Abstract # 267

Anesthetic Management of Complete Placenta Previa and Placenta Accreta with Massive Hemorrhage, with Failed Uterine Artery Embolization in the Interventional Radiology Suite Necessitating Emergent Total Abdominal Hysterectomy

Introduction: Placenta Accreta (PA) refers to abnormal placental implantation into the uterine myometrium and is a major cause of maternal morbidity. The incidence of PA has increased in recent years which may be because of increased cesarean section rates.

Case Report: We report a case of a 27 year old female G7P2A2 who was scheduled for cesarean hysterectomy at 37 wks of gestation due to complete placenta previa and PA. Preoperative Hb was 10.7 and platelets were 250k. Arterial line and cell saver were kept as back up in the operating room and two units of PRBC were on hold. A combined spinal epidural anesthesia was performed at L3 – L4 level on the first attempt. Surgical level was T-4 bilaterally. A midline vertical incision was made and a healthy baby was born, 30-U oxytocin IV started, and the placenta was manually removed from the lower uterine segment to preserve the uterus for future fertility instead of performing a hysterectomy because the OB team questioned whether there was a true placenta accreta. Upon uterine closure, “oozing” was noted and two doses of methergine (0.2 mg IM) were given. Hextend 6% was started and the OB team declined cell salvage. EBL was 2500 mL, Haemacue was 5.1; two units of PRBC and 2nd bag Hextend 6% started. Because of hemodynamically instability, a phenylephrine drip was started (0.1mcg/kg/min), arterial line placed and laboratory work up showed Hb of 6.6. At the end of surgery, marked vaginal bleeding was noted and a Bakri balloon was placed to tamponade the bleeding uterus. Transferred to ICU where another two units of PRBC were given. Hb was 8.2. Patient transported to the interventional radiology suite for bilateral uterine artery embolization (UAE). After difficulty in UAE, Bakri balloon dislodged from the uterus with significant hemorrhage (1500 mL). A STAT condition was called and patient was transferred to the OR for an emergency hysterectomy. At end of surgery, patient again transferred to ICU intubated and eventually discharged home with baby on the 7th post-operative day without further complication.

Discussion: An abnormally adherent placenta is often a cause for continued bleeding which may lead to peripartum hysterectomy. Management of these patients includes multidisciplinary team approach including an expert surgical team, anesthesiologist, critical care specialist and also an interventional radiologist. While conservative surgical management provides an option for future fertility, decision should be made very carefully to decrease maternal morbidity in the event of emergent hysterectomy.

Conclusion: Since the incidence of PA is increasing, screening should be done preoperatively to assess risk for bleeding and peripartum hysterectomy. Anesthesiologist should be ready for any kind of hemorrhagic event and be ready for hemodynamic resuscitation keeping in mind that UAE can fail in certain circumstances.