OBJECTIVE: To discuss problems faced in the management of emergency and elective cesarean sections with known or unknown abnormal placental placement and their management.

Study Design: Retrospective observational study.

Place and Duration of Study: Different Hospitals for the last 7 years from 2013 to 2020.

Methodology: This retrospective observational study of 120 cases was selected for data collections that underwent anesthesia. Variables under study were age, weight, type of abnormal placenta, fluid, blood/blood products given, duration, pregnancies, different placements and all contribute to major obstetric hemorrhage, and maternal morbidity. Placenta previa and abruptio placentae are the common cause of antepartum hemorrhage. Placenta accreta is the penetration of the myometrium by placental villi and the risk of accrete increases in women with Previa increases 3-61% in the quaternary C-section and it is becoming the leading cause of cesarean hysterectomy.

The average blood loss during the delivery of patients with placenta accreta is 3-5L. This amount of blood loss is difficult to manage under spinal anesthesia and previously general anesthesia was advocated to manage these cases.

The choice of anesthesia for managing such cases was controversial in the past but any type of anesthesia can be used safely considering the condition of mother and fetus. The concept of “more control” during general anesthesia is not supported by literature. The main concerns in managing such cases are intraoperative monitoring of patients, replacement of fluid loss with crystalloid or colloids, blood, and blood products. This study aims to share the experience of managing these cases of obstetric hemorrhages during elective and emergency cesarean sections.
emergency surgery with abnormal placental placement and outcome of operations.

**METHODOLOGY**

Total of 120 patients were included in this retrospective observational study which was started after approval of the hospital ethics committee (IERC/ANES/14/2020), (Different hospitals for the last 7 years from 2013 to 2020). All elective, emergency, booked and unbooked cases were enrolled in this comparative study. The sample size was calculated with the WHO sample size calculator and it was 100 patients but we included 120 patients to increase the strength of the study. It was non probability sampling based on convenience.

**Inclusion Criteria:** All patients reporting for emergency or elective cesarean section with known or unknown abnormal placental placement were included.

**Exclusion Criteria:** Non-consenting patients were excluded.

The general anesthesia with Preoxygenation, IV propofol 120-150 mg, and suxamethonium 100 mg were standard in all known abnormal placental placement patients followed by endo tracheal intubation (ETT) of 7mm. After securing ETT, the anesthesia was maintained on 100% oxygen and isoflurane mixture followed by atracurium 30 mg in all patients. The spinal anesthesia was used in patients with low risk of bleeding and if a placental abnormality was not exactly known previously even on abdominal ultrasound. The standard 25G or 26 or 27 Quincke Babcock spinal needle was used for regional anesthesia. Each spinal anesthesia patient was co loa-ded with Ringers Lactate solution with 18 G cannula and hyperbaric 0.5% bupivacaine 2ml was given at L2-3 or L3-4 space by the same anesthetist. After spinal anesthesia patients were placed supine with 10-15% position and surgery was started after the onset of sensory and motor block. The vital signs of the patients were monitored with basic vital sign monitor and the arterial line was passed in the left radial artery in cases where heavy blood loss was anticipated. We arranged 2 units of grouped and cross-matched blood for each patient known to have abnormal placental placement as a standard protocol for such patients. The records of total blood, colloids, and crystalloids transfused intra-operatively were maintained. The inotropic support with norepinephrine, adrenaline, and or ketamine was individualized for each patient. The patients either had a cesarean section followed by hysterectomy or cesarean section with preservation of the uterus. Any morbidity or mortality during surgery was also recorded.

The data thus obtained in all patients was subject to analysis with Statistical Package for the Social Sciences (SPSS) version 21. The data was presented in percentages.

**RESULTS**

A total of 120 patients were operated having abnormal placentation. The incidence of Placenta previa 90 (75%), and Accreta was 30 (25%). Primigravida patients were 19 (15.8%) and Multigravida patients were 101 (84.1%). Hysterectomy was done in 28 (23.3%) patients (Table-I). Spinal anesthesia was given in 50 (41%) patients while 70 (58.3%) patients have general anesthesia. The spinal anesthesia was later on converted to general anesthesia in 32 (26.6%) patients out of 50 (41%). Only 12 (10%) patients were reopened for uncontrolled bleeding and 4 (3.3%) patients were sent to tertiary care hospital for further management (Table-II). The surgeon was called for help in 24 (20%) of patients and bladder injury occurred in 25 (20.8%) patients. No mortality was found during this period (Table-III).

**DISCUSSION**

The placental abnormalities are a constant threat to the life of mother and fetus due to heavy peroperative bleeding which is very difficult to manage. Placenta accreta vera, placenta increta, placenta percreta, and previa are the common abnormal placental
placements. There are various theories for the development of abnormal placenta but it can be found without these known causes and incidence has increased over the last several years.

Few factors responsible for placenta previa include advanced maternal age, multiparity, history of dilation and curettage, hypertensive disorders, and smoking which are also risk factors for accreta in patients with a placenta previa. The placenta accreta usually resulted in cesarean hysterectomy where the placenta is left attached and hysterectomy is carried out. Whatever is the causation, the main problems are sudden intraoperative hemorrhage. To manage this massive bleeding a multidisciplinary team is mandatory to timely arrange blood and blood products, essential lifesaving drugs, and monitoring. In our hospital, we had a protocol for managing such cases in which 2 units of blood were asked for each patient with risk of bleeding and keeping up to 6 along with fresh frozen plasma and even platelets in triple 1 regime in massively bleeding patients. The arterial line was passed in the left radial artery and central venous line (CVP) was passed in high-risk cases, otherwise, two large-bore 14 or 16 g cannula were passed before starting anesthesia. The drugs like atropine, adrenaline, and ephedrine were diluted and given in IV boluses whereas norepinephrine and dobutamine were given in infusions. The novel approaches to control bleeding in the placenta increta in the first trimester were uterine artery embolization as described by Majd et al. However this facility was not available with us. Mathew Burteilow in his article has described massive blood transfusion protocol for the management of postpartum hemorrhage and their protocols are similar to our protocols. The 6:4:1 ratio for blood, fresh frozen plasma, and platelets was used in their study but we followed our protocol where the ratio was 1:4 for blood and FFP's and platelets were only used if found below the normal. A study by Wang et al have mentioned the use of aortic balloon occlusion for controlling intraoperative hemorrhage in placenta previa increta and percreta but even this method is not available with us. Yousaf et al, has concluded in their meta-analysis about the use of endovascular interventions as an effective method of controlling hemorrhage and decreasing hysterectomy rate. Whatever is the management technique, antenatal ultrasonography helps diagnose such cases and the adopting management accordingly. Similarly, intraoperative cell salvage techniques and allogenic transfusions can be very helpful in these cases as mentioned by Zeng et al.

There was no mortality in our patients even after transfusing 10 units of blood and blood products. The main focus was to maintain blood pressure intraoperatively and we aimed to maintain systolic blood pressure >90mmHg by all means. This aim was achieved with blood loss replacement with blood and blood products and decreasing depth of anesthesia. The inotropic drugs boluses were given to support blood pressure. Thus, we have seen in our experience that if we keep the systolic blood pressure >90mmHg, we can hope for a better outcome. The bleeding can be so massive that despite all efforts, it becomes difficult to maintain blood pressure and sometimes ketamine IV can help in those situations. All the anesthesia gases were turned off while giving only IV ketamine 1-1.5 mg/kg body weight which being sympathomimetic temporarily supported the blood pressure.

CONCLUSION

Abnormal placental placement is a threat to mother life as well fetus and team of dedicated doctor is required to deal with this emergency. Use of inotropes can help to save the precious lives.

Conflict of Interest: None.

Authors’ Contribution

MA: Direct contribution to the conception, design, analysis and interpretation of data.

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