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CASE STUDY OF ABRUPTIO PLACENTAE IN PREGNANCY

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ABSTRACT

Placental abruption occurs when the placenta partly or completely separates from inner wall of the uterus before delivery of baby,usually after 20 weeks of pregnancy.Placental abruption can deprive the baby of oxygen and nutrients and can cause heavy bleeding in mother.Placental abruption happens suddenly and endangers both mother and the baby.Advanced age pregnancy, parity, smoking, pregnancy induced hypertension,pre-eclampsia and previous incidence of abruptio placentae are predisposing factors.The risk of PIH is estimated at 1:1500 pregnancies and is responsible for high number of maternal and fetal deaths worldwide.The major complications of PIH include pre-eclampsia,eclampsia,abruptio placentae(AP),intrauterine growth retardation(IUGR),low birth weight babies(LBW),fetal distress and neonatal deaths.The incidence of Abruptio Placentae varies from 0.5% to 1.0% worldwide.In India it ranges from 2.5% to 3.8%.

KEYWORDS:Abruptio Placentae,PIH,Pre-eclampsia

INTRODUCTION

Women during pregnancy are susceptible to experiencing severe complications that can pose a threat to their lives during pregnancy,childbirth or postpartum period.Hypertensive disorders are prevalent worldwide and represent significant medical complication in pregnancy.Chronic hypertension in pregnancy is often accompanied by several maternal risks,including PIH,preeclampsia,resistance of insulin and placental abruption.

Placental abruption classically defined as complete or partial separation of normally implanted placenta before delivery.At least 50 different risk factors or risk markers for placental abruption have been reported with smoking,preeclampsia and history of previous placental abruption being the strongest.Although many risk factors or risk markers are known, the cause of placental abruption often remains unexplained.

Abruption is thought to occur following a rupture of maternal vessels within the basal layer of the endometrium.Blood accumulates and splits the placental attachment from the basal layer.The detached portion of the placenta is unable to function,leading to rapid fetal compromise.

There are three main types of placental abruption:

1.Revealed-bleeding tracks down from the site of placental separation and drains through the cervix.
This results in vaginal bleeding.

2.Concealed-the bleeding remains within the uterus and typically forms a clot retroplacentally..This bleeding is not visible,but can be severe enough to cause systemic shock.

3.Mixed-In this type,some part of blood collects inside(concealed) and a part is expelled out(revealed).Usually one variety predominates over the other.

The clinical implications of a placental abruption vary based on the extent of the separation and the location of the separation.Placental abruption can be complete or partial and marginal or central.

The classification of placental abruption is based on the following clinical findings.

Class 0:Asymptomatic
*Discovery of blood clot on maternal side of a delivered placenta.
*Diagnosis is made retrospectively.

Class 1:Mild
*No sign of vaginal bleeding or small amount of vaginal bleeding.
*Slight uterine tenderness .
*Maternal blood pressure and heart rate WNL.
*No signs of fetal distress.

Class 2:Moderate
*No sign of vaginal bleeding to a moderate amount of vaginal bleeding.
*significant uterine tenderness with tetanic contractions.
*Change in vital signs:maternal tachycardia,orthostatic changes in blood pressure.
*Evidence of fetal distress.

*Clotting profile alteration:hypofibrinogenemia.

Class 3:Severe
*No sign of vaginal bleeding to heavy vaginal bleeding.
*Tetanic uterus/board-like consistency on palpation .
*Maternal shock.
*Clotting profile alteration :hypofibrinogenemia and coagulopathy.
*Fetal death.

TREATMENT-

It isn't possible to reattach a placenta that is separated from the wall of the uterus.Treatment options for placental abruption depend on the circumstances:

***THE BABY ISN'T CLOSE TO FULL TERM**

1) If the abruption seems mild,your baby's heart rate is normal and it's too early for baby to be born,patient is hospitalized for close monitoring.
2)If the bleeding stops and baby's condition is stable,bed rest is given to patient.
3)Medications for baby's lung maturity and for protection of brain are given.Delivery of baby is done in severe cases.

***THE BABY IS CLOSE TO FULL TERM**

1)Generally after 34 weeks of pregnancy,if the placental abruption seems minimal,patient is closely monitored and then vaginal delivery might be possible.
2)If the abruption worsens or interferes with baby's health,then immediate delivery by C-section is required.

CASE REPORT

A 24 year old registered female patient having obstetric history as primi with full term pregnancy with Abruptio Placentae with k/c/o PIH since 1 month.Patient was on antihypertensives Tb.Labet 100mg 1tds and Tb.Nicardia 10mg 1tds.She was complained of p/v bleeding since half hours with amount of bleeding as 1 pad was fully soaked.
Patient was afebrile and her vitals were:
O/E-P-88/min
BP-200/110mmHg;pedal edema,facial puffiness noted.
SPO2-99%;RR-20/min;
Temp-98.4Degree Fahrenheit

Per abdominally uterus was full term,1 contraction of 25 seconds in 10 minutes,FHS 144/min and head was on brim.Per vaginal examination showed cervical dilation of 1cm,cervix was riped,small blood clot was noted.

With overall examination; diagnosis was near by indicating to abruptio placentae with PIH hence all lab investigations were done in emergency,patient was informed to honorory.Inj.mgso4 loading dose of 14 gm was given.Inj.mgso4; 5gm on bilateral buttocks were given intramuscularly and 4gm with 100 ml NS was given in iv route. After all pre op medications and lab patient was posted emergency for lscs for abruptio placentae with pre-eclampsia .Before the emergency lscs informed consent of patient was taken.Abdomen was opened layerwise.Baby was delivered safely.Retroplacental clot of 180 gm was removed.Uterus was closed layerwise ,abdomen was closed and haemostasis was achieved.With vaginal toileting and after dressing of abdomen region, patient was shifted from ot to ward in stable condition.

After emergency LSCS patient was shifted to ward,iv antibiotics,iv analgesics,iv fluids were given.On post op day 1 BT transfusion was done.BP was monitored and accordingly antihypertensives were given.Reflexes of knee,plantar,ankle were monitored and Inj.mgso4 maintenance doses were not given due to controlled BP readings.Barbiturates were added for 3 days for preventing seizures due to uncontrolled BP.Patient was monitored for 5 days .Till post of 5 days patient's BP was in normal range.Patient was on antihypertensives Tb.Labet 100mg 1tds and Tb.Nicardia 10 mg 1tds. After dressing on 5th day patient was discharged.After discharge, patient was advised for maintaining BP records for 3 times.Patient was informed about signs of preeclampsia and PIH as Headache,nausea,vomiting,blurring of vision,burning sensation in chest .If any of the signs observed then patient was advised to visit hospital.

***FOLLOW UP**

The patient visited on post op 8th day of lscs with BP records.BP records were normal.Dressing of patient was done and all stitches were removed. Antihypertensives were continued for next 4 days and patient was asked to come with BP records.

***DISCUSSION**

The incidence of Abruptio placentae is uncommon yet serious complication of pregnancy.Treatment protocol of this condition depends upon 3 classes and patient's presenting condition at time of admission.In emergency cases immediate delivery of baby is required.Blood loss is needed to be corrected.

***CONCLUSION**

Abruptio placentae is urgent obstetrical emergency and can occur during second half of pregnancy.Immediate clinical diagnosis on basis of clinical signs and symptoms are required and immediate management of patient and baby is required.

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