

10-2013

A Case of Cesarean Hysterectomy for Placenta Previa and Percreta

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Recommended Citation

Talati A, Prassana P, D'Souza S, Kashikar A. A Case of Cesarean Hysterectomy for Placenta Previa and Percreta. MCC Meeting, Oct 2013.

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INTRODUCTION

Patients with placenta percreta pose significant complicated issues for the anesthesiologist and obstetrician, especially massive hemorrhage.

We present a case whereby a patient with placenta previa and percreta underwent a total intravenous anesthetic (TIVA) for a cesarean hysterectomy and thoracic epidural for bilateral iliac artery balloon occlusion and postop analgesia.

CASE DESCRIPTION

A 35 year-old G8P4 with history of multiple D&Cs and c-section, presented with complete placenta previa and percreta for elective c-section and hysterectomy. The percreta invaded the bladder with close proximity to iliac vessels.

Multidisciplinary planning and simulation was conducted prior to surgery. Thoracic epidural was placed for preoperative iliac artery balloon catheterization and postoperative analgesia.

C-section was performed under general anesthesia and maintained with TIVA. Balloon catheters were inflated following fetal delivery. Placenta was left in situ and hysterectomy performed with minimal blood loss.

The patient was extubated and both the patient and baby had an uneventful recovery.



Pelvic MRI revealing placental invasion of uterus and dome of bladder

REFERENCES

1. Obstet Gynecol 2012; 120:207-11
2. Curr Opin Anesthesiol 2011; 24:274-81
3. <http://www.ochsnerjournal.org> The Ochsner Journal; Spring 2011; 11 (1): 84-8
4. Am J Obstet Gynecol 2005; 193:1045-9
5. Spine J 2012; 12: 646-51
6. Int J Obstet Anesth 2011; 20(1): 70-73

DISCUSSION

- Placenta accreta: part of the placenta, or the entire placenta, invades and is inseparable from the uterine wall.
- Placenta percreta: invasion through the myometrium and serosa, occasionally other organs, such as the bladder.¹
- Life-threatening obstetric condition. Potential for massive hemorrhage² and requires a multidisciplinary approach to perinatal management.³
- Risk factors for accreta: previous cesarean delivery, advanced maternal age, multigravidity and multiparity, previous curettage and previa, hypertensive disorders and smoking.⁴
- Thoracic epidural: bilateral iliac artery balloon catheterization and postoperative analgesia (large classical incision for hysterectomy), shown to reduce postoperative opiate requirements.⁵
- TIVA: avoids the risks of uterine atony associated with volatile anesthetics, also reduced risk of PONV.
- Bilateral iliac artery balloon catheterization: insufficient data on efficacy shown to help decrease the potential for massive hemorrhage.²
- Bilateral iliac artery balloon catheterization is not without risks including: pseudoaneurysms, arterial rupture, compromised vascular supply due to acute thrombosis, retained catheters, massive hemorrhage due to and despite catheterization.⁶
- Short-burst radiation was used to minimize radiation exposure to the fetus.

CONCLUSION

While no one type of anesthesia is superior to the other, utilization of iliac artery balloon catheterization and a combination of total intravenous anesthesia with a thoracic epidural may potentially decrease the potential for massive hemorrhage and provide superior postop analgesia allowing for shorter length of stays.