Bölüm 27

DOĞUM KOMPLİKASYONLARI

Selcan SINACI [1]

Postpartum Kanama

WHO tanımı; postpartum 24 saat içinde kan kaybı ≥500 ml olması durumunda postpartum kanama, ≥1000 ml olması durumunda şiddetli postpartum kanama varlığıdır (1). İnsidansı % 1-3 arasındadır (2).

Gebeliğin son dönemlerinde uterin arter kan akışı 500-700 ml/dk'dır ve bu akım kalp debisinin yaklaşık % 15'ini oluşturur, gebeliğin bu normal fizyolojik mekanizması nedeniyle doğum sırasında masif kanama ihtimali yüksektir. Gebede kan hacmi yaklaşık 1500-2000 ml artar, gebeler hematokritte belirgin azalma olmaksızın kan hacmindeki artış kadar kanamayı tolere edebilir (3). Kan kaybı; gebelik hipervolemisine hematokritte her %3'lük düşüş için 500 ml eklenerek hesaplanabilir.

Doğumdan sonra ilk 24 saat içinde olan kanamalar erken ya da primer, 24 saat ile 12 hafta arasında olanlar ise geç ya da sekonder olarak adlandırılır (4).

Uterin Atoni

Erken postpartum kanamanın en sık sebebidir. Atoni tanısı genellikle doğum eyleminin üçüncü evresinin rutin yönetiminde uterin masaj ve oksitosine rağmen uterus yeterince kontrakte olmaması ile konur.

Risk Faktörleri:

- Geçirilmiş uterin atoni hikayesi
- Primiparite (5) ve multiparite (6)
- Polihidramnios, çoğul gebelik, makrozomi gibi uterusun aşırı gerildiği durumlar
- Presipite ya da uzamış eylem
- Terbutalin, magnezyum, halotan gibi uterusu gevşetici ajanların kullanımı
- Doğumun oksitosin ya da prostaglandin ile indüksiyonu (5)
- Koryoamniyonit

Tedavi:

Alt genital traktus yaralanması, plasenta retansiyonu ve uterin rüptür gibi tanılar ekarte edildikten sonra bimanuel masaj ve/veya kompresyon uygulanır, medikal uterotonik tedavi başlanır.

Medikal Tedaviye yanıt alınamadığı durumlarda;

- Anjiyografik Uterin Arter Embolizasyonu
- Uterin kompresyon sütürleri (B-Lynch Sütürleri); iskemik nekroz, adhezyon, uterin duvar hasarına neden olur.
- Uterin Tampon veya balon tamponad (Bakri Balon)
- Uteroovaryan Damar Ligasyonu

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engellediğinden uterin hipertonus amniyon sıvı embolisini en az arttıran durum olarak karşımıza çıkar. (101)

Öncelikle pulmoner ve sistemik hipertansiyon oluşan başlangıç fazı görülür. Pulmoner vazokonstrüksiyonun (pulmoner vasküler direçte artış, pulmoner hipertansiyon, sağ kalpten sol kalbe geçiş) ardından sistemik vasküler rezistansta ve kardiyak outputta azalma oluşur (102). Ardından DIC, ARDS, beyin hasarı oluşur (100).

Tanı:

Postmortem konur (otopsi). Maternal sirkülasyonda fetal hücrelerin varlığı görülür. (103)

Amniyon sıvı embolisi tanı kriterleri; (100)

1. Hem hipotansiyon hem solunum yetmezliğinin olduğu ani gelişen kardiyopulmoner arrest
2. DIC dökümantasyonu; dilusyonel ya da şokla ilgili tüketim koagülopatisine neden olmak için yeterli kan kaybından önce koagülopati saptanmalıdır.
3. Klinik başlangıç doğum sırasında ya da plasental doğumdan sonraki 30 dakika içinde
4. ≥38°C ateş olmaması

Yaklaşım:

Acil resüsitasyon uygulanmalıdır. Trakeal entübasyon, kardiyopulmoner resüsitasyona acil olarak başlanmalıdır. Ancak herhangi bir girişim tipinin maternal veya fetal prognozu iyileştirdiğini gösteren bir kanıt yoktur. (100)

Prognoz:

Maternal mortalite yüksektir (% 60-90) (104,105). Yaşasa dahi kalıcı beyin hasarı sıktır (102). Sadece % 8'i nörolojik olarak sağlamdır. Nörolojik hasarın nedeni başlangıç aşamasında görülen oksijen saturasyonundaki derin düşüştür. Fetal neonatal sağ kalım % 70 olarak bildirilmiştir (99). Yaşayan fetusların % 50'sinde nörolojik sekel izlenir.

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