

MODERN METHODS OF SURGICAL TREATMENT FOR PLACENTA AGGREGATION

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Annotation.

The problem of obstetric bleeding is still relevant today. Massive blood loss and hemorrhagic shock is one of the leading causes of maternal death. Approximately 10% of all bleeding in obstetrics is accounted for by placenta accreta and violations of its separation. The etiopathogenesis of this condition remains poorly understood. According to one hypothesis, the ingrowth of placental tissue into the uterine wall occurs as a result of defective decidualization due to surgical interventions on the uterus and excessive invasion of the trophoblast.

Key words: trophoblast, increment, placenta accreta, hysterectomy, caesarean section.

СОВРЕМЕННЫЕ МЕТОДЫ ОПЕРАТИВНОГО ЛЕЧЕНИЯ ПРИ ВРАСТАНИИ ПЛАЦЕНТЫ

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Аннотация.

Проблема акушерских кровотечений в настоящее время по-прежнему остается актуальной. Массивная кровопотеря и геморрагический шок является одной из ведущих причин материнской смертности.

Примерно 10% всех кровотечений в акушерстве приходится на долю приращения плаценты и нарушений ее отделения. Этиопатогенез данного состояния остается не совсем изученным. Согласно одной из гипотез, врастание плацентарной ткани в стенку матки происходит в результате дефектной децидуализации вследствие хирургических вмешательств на матке и избыточной инвазии трофобласта.

Ключевые слова: трофобласт, приращение, врастание плаценты, гистерэктомия, кесарева сечения.

Currently, the average incidence of placenta accreta is 1 case per 560 births in the Andijan region. Given the upward trend in cesarean section rates worldwide, the risk of placenta previa and accreta increases linearly [1, 2, 3, 4]. Placenta accreta is classified according to the degree of

its invasion into the myometrium, distinguishing placenta accreta vera (villi penetrate into the submucosal zone of the myometrium), placenta increta (villi penetrate into the myometrium) and placenta percreta (invasion of the myometrium and serous membrane of the uterus, bladder, etc.). The high-risk group for placenta accreta includes women with uterine surgery: uterine curettage, hysteroscopy, endometrial polyp removal, conservative myomectomy, chronic endometritis, Asherman syndrome, abnormal development of the genital organs [5, 6].

Diagnosis of placenta accreta is complicated by a poor clinical picture and the absence of specific ultrasound signs with normal localization and shallow invasion of the placenta into the myometrium [9]. For timely detection of placenta accreta, it is necessary to be especially vigilant in women with a history of cesarean section and myomectomy when placenta previa is located along the anterior wall of the uterus. The clinical picture, micro- or macrohematuria (with growth into the posterior wall of the bladder), acute abdomen with signs of intra-abdominal bleeding, allows one to suspect an accretion in placenta previa before birth. To exclude placenta accreta at the stage of outpatient monitoring of a pregnant woman, the method of choice is ultrasound with Doppler. Ultrasound data serve as an indication for MRI in the II-III trimester of pregnancy. Additional examination methods are necessary to determine the volume and tactics of surgical intervention, predict blood loss and possible complications during the operation. Until recently, the only method of resolving this obstetric situation was considered to be a planned hysterectomy during cesarean section [7]. The rapid development of endovascular surgery allows the doctor not only to control and minimize intraoperative blood loss, but also to avoid hysterectomy, preserving the woman's reproductive function. Performing hysterectomy after delivery or during cesarean section has long been considered the traditional approach as an elective or emergency procedure in cases of massive obstetric hemorrhage [9]. Later, organ-preserving techniques began to be developed aimed at preserving fertility, for example, deliberately leaving the placenta in the uterus [7, 9, 12]. In this conservative management, the incision is made above the superior edge of the placenta. An incision of the uterus outside the location of the placenta (usually a bottom caesarean section) is also recommended by domestic scientists. The umbilical cord is tied and cut as close to the placenta as possible without attempting to separate it from the uterine wall. Oxytocin is not given as it may cause small areas of the placenta to separate, followed by bleeding. The advantage of this technique is the minimization of intraoperative blood loss.

Russian researchers widely use and describe various modern methods of surgical prevention and control of bleeding (occlusion of the corresponding arteries; ligation of the internal iliac arteries; use of Satinsky vascular clamps; application of tourniquet tourniquets to the base of the broad ligaments and the cervical-isthmus region; controlled balloon tamponade of the uterus, etc.)

Purpose of the study. In recent years, operating gynecologists have considered it necessary to abandon attempts to separate the placenta in patients with placenta accrete in order to avoid massive bleeding. Today, there are organ-preserving methods for resolving patients with placenta accreta after cesarean section.

In the perinatal center of Andijan Andijan, 16 patients with placenta previa and accretion of the placenta into the scar after previous cesarean sections were operated on in 2022-2023. On average, the incidence of placenta accrete was 16 cases per 8935 births for the total number of births during this time.

Material and research methods. The 16 examined patients were divided into 2 groups. The two groups did not differ in age, number of pregnancies, parity, number of previous cesarean sections, mean gestational age at delivery, and mean birth weight. All subjects had a history of cesarean section, which confirms the literature data on uterine scars. Half of the study patients had grade I. Caesarean section was carried out as planned - (45%), in the other half (55%) - emergency. In every fifth patient (20.2%) the study showed no signs of placenta accreta on ultrasound; it was detected intraoperatively - upon opening the abdominal cavity, a pronounced vascular pattern was found in the area of the lower segment of the uterus. The patients were divided into two groups depending on the option of cesarean section:

I-Group (8 women)

II-Group (8 women)

In group I, laparotomy was performed on the old scar

In group II, the fetus was removed by bottom caesarean section. Research results. In the first group, in almost all patients the fetus was removed transplacentally, which initiated the onset of massive bleeding. Of the 8 women, 4 (50%) underwent hysterectomy; the rest managed to avoid removal of the uterus by using ligation of the internal iliac arteries; adequate infusion therapy was carried out in combination with hemostatic sutures: fresh frozen plasma and erm mass were used. In the group of patients who underwent cesarean section in the lower uterine segment, the total blood loss was more than 1.5-2 liter

In the second group, the fetus was removed through an incision in the fundus of the uterus, without affecting the area of attachment of the placenta - bottom caesarean section. The advantage of this method is less blood loss; in only 1 (13%) of 8 patients the volume of blood loss was 2 liters. This surgical approach creates more comfortable conditions for the (surgeon) obstetrician-gynecologist when performing metroplasty, since the fetus is removed and the bladder can be better separated and the lower edge of the unchanged myometrium can be visualized. After the newborn was delivered, the placenta was left in place, and the incision on

the uterus was sutured with a 2-row vicryl suture. For the purpose of hemostasis, the following method was used: extravasal - ligation of the great vessels from the outside. Then an incision was made in the lower segment of the uterus to remove the placenta, excise the altered myometrium and metroplasty. An important point is that women of group II managed to maintain reproductive function.

Conclusions. In the Andijan community center, a plan has recently been developed for the management of women with placenta accreta:

1. Hospitalization as planned at 36-37 weeks with ultrasound confirmation.
2. Conduct additional examination and preparation of donor blood.
3. Determine surgical tactics and participants in the operation who perform hysterectomy.
4. Prevention of thromboembolism of the lower extremities.
5. During the operation, the presence of an angiosurgeon and transfusiologist is desirable.
6. If placenta accreta occurs, a cesarean section is performed.
7. After removing the fetus, without touching the placenta, close the wound
8. An incision in the lower uterine segment to remove the placenta, excision of the myometrium and perform metroplasty.

The effectiveness of organ-preserving surgery PAS increases by 100% when using compression sutures and devascularization of the uterus. Multidisciplinary approach for PAS: reduces the frequency of emergency operations, large volume of blood transfusions, reduces the frequency of re-operations after 7 days. As well as modern organ-preserving methods for resolving patients with placenta accreta after cesarean section, the main goal of which is to avoid hysterectomy and preserve women's fertility!

Literature:

1. Bashmakova N.V., Davydenko N.B., Malgina G.B. Monitoring obstetric "near miss" in the strategy for the development of obstetric services // Russian Bulletin of Obstetrician-Gynecologist. 2019. T. 19, No. 3. P. 5-10.
2. "Clinical guidelines for caesarean section." Tashkent, 2010. Under the leadership of A.I. Kamilov.
3. Clinical recommendations "Caesarean section. Indications, methods of pain relief, surgical technique, antibiotic prophylaxis, management of the postoperative period" Moscow, 2014.
4. Abnormally invasive placenta-prevalence, risk factors and antenatal suspicion: results from a large population-based pregnancy cohort study in the Nordic countries / L. Thurn, P.G. Lindqvist, M. Jakobsson [et al.] //B. J. O. G. 2016. Vol. 123, No. 8.

5. American Academy of Pediatrics and American College of Obstetricians and Gynecologists.
6. Obstetric and medical complications Jn: American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6 th ed. Elk Grove Village, JL: American academy of Pediatrics-2018-P.175-204. 6. Booker W., Moroz L. Abnormal placement // Seminars in perinatology. 2019
7. Durnwald C., Mercer B. Uterine rupture, perioperative and perinatal morbidity after single-layer and double-layer closure at cesarean delivery. American Journal of Obstetrics and Gynecology 2013, 189 (4): 925-9
8. Global causes of maternal death: a WHO systematic analysis / L. Say, D. Chou, A. Gemmill [et al.] // Lancet Glob. Health. 2014.
9. Placenta Accreta Spectrum (PAS) disorders: incidence, risk factors and outcomes of different management strategies in a tertiary referral hospital in Minia, Egypt: a prospective study / S. El. Gelany, M. H. Mosbeh, E. M. Ibrahim [et al.] // BMC Pregnancy and Childbirth. 2019.
10. The management and outcomes of placenta ac-creta, increta, and percreta in the UK: a population-based descriptive study / K. E. Fitzpatrick, S. Sellers, P. Spark [et al.] // B. J. O. G. 2014.