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Balloon displacement during caesarean section with pernicious placenta previa: A case report

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Core Tips: It is well known that postpartum haemorrhage is one of the most serious complications in malignant placenta previa caesarean section, and it is also the most concerning problem for medical staff. Currently, preventive interventional therapy has been able to prevent postpartum haemorrhage to a large extent, but its surgical complications need to be acknowledged, given that they are often overlooked. This article introduces a case of adverse consequences caused by a interventional therapy complication to provide some information for medical staff's clinical work.

Abstract

BACKGROUND

For the past few years, preventive interventional therapy has been widely used domestically and overseas, bringing great benefits to pregnant women at high-risk for complications, such as pernicious placenta previa (PPP) and placenta accreta. Nevertheless, there are still few reports on surgical complications related to interventional therapy, and its safety should be a concern.

CASE SUMMARY

We report a 36-year-old pregnant woman with PPP who underwent balloon implantation in the lower segment of the abdominal aorta before caesarean section. However, the balloon shifted during the operation, which damaged the arterial vessels after filling, resulting in severe postpartum haemorrhage in the patient. Fortunately, after emergency interventional stent implantation, the patient was successfully relieved of the massive haemorrhage crisis.

CONCLUSION

It seems that massive postoperative bleeding has been largely avoided in preventive interventional therapy in high-risk pregnant women with placenta-related diseases, but surgical complications related to intervention therapy can also cause adverse consequences. It is equally important for clinical doctors to learn how to promptly identify and effectively treat these rare complications.

Keywords: Pernicious placenta previa; Caesarean section; Abdominal aortic balloon; Case report

INTRODUCTION

Pernicious placenta previa (PPP) is placenta previa that occurs at the uterine scar incision from a previous caesarean section[**Error! Reference source not found.**]. Uncontrolled and fatal postpartum

haemorrhage is the main threat to such pregnant women. Research statistics have shown that[**Error! Reference source not found.**] it is common for patients with placenta previa undergoing caesarean section to experience intraoperative bleeding of up to 3000 ml, this occurs in up to 90%, and approximately 10% of them even experience bleeding exceeding the rare 10000 ml. Massive postpartum haemorrhage can easily lead to complications such as haemorrhagic shock, disseminated intravascular coagulation (DIC), and multiple organ failure, endangering the safety of pregnant women and newborns[**Error! Reference source not found.**]. Even in severe cases, some patients have to undergo hysterectomy, which can cause great harm to their physical and mental health[**Error! Reference source not found.**]. In recent years, the use of abdominal aortic balloons to control bleeding has been widely used in caesarean section for placenta previa[**Error! Reference source not found.,Error! Reference source not found.**]. Temporarily filling the arterial balloon before stripping the placenta not only effectively reduces intraoperative blood loss, and provides a clear surgical field, but also more importantly, reduces the rate of hysterectomy[**Error! Reference source not found.**]. However, this kind of intervention also has corresponding surgical complications[**Error! Reference source not found.**], such as vascular injury, pseudoaneurysm,

arterial thrombosis[**Error! Reference source not found.**], ischaemia reperfusion injury, and foetal radiation exposure. We describe a rare complication that occurred during abdominal aortic balloon occlusion combined with caesarean section in a pregnant woman with PPP and give some opinions on this phenomenon.

CASE PRESENTATION

1 Chief complaints

A 36-year-old woman was admitted to the hospital to terminate her pregnancy due to a recurrence of brucellosis after 20+4 weeks of pregnancy.

History of present illness

The patient experienced an elevated body temperature two weeks earlier, even reaching a maximum of 41 °C. She took antibiotics and antipyretic analgesics for symptomatic treatment of her brucellosis. At the same time, this pregnant woman reported that the foetal movement response significantly decreased 10 days ago. Due to fear of medication leading to foetal intrauterine death or abnormalities, after her body temperature returned to normal, she went to our hospital to ask for termination of pregnancy.

History of past illness

The patient was diagnosed with brucellosis 6 months ago. After

symptomatic treatment in other hospitals, her condition improved, and since then, the patient stopped taking the medicine herself.

Marital and reproductive history

The patient was married at the age of 21 years. She had been pregnant a total of 5 times thus far, with two previous deliveries being caesarean sections (in 2008 and 2017) and two induced abortions.

Personal and family history

The patient denied any infectious disease and ¹any relevant family history of placenta previa.

Physical examination

On physical examination, the patient's vital signs were as follows: body temperature (T), 36.1 °C; blood pressure (BP), 113/79 mmHg; heart rate (HR), 91 beats per min; respiratory rate (RR), 16 breaths per min, height, 165 cm; weight, 70 kg. Specialist inspection: The pregnant woman's abdomen showed a gestational bulge with an abdominal circumference of 96 cm, and her pelvic floor was at the navel level. At this time, the foetal heart rate was 148 beats/min, but the contractions were not palpable. In gynaecological diagnosis, the cervical canal was not ruled out, the uterine orifice was not open, and the foetal membrane was not broken.

Laboratory examinations

Routine blood tests showed a haemoglobin level of 85 g/L and a C-reactive protein level of 19.95 mg/L. Blood biochemical analysis indicated an albumin level of 28.5 g/L and a blood alkaline phosphatase level of 189.0 mmol/L.

Imaging examinations

Prenatal ultrasound examination revealed that the pregnant woman had central placenta previa and currently had subchorionic haemorrhage.

FINAL DIAGNOSIS

The patient was diagnosed with placenta accreta without bleeding, central placenta previa, pregnancy with uterine scars, mid-term induced abortion, brucellosis, subchorionic haematoma, pregnancy with liver damage, pregnancy with hypoproteinaemia, pregnancy with anamia and pregnancy 5, delivery 2, and pregnancy 20+4 weeks.

TREATMENT

The patient experienced fever again after admission and sustained lower abdominal pain without any underlying cause. Urgent pelvic ultrasound examination revealed local detachment of the placenta. Considering the changes in the patient's condition, it is

recommended to undergo caesarean section and embryo removal surgery. Due to the clear diagnosis of central placenta previa and placenta accreta in the patient, there is a high possibility of acute massive bleeding during surgery. Therefore, to reduce the amount of bleeding, a balloon placement surgery in the lower segment of the abdominal aorta (Figure 1A-B) was performed before the caesarean section, and immediately after the intervention surgery, a “transverse incision caesarean section for embryo retrieval in the lower segment of the uterus” was performed.

After entering the abdomen, it was found that the bladder peritoneum was tightly adhered to the the previous uterine scar. The placenta was implanted in the scar of the previous caesarean section of the uterus, and the surface blood vessels were dilated (Figure 2), making it impossible to push down the bladder peritoneum. The uterus was transversely cut 1cm above the scar, and a large amount of brownish-red purulent thread-like blood gushed out of the uterine cavity. After puncturing the amniotic membrane, a 470 g baby boy was delivered, but the foetus died, most likely due to intrauterine infection, then the pungent, pale yellow-green was immediately aspirated. After the delivery of the dead foetus, extensive implantation and adhesions of placental tissue were observed in the posterior wall, left and right walls, and lower segment of the uterus.

Bleeding was active at the dissection site, and the obstetrician immediately filled the abdominal aortic balloon at this time. The blocking effect was observed to be poor, and the amount of bleeding did not decrease. Then, after the tourniquet was tied in the vascular free zone of the broad ligament in the lower segment of the uterus, the ascending branches of the bilateral uterine arteries were ligated, the posterior wall and the lower segment of the uterus were sutured with “8” shaped sutures for haemostasis and symptomatic treatment to promote uterine contraction, and the bleeding of the wound caused by the separation of uterus and placenta was reduced. Due to the time of filling of the abdominal aortic balloon up to 15 minutes, the balloon was immediately emptied. At this time, the patient’s blood pressure suddenly dropped to 60/30 mmHg. Blood transfusion and fluid replacement were immediately performed to treat shock. At the same time, bilateral appendages and abdominal cavities were examined, and a dark red haematoma ¹ with a diameter of approximately 10 cm was found on the right side of the sacral promontory of the posterior peritoneum, with irregular range and significant fluctuations and no significant increase in blood pressure after deep pressure treatment. We palpated the patient’s bilateral dorsalis pedis arteries, and the pulsation of the right artery was significantly weaker than that of the left. We had reason to suspect

that the patient's abdominal aortic balloon shifted and injured the artery after filling it. Immediate angiography was performed to confirm the diagnosis, and it was observed that the patient's right common iliac artery was torn and bleeding, with blood extravasation forming a haematoma (Figure 3). Immediately, we requested that an interventional physician perform the right common iliac artery covered stent implantation surgery. Postoperative angiography showed that the lumen of the right common iliac artery was unobstructed, the stent was well unfolded, and no definite contrast agent leakage was observed. The ruptured vessel was successfully repaired (Figure 4), and the patient's vital signs gradually stabilized. The total duration of this surgery was 5 hours, with a blood loss of approximately 3000 ml. During the surgery, 10 U of red blood cell suspension and 1000 ml of plasma were transfused.

OUTCOME AND FOLLOW-UP

After the surgery, the patient was transferred to an intensive care unit for continued close monitoring, and received active treatment, such as anti-infection therapy, promotion of uterine contractions, and correction of anaemia. After recovery, the patient was discharged from the hospital.

DISCUSSION

With the reform of China's family planning policy, the number of caesarean sections and the difficulty of surgery are constantly increasing, especially for high-risk pregnant women with placenta previa and placenta accreta spectrum (PAS) diseases. It has been reported that the incidence rate of pernicious placenta previa patients in China is 0.31%-0.89%, and approximately 53.3% of PPP patients have PAS[**Error! Reference source not found.**], which means that obstetricians and anaesthesiologists face greater challenges. For pregnant women with placenta previa or placental implantation diseases, preoperative preventive intervention treatments such as abdominal aortic balloon implantation and uterine artery embolization allow doctors rescue patients with postpartum haemorrhage and have achieved significant results both domestically and internationally[**Error! Reference source not found.**]. However, inevitably, there are still many worrisome aspects to interventional therapy, such as whether X-ray exposure is harmful to the foetus, whether preventive intervention surgery can completely avoid postpartum haemorrhage, and whether arterial blockade can cause ischaemi damage to other organs, which are all worthy of attention.

The main feature of our case is the occurrence of a rare complication, injury to the common iliac artery caused by filling the

abdominal aortic balloon after unforeseen displacement.

The possible reasons for the occurrence of this rare complication are as follows: (1) The preoperative abdominal aortic balloon implantation surgery for patients undergoing caesarean section is performed using digital subtraction angiography (DSA) equipment in the interventional surgery room. After completion, the patient needs to be transported to the operating room for caesarean embryo removal. During this period, multiple handling of the patient is inevitable, and frequent and nonstandard bed transfer processes lead to the displacement of the abdominal aortic balloon. (2) During caesarean section, the delivery of the foetus requires external force to compress the fundus of the uterus, and the surgeon usually pushes directly above the abdominal aortic balloon. Inappropriate force may also be one of the reasons for balloon displacement. (3) Pregnant women have a different abdominal pressure from ordinary people. When the foetal placenta is delivered and amniotic fluid flows out, the uterine volume decreases, and the abdominal pressure drops suddenly. The changes in pressure before and after can cause the fixed balloon to shift. (4) After the balloon was correctly placed in position, the arterial sheath at the femoral artery puncture point and balloon catheter were not well fixed. Although the adhesive used for fixation during the surgery in this case did not fail, it is still possible

that the catheter had moved outwards. (5) The discrepancy between the size of the balloon catheter and the patient's blood vessels, as well as the inadequate placement of the balloon catheter, are also reasons for this shift.

Summary of experience and lessons learned from this case: (1) For the delivery of fetuses of pregnant women with pernicious placenta previa accompanied by placental implantation, it is necessary to pay attention to the prevention and treatment of severe postpartum haemorrhage, and multidisciplinary cooperation is essential. All departments should make comprehensive preoperative preparations and take corresponding measures, including preinstall abdominal aorta or bilateral common iliac artery balloon blockers in the interventional radiology department to prevent bleeding during placenta removal. The obstetrics department should develop a rigorous surgical plan and be equipped with sufficient qualified and experienced surgeons. The anaesthesia department should prepare for the rescue of intraoperative massive bleeding, such as invasive blood pressure monitoring, multiple infusion pathways, rapid airway establishment plans, blood products, and liquid resuscitation supplies. At the same time, the intensive care department (ICU) and nursing team should conduct rigorous postoperative observations and meticulous care. (2) At present, preoperative arterial balloon

implantation has been performed under ultrasound guidance instead of X-ray[Error! Reference source not found.]. Ultrasound monitoring equipment not only prevents physicians and patients from receiving radiation but also foetuses. Moreover, this technology does not require specialized hybrid operating rooms, greatly saving operating time and reducing the occurrence of balloon catheter displacement due to transportation. At the same time, ultrasound can be used to dynamically monitor the position of the balloon, adjust the position deviation in a timely manner, avoid complications caused by this, and ensure the safety of the mother and baby. (3) The catheter needs to be fix in a more meticulous manner, such as marking the catheter and skin at the puncture point after successful placement, to observe its position at any time, determine whether it is dislodged and determine whether the balloon is displaced. (4) Even a perfect preoperative preparation cannot completely avoid the occurrence of all unexpected situations. Pernicious placenta previa and balloon displacement can both lead to the occurrence of severe bleeding in patients. As in this case, the combination of two risk factors further increases the risk and volume of bleeding, leading to uncontrollable massive bleeding during surgery, making the patient's condition even more dangerous. Therefore, surgeons should maintain a vigilant mentality, handle possible critical situations with

cautious and meticulous surgical operations, and summarize experiences and lessons in a timely manner. Only in this way can we ensure the safety of patients' lives.

CONCLUSION

Pregnant women with pernicious placenta previa often need preventive interventional therapy before undergoing caesarean section, which can significantly reduce the incidence of postpartum haemorrhage and a series of serious adverse consequences. However, the patient experienced a rare complication of balloon displacement, which led to more severe postpartum haemorrhage. Yet, after timely identification and multidisciplinary collaboration in diagnosis and treatment, the life of this pregnant woman was ultimately saved. Thus, any treatment method has complications, so regardless of the probability of occurrence, clinical doctors should remain vigilant, be prepared to face all possible critical situations, gain clinical experience, and protect the patient's life.

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