PLASENTAL ANOMALİLER VE PLASENTA AKREATA SPEKTRUMU YÖNETİMİ

6 BÖLÜM

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Ayşe ALTINDİŞ BAL[1]

AKREATA SPEKTRUMU: TANI VE GÖRÜNTÜLEME

Giriş

Plasenta Akreata Spektrumu (PAS); ekstravillöz trofoblastların miyometriyuma, uterin serozaya, mesaneye ya da parametriyuma anormal invazyonunu tanımlamak için kullanılan genel bir terimdir. Plasentanın uterus duvarından elle tam olarak ayrılamadığı, plasentanın genellikle cerrahi olarak çıkarılması gerektiği ve bu sırada oluşan kanama ile maternal morbidite ve mortalite riski taşıyan bir komplikasyon olması nedeniyle klinik olarak önemlidir. Prevelansı dünya genelinde artan sezaryen oranlarına paralel olarak artmaktadır; en yüksek riskli grup geçirilmiş sezaryen öyküsü olan ve plasenta previa tanısı olan hastalardır. Patogenezinde endometrial-miyometrial ara yüzde, derin plasentasyona izin veren birincil veya ikincil anatomik defektler olduğu düşünülmektedir. PAS olasılığı yüksek olan hastalar doğum öncesi ultrasonografi ile tespit edildiği takdirde ideal olan doğum sürecinin multidisipliner bir ekip tarafından yönetilmesidir.

Tanım

Plasenta akreata ilk olarak 1937 yılında Irving ve Hertig tarafından tanımlanmıştır (1). Klinik olarak; doğum sırasında plasentanın bir kısmının veya tamamının alttaki uterus duvarına anormal şekilde bağlanması, histopatolojik olarak ise; arada desidua olmadan doğrudan miyometriyuma bitişik plasental villusların varlığı olarak tanımlanmıştır. 1966 yılında Luke ve arkadaşları tarafından, villöz

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mak, hızlı eritrosit transfüzyonu ile doku oksijenizasyonunu sağlamak, taze donmuş plazma ve eritrosit vererek koagülopatiyi önlemek/ düzeltmek önemlidir. Özetle; beklenmedik PAS vakalarında stabiliteye göre karar vermek önemlidir. Stabil hastada bekleme/transfer mümkünken, masif kanama veya fetal distres varsa hızlı ama plasentadan uzak histerotomi ve geçici kontrol yöntemleri tercih edilmelidir.

POSTOPERATİF BAKIM

PAS cerrahisi geçiren hastalarda postoperatif yoğun bakım yatağı hazır bulunmalıdır. Masif replasman nedenli pulmoner ödem, akut transfüzyon ilişkili akciğer hasarı riskleri olan vakaların olası mekanik ventilatör desteği ihtiyacı göz önünde bulundurulmalıdır (16). Dolaşım desteği ihtiyacı gelişen hastalarda vazopressör tedavisi ve invaziv hemodinamik monitorizasyon gerekebilir.

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