Clinics in Surgery

Editorial
Published: 25 Oct, 2017

Anesthetic Approach of a Patient with Plasenta Previa Totalis and Gestational Thrombocytopeny

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Editorial

Placenta previa is the partial or complete closure of the internal cervical os with placenta. The most characteristic clinical finding is painless vaginal bleeding after the 2nd trimester. Gestational thrombocytopenia is known to have a platelet count below 150000/mm^3. Here we present a patient with placenta previa totalis with massive hemorrhage.

A 26-year-old, 28- gestational week pregnant woman was admitted to emergency service due to vaginal bleeding, placenta previa totalis was diagnosed via US and cesarean operation planned. Anamnesis and laboratory examinations showed no pathological findings except that the platelet count was 133000/mm^3. She didnot use any anticoagulant and/or medication that could lead to bleeding during pregnancy. In the operating room basaline vital values; Blood Pressure (BP)=131/74 mmHg, Heart Rate (HR)=114 beats/min, saturation=99% 1460 gr, 7-8 APGAR girl baby was delivered 2 units Erythrocyte Suspension (ES) was given during the operation. She was extubated and discharged to service room without any problem1 hr postoperatively, becouse of unavoidable hemorrhage despite fundus massage and uterotonics, she came to operating room for diagnostic laparotomy. She was monitored; BP=90/61 mmHg, HR=122 beat/min, sat=97%, Hemoglobin=6.9. Central venous catheterization and arterial monitoring was performed. Hysterectomy was performed for severe bleeding despite uterotonic and hypogastric artery ligation. During the hysterectomy, bladder was opened accidentally due to adhesions. Urology consultation was requested. During the operation, 6 units of ES, 4 units of Fresh frozen plasma (TDP) was administered. Thrombocyte Suspension (TS) could not be given for it wasnot prepared yet. As the bleeding continued and the hemodynamics deteriorated, the bleeding centers were filled with a buffer, and was admitted to İntensive Care Unit (ICU). In ICU her hemoglobin was 6.5 gr/dL, thrombocyte=29000 mm^3 3 units of ES, 2 units of TDP and 12 units of platelets were given intermittently. Patients with normal vitals and laboratory values was extubated 6 hr postoperatively in ICU. 24 hr postopeartively, she had 3rd operation of Ureteroneocystostomy+doublejstent by urology without any problem. She was admitted to ICU again for 24 hr, and followed-up in Gynecology and obstetric service for 10 days. She was discharged with the proposal to come to the urography clinic 20 days later.

Reoperation due to bleeding is reported to be 12% - 33% of placenta previa cases. Cesarean hysterectomy has high-risc operative mortality,and requires multidisciplinary approach. and careful follow-up in terms of massive haemorrhage.

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Received Date: *10 Aug 2017*
Accepted Date: *19 Oct 2017*
Published Date: *25 Oct 2017*

Citation:
Büyükerkmen E, Baki ED, Arıcan H, Sivaci R. Anesthetic Approach of a Patient with Plasenta Previa Totalis and Gestational Thrombocytopeny. Clin Surg. 2017; 2: 1692.