reflect the bladder down.

Diathermy is never used due to the unpredictable depths of penetration and potential trauma to the bladder.

Also, these vessels, often Venus are intimate, with the bladder fundus and not easy lifted to ligate.

Once this is achieved, the bladder is carefully peeled of the lower aspect of the uterus until the cervix can be palpated of the thinner opposing walls of the vagina have felt.

Usually, when the non-invaded area of the uterus is reached, the consistency of the uterine wall becomes much firmer, pale, indicating how much uterus remains to repair the rent.

A second: ligature is placed to Include the infundibular pelvic ligament with the ovaries and uterine arteries and veins, and secure behind the bladder on the lower part of uterus neck tying a knot as described during the insertion of the first ligature.

By doing this, very little blood enters or leaves the uterus, which is usually indicated by the paler and reduced tone during the next step of surgery.

This technique for temporary haemostasis is a suitable for postpartum haemorrhage due to other causes, such as waiting for the anaesthetist to catch up with blood and blood products before proceeding or waiting for help.

The surface of the uterine wall affected by the placenta accrete is easily delineated by the characteristics described above.

Most of the affected area is where there is an obvious mass, and any mildly adherent area is beyond, it is usually secured with the help of deep- haemostatic sutures.

The affected area in the anterior uterine wall and the placenta in-situ will be removed by cutterly.

Once the affected area of the anterior uterine wall and the placenta removed the lowest segment is repaired with interrupted sutures, with each surgeon starting from each side and to maintain symmetry.

Please observe how little blood is lost after the application of a flexible suture.

The second layer is closed by continuous sutures.

Once this is completed, both the ligatures are removed, and the uterus is massaged to observe for return of uterine tone and if there are any active bleeding points.

Any bleeding areas are secured by what we refer to as a box suture.

This is where the suture is applied in such a way of both edges of the uterus are compressed together the securing any large open sinuses.

Finally, **both uterine arteries are ligated.**

This involved inserting a suture one centimetre below the incision and one cm in the myometrium from the side of the uterus, just below the incision and not entirely anteriorly.

Again, checking that there is no bowel behind the uterus, or the area operated on.

The woman in this case requests is **sterilization**, so **Filshie clips** were applied the most proximal area of the fallopian tube and shown the tube of completely occluded by the clips.

Once this was done and the operation complete the placenta with uterine wall still attached is sent for histology.

The total bloodless in this case was 800 miles. The woman did not need a blood transfusion, had an uneventful recovery with a 4-day post op hospital stay.

Both baby and mother were discharged on the same day.

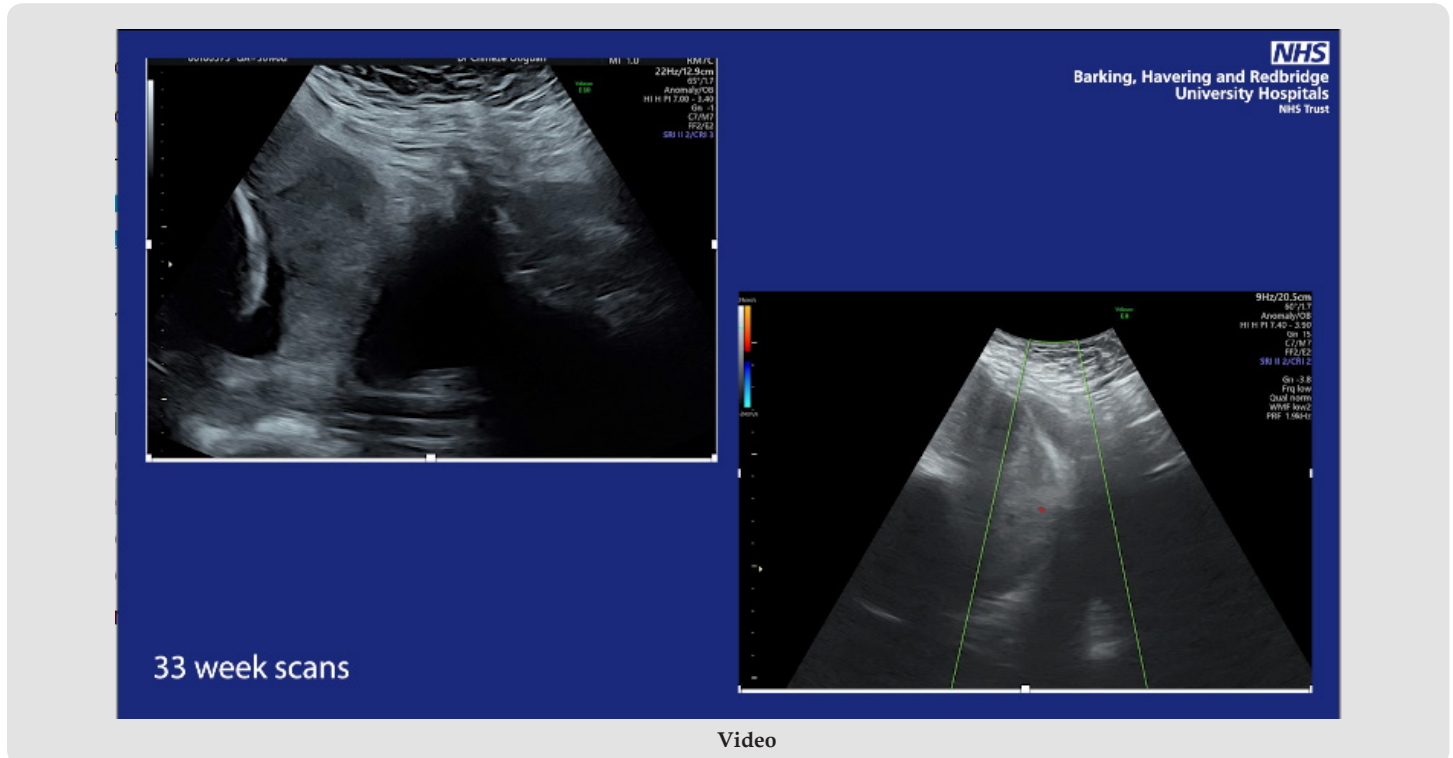
A histology confirms a diagnosis of placenta accrete.

Oh review. three months later the woman has resumed menstruation and an ultrasound of the uterus revealed a well involuted uterus with minimal evidence of such significant surgery.

It is important for obstetrics and gynaecology Trainees everywhere to understand how to identify and manage This increasingly complex condition, which will increase because of the rise in caesarean section rates all over the world. I also feel, it is important, we developed techniques that can be easily implemented in resource poor countries who do not have the sophisticated interventional radiology services and often poor transfusion services too.

I wish to thank my team, radiologists the transfusion practitioners, interventional radiology, theatre staff and medical photographers - who make this type of complex surgery appear straightforward, simple but extremely effective.

Thank you.



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