Bölüm
11

PLASENTA İNVAZYON ANOMALİLERİ

Harun Egemen TOLUNAY[1]

Plasenta invazyon anomalileri, plasentanın myometriuma değişik derecelerde anormal olarak yapışmasıdır. Günümüzde bu invazyon anomalilerinin sıklığında artış vardır. Artışın asıl nedeni artmış sezeryan sayılarıdır. Plasenta invazyon anomalisi görülen hastaların tedavisi (PİA; plasenta akreata, inkreata veya perkreata) geniş ölçüde değişiklik göstermektedir. PİA ; maternal mortalite ve morbiditenin en önemli nedenlerindendir. Peripartum kanama ve plasentanın doğurtulması sırasında aşırı kanama riski vardır, histerektomi sıklıkla gerekebilir, mesane, üreter ve barsak yaralanma riski artmıştır, yoğun bakım gereksinimi artar. Tedavisi için öneriler olgu serileri ve sunumları, kişisel deneyim, uzman görüşü ve iyi klinik değerlendirmeye dayanmaktadır. Plasenta akreata, inkreata ve perkreata tedavisi perkreata ekstrauterin dokuya yayılmadığı sürece temelde benzerdir. PİA, multidisipliner preoperatif ve intraoperatif değerlendirme gereken klinik durumlardan birisidir ve perinatalog, jinekolog-onkolog, ürolog, anesteziolog, neonatalogtan oluşan bir takım ile mutlaka III. düzey merkezlerde yaklaşım planlanmalıdır.

ETYOLOJİ VE PLASENTA İNVAZYON ANOMALİSİ ŞÜPHESİNDE PRENATAL BAKIM

Plasenta invazyon anomalilerinde etyolij kesin olarak bilinmemektedir. Ancak çeşitli teoriler vardır. Bunlar defektif desidualizasyon , aşırı ekstravillöz trofoblastik invazyon ve histerotomi skarında defektif vasküler remodeling olarak sayılabilir. Patolojik invazyon derinliğini belirleyen faktörler de bilinmemektedir. Risk faktörleri plasenta previa varlığı, geçirilmiş uterin cerrahi, maternal yaş, multiparite, uterin küretaj, uterin radyasyon, endometrial ablasyon, Asherman sendromu, myomlar , uterin anomaliler, sigara, IVF gebelikler ve hipertansif hastalıklar olarak sayılmaktadır. PİA'dan şüphe edilen tüm hastalara, tanı ve muhtemel sekeller

[1] Op. Dr., T.C.Sağlık Bakanlığı Etlik Zübeyde Hanım Kadın Hastalıkları Eğitim ve Araştırma Hastanesi

riski düşünüldüğünde görüntüleme bulgularına dayanarak bir sezaryen histerektomisinin önerilmesinin tedavi için en mantıklı ve güvenli yaklaşım olduğuna inanılmaktadır. Sezaryen histerektomisinin planlanması ve plasentanın hareket ettirilmeden in situ bırakılması önerilmektedir. Stabil hastalarda doğum , gebeliğin 34+0 ila 35+6 haftaları arasında planlanmalıdır. Prosedür, pelvis hemorajisini ve bunun komplikasyonlarını tedavi edebilecek deneyime sahip uzmanların bulunduğu bir hastanede planlanmalıdır. Antenatal kortikosteroidler, standart kılavuzlara göre uygulanmaktadır. Plasenta implantasyon anomalisi görülen gebelik doğumları sırasında veya sonrasında hemorajinin azaltılması için mevcut ise balon kateterli veya arteriyel embolizasyonlu profilaktik endovasküler girişim uygulanabilir. Nadir durumlarda, gelecekte çocuk sahibi olmak istenirse ve risklerle ilgili olarak yoğun bir şekilde danışıldıktan sonra uterin koruyucu cerrahi denenebilir (51,52,53,54,55).

REFERANSLAR

1. Collins SL, Chantraine F, Morgan TK, Jauniaux E. Abnormally adherent and invasive placenta: a spectrum disorder in need of a name. *Ultrasound Obstet Gynecol*. 2018;51(2):165–166. doi:10.1002/uog.18982.
2. Obstetric Care Consensus No. 7: Placenta Accreta Spectrum. Obstet Gynecol 2018; 132:e259.
3. Collins SL, Alemdar B, van Beekhuizen HJ, et al. Evidence-based guidelines for the management of abnormally invasive placenta: recommendations from the International Society for Abnormally Invasive Placenta. Am J Obstet Gynecol 2019; 220:511.
4. Publications Committee, Society for Maternal-Fetal Medicine, Belfort MA. Placenta accreta. Am J Obstet Gynecol 2010; 203:430.
5. Eller AG, Bennett MA, Sharshiner M, et al. Maternal morbidity in cases of placenta accreta managed by a multidisciplinary care team compared with standard obstetric care. Obstet Gynecol 2011; 117:331.
6. Shamshirsaz AA, Fox KA, Salmanian B, et al. Maternal morbidity in patients with morbidly adherent placenta treated with and without a standardized multidisciplinary approach. Am J Obstet Gynecol 2015; 212:218.e1.
7. Bartels HC, Rogers AC, O'Brien D, et al. Association of Implementing a Multidisciplinary Team Approach in the Management of Morbidly Adherent Placenta With Maternal Morbidity and Mortality. Obstet Gynecol 2018; 132:1167.
8. Tikkanen M, Paavonen J, Loukovaara M, Stefanovic V. Antenatal diagnosis of placenta accreta leads to reduced blood loss. Acta Obstet Gynecol Scand 2011; 90:1140.
9. Eller AG, Porter TF, Soisson P, Silver RM. Optimal management strategies for placenta accreta. BJOG 2009; 116:648.
10. Pri-Paz S, Fuchs KM, Gaddipati S, et al. Comparison between emergent and elective delivery in women with placenta accreta. J Matern Fetal Neonatal Med 2013; 26:1007.
11. Wright JD, Pri-Paz S, Herzog TJ, et al. Predictors of massive blood loss in women with placenta accreta. Am J Obstet Gynecol 2011; 205:38.e1.
12. Stotler B, Padmanabhan A, Devine P, et al. Transfusion requirements in obstetric patients with placenta accreta. Transfusion 2011; 51:2627.
13. Bishop S, Butler K, Monaghan S, et al. Multiple complications following the use of prophylactic internal iliac artery balloon catheterisation in a patient with placenta percreta. Int J Obstet Anesth 2011; 20:70.
14. Lilker SJ, Meyer RA, Downey KN, Macarthur AJ. Anesthetic considerations for placenta accreta. Int J Obstet Anesth 2011; 20:288.

15. Taylor NJ, Russell R. Anaesthesia for abnormally invasive placenta: a single-institution case series. Int J Obstet Anesth 2017; 30:10.
16. D'Antonio F, Iacovelli A, Liberati M, et al. Role of interventional radiology in pregnancy complicated by placenta accreta spectrum disorder: systematic review and meta-analysis. Ultrasound Obstet Gynecol 2019; 53:743.
17. Ojala K, Perälä J, Kariniemi J, et al. Arterial embolization and prophylactic catheterization for the treatment for severe obstetric hemorrhage*. Acta Obstet Gynecol Scand 2005; 84:1075.
18. Shrivastava V, Nageotte M, Major C, et al. Case-control comparison of cesarean hysterectomy with and without prophylactic placement of intravascular balloon catheters for placenta accreta. Am J Obstet Gynecol 2007; 197:402.e1.
19. Sewell MF, Rosenblum D, Ehrenberg H. Arterial embolus during common iliac balloon catheterization at cesarean hysterectomy. Obstet Gynecol 2006; 108:746.
20. Arora N, Matheny ME, Sepke C, Resnic FS. A propensity analysis of the risk of vascular complications after cardiac catheterization procedures with the use of vascular closure devices. Am Heart J 2007; 153:606.
21. Barth WH Jr, Kwolek CJ, Abrams JL, et al. Case records of the Massachusetts General Hospital. Case 23-2011. A 40-year-old pregnant woman with placenta accreta who declined blood products. N Engl J Med 2011; 365:359.
22. Angstmann T, Gard G, Harrington T, et al. Surgical management of placenta accreta: a cohort series and suggested approach. Am J Obstet Gynecol 2010; 202:38.e1.
23. Ordoñez CA, Manzano-Nunez R, Parra MW, et al. Prophylactic use of resuscitative endovascular balloon occlusion of the aorta in women with abnormal placentation: A systematic review, meta-analysis, and case series. J Trauma Acute Care Surg 2018; 84:809.
24. Okada A, Nakamoto O, Komori M, et al. Resuscitative endovascular balloon occlusion of the aorta as an adjunct for hemorrhagic shock due to uterine rupture: a case report. Clin Case Rep 2017; 5:1565.
25. Stensaeth KH, Sovik E, Haig IN, et al. Fluoroscopy-free Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) for controlling life threatening postpartum hemorrhage. PLoS One 2017; 12:e0174520.
26. Shoji T, Tarui T, Igarashi T, et al. Resuscitative Endovascular Balloon Occlusion of the Aorta Using a Low-Profile Device is Easy and Safe for Emergency Physicians in Cases of Life-Threatening Hemorrhage. J Emerg Med 2018; 54:410.
27. Morrison JJ, Galgon RE, Jansen JO, et al. A systematic review of the use of resuscitative endovascular balloon occlusion of the aorta in the management of hemorrhagic shock. J Trauma Acute Care Surg 2016; 80:324.
28. Manzano-Nunez R, Escobar-Vidarte MF, Orlas CP, et al. Resuscitative endovascular balloon occlusion of the aorta deployed by acute care surgeons in patients with morbidly adherent placenta: a feasible solution for two lives in peril. World J Emerg Surg 2018; 13:44.
29. Society for Maternal-Fetal Medicine (SMFM). Electronic address: pubs@smfm.org, Gyamfi-Bannerman C. Society for Maternal-Fetal Medicine (SMFM) Consult Series #44: Management of bleeding in the late preterm period. Am J Obstet Gynecol 2018; 218:B2.
30. Shamshirsaz AA, Fox KA, Erfani H, et al. Outcomes of Planned Compared With Urgent Deliveries Using a Multidisciplinary Team Approach for Morbidly Adherent Placenta. Obstet Gynecol 2018; 131:234.
31. Bowman ZS, Manuck TA, Eller AG, et al. Risk factors for unscheduled delivery in patients with placenta accreta. Am J Obstet Gynecol 2014; 210:241.e1.
32. Warshak CR, Ramos GA, Eskander R, et al. Effect of predelivery diagnosis in 99 consecutive cases of placenta accreta. Obstet Gynecol 2010; 115:65.
33. Robinson BK, Grobman WA. Effectiveness of timing strategies for delivery of individuals with placenta previa and accreta. Obstet Gynecol 2010; 116:835.
34. Oyelese Y, Smulian JC. Placenta previa, placenta accreta, and vasa previa. Obstet Gynecol 2006; 107:927.

35. Wong HS, Hutton J, Zuccollo J, et al. The maternal outcome in placenta accreta: the significance of antenatal diagnosis and non-separation of placenta at delivery. N Z Med J 2008; 121:30.
36. Clark SL, Phelan JP, Yeh SY, et al. Hypogastric artery ligation for obstetric hemorrhage. Obstet Gynecol 1985; 66:353.
37. Papp Z, Tóth-Pál E, Papp C, et al. Hypogastric artery ligation for intractable pelvic hemorrhage. Int J Gynaecol Obstet 2006; 92:27.
38. Unal O, Kars B, Buyukbayrak EE, et al. The effectiveness of bilateral hypogastric artery ligation for obstetric hemorrhage in three different underlying conditions and its impact on future fertility. J Matern Fetal Neonatal Med 2011; 24:1273.
39. Fox KA, Shamshirsaz AA, Carusi D, et al. Conservative management of morbidly adherent placenta: expert review. Am J Obstet Gynecol 2015; 213:755.
40. Legendre G, Zoulovits FJ, Kinn J, et al. Conservative management of placenta accreta: hysteroscopic resection of retained tissues. J Minim Invasive Gynecol 2014; 21:910.
41. Hequet D, Morel O, Soyer P, et al. Delayed hysteroscopic resection of retained tissues and uterine conservation after conservative treatment for placenta accreta. Aust N Z J Obstet Gynaecol 2013; 53:580.
42. Rein DT, Schmidt T, Hess AP, et al. Hysteroscopic management of residual trophoblastic tissue is superior to ultrasound-guided curettage. J Minim Invasive Gynecol 2011; 18:774.
43. Rupley DM, Tergas AI, Palmerola KL, Burke WM. Robotically assisted delayed total laparoscopic hysterectomy for placenta percreta. Gynecol Oncol Rep 2016; 17:53.
44. Lee PS, Kempner S, Miller M, et al. Multidisciplinary approach to manage antenatally suspected placenta percreta: updated algorithm and patient outcomes. Gynecol Oncol Res Pract 2017; 4:11.
45. Steins Bisschop CN, Schaap TP, Vogelvang TE, Scholten PC. Invasive placentation and uterus preserving treatment modalities: a systematic review. Arch Gynecol Obstet 2011; 284:491.
46. Sentilhes L, Ambroselli C, Kayem G, et al. Maternal outcome after conservative treatment of placenta accreta. Obstet Gynecol 2010; 115:526.
47. Palacios Jaraquemada JM, Pesaresi M, Nassif JC, Hermosid S. Anterior placenta percreta: surgical approach, hemostasis and uterine repair. Acta Obstet Gynecol Scand 2004; 83:738.
48. Chandraharan E, Rao S, Belli AM, Arulkumaran S. The Triple-P procedure as a conservative surgical alternative to peripartum hysterectomy for placenta percreta. Int J Gynaecol Obstet 2012; 117:191.
49. Clausen C, Lönn L, Langhoff-Roos J. Management of placenta percreta: a review of published cases. Acta Obstet Gynecol Scand 2014; 93:138.
50. Teixidor Viñas M, Belli AM, Arulkumaran S, Chandraharan E. Prevention of postpartum hemorrhage and hysterectomy in patients with morbidly adherent placenta: a cohort study comparing outcomes before and after introduction of the Triple-P procedure. Ultrasound Obstet Gynecol 2015; 46:350.
51. Resnik, Robert, Robert M. Silver, and Lynn L. Simpson. "Clinical features and diagnosis of placenta accreta spectrum (placenta accreta, increta, and percreta)."
52. Aydın Y. (2015). Plasenta Previa ve Plasenta İnvazyon Anomalileri. Turkiye Klinikleri Gynecology Obstetrics-Special Topics, 8(4), 57-61.
53. Karaman E, Kolusarı A, Çetin O, et al. Local resection may be a strong alternative to cesarean hysterectomy in conservative surgical management of placenta percreta: experiences from a tertiary hospital. J Matern Fetal Neonatal Med. 2017;30(8):947–952. doi:10.1080/14767058.2016.1192119
54. Şule Göncü Ayhan, Deniz Esinler, Gülhan Çetinkaya, Elif Gülşah Diktaş, Aykan Yücel, Özlem Moraloğlu Tekin. Primipar plasenta previa tespit edilen hastalarda risk faktörleri ve gebelik sonuçları. Perinatoloji Dergisi 2017;25(3):S22 DOI: 10.2399/prn.17.S001001
55. Cim N, Tolunay HE, Boza B, et al. Use of ARFI elastography in the prediction of placental invasion anomaly via a new Virtual Touch Quantification Technique. *J Obstet Gynaecol*. 2018;38(7):911–915. doi:10.1080/01443615.2018.1433646