International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

Primigravida Patient with Placenta Previa Totalis; A Case Report

Nyoman Kabella Cinthya Devi[1], I Gusti Gede Mayun Surya Darma[2]

[1]Intern Doctor of Obstetric and Gynecology RSUD Wangaya Denpasar, Bali, Indonesia

[2]Obstetric and Gynecology Specialist RSUD Wangaya Denpasar, Bali, Indonesia

Abstract: ***Placenta previa is a placenta located in front of the birth canal (prae = in front; vias = way) which implants in the lower uterine segment, so that it covers part or all of the birth canal which is characterized by uterine bleeding that can come out through the vagina without any pain in the uterus. the last trimester of pregnancy, especially in the eighth month. In the case of a 25 year old woman, 37 weeks 1 day of gestation, pregnant for the first time. The patient complained of vaginal bleeding since 06.00 WITA (8 March 2022), fresh red color, about 5 times changing pads. There were no complaints of pain bleeding. The risk factors for placenta previa are not known for certain, but from several studies it has been reported that the highest frequency of placenta previa occurs in elderly mothers, multiparity, history of cesarean section and previous abortions and lifestyle that can also affect the increased risk of placenta previa. In this case the pregnancy was terminated by emergency cesarean section.***

Keywords: primigravida, placenta previa

1. Introduction

Placenta previa is a placenta located in front of the birth canal (prae = in front; vias = way) which implants in the lower uterine segment, so that it covers part or all of the birth canal which is characterized by uterine bleeding that can come out through the vagina without any pain in the uterus. the last trimester of pregnancy, especially in the eighth month.[1] While the normal location of the placenta is on the front wall or back wall of the uterus in the uterine fundus area, so it is divided into 3 levels, namely: total placenta previa, partial placenta previa, marginal placenta previa, and low-lying placenta.[2] The risk factors for placenta previa are not known for certain, but from several studies it has been reported that the highest frequency of placenta previa occurs in elderly women, multiparity, history of cesarean section and previous abortions and lifestyle that can also affect the increased risk of placenta previa.[1-4]

The clinical picture may be painless recurrent vaginal bleeding. Bleeding usually occurs at the end of the second trimester. The first bleeding is not profuse and may stop on its own. But bleeding can come back again for no apparent reason after some time.[2,6-8] The diagnosis can be made clinically and ultrasonographically.[5]

Complications can occur to the mother and baby, during pregnancy, the mother can cause antepartum bleeding which can cause anemia; shock; placenta accreta, increta, percreta; postpartum hemorrhage[9-11] and fetal position abnormalities so that the breech position and transverse position increase.[2-5] Therapy can be active or expectant according to the condition of the mother and child; amount of bleeding; opening; and the degree of placenta previa. With prompt and appropriate treatment, complications can be prevented.[9-11]

2. Case Report

25 years old woman, 37 weeks 1 day of gestation, first time pregnant. LMP: 26 June 2021 EDD: 03 April 2022. The patient complained of vaginal bleeding since 06.00 WITA (8 March 2022), fresh red color, about 5 times changing pads. There were no complaints of pain during bleeding. The patient admitted that he did not feel intermittent abdominal pain, watery discharge (-), fever (-). The baby's movements are still actively felt. The patient denied a history of diabetes, hypertension, surgery and a family history of disease. From examination, the patient's vital signs were still within normal limits, Leopold 1 was palpable in large round and soft parts, the height of the uterine fundus was 32 cm, Leopold 2 was palpable hard and elongated on the right and palpable small parts on the left, Leopold 3 was palpable hard and bouncy. Examination of the genitalia: Inspection: Vulva/urethra calm. Blood laboratory examination: Hemoglobin 11.5 g/dL; Hematocrit 35.0%; WBC 22.89 103/ul; Platelets 232 103/ul. Based on the results of ultrasound examination, the patient showed a live single head presentation, FHR (+), FHR (+), BPD 8.76 cm, AC 30.89 cm, HC 31.70 cm, FL 6.87 cm, TBJ 2612 grams and the posterior corpus placenta covered the birth canal. The patient received IVFD therapy of furtrolite 500cc 20 drops per minute, Ceftriaxone 2gram IV, and underwent immediate caesarean section. From the results of classical sectio cecaria surgery, the baby was a boy, birth weight 2600, body length 48 cm, Apgar score: 8-9.

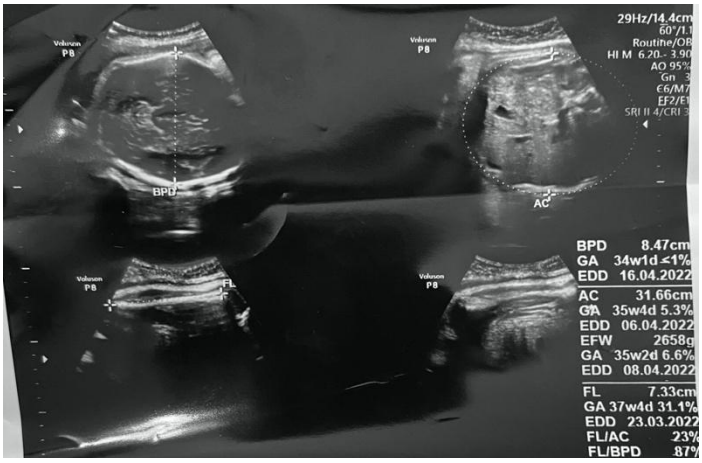

Figure 1: Ultrasound overview

3. Discussion

Placenta previa is a condition in which part or all of the placenta enters the lower uterine segment which is characterized by uterine bleeding that can come out through the vagina without pain and is classified based on ultrasound imaging.[12] Antepartum bleeding caused by placenta previa usually occurs in the third trimester because At that time, the lower uterine segment undergoes more changes as the pregnancy progresses, the lower uterine segment dilates, and the cervix begins to open. Bleeding occurs when the placenta is located above the internal uterine os or in the lower uterine segment. The formation of the lower uterine segment and the opening of the internal os will cause the placenta to tear at the attachment site. [4,7,14] Based on the history, the patient complains of fresh red vaginal bleeding, about 5 times changing pads. No complaints of bleeding during pregnancy. In this case it makes us think of the presence of placenta previa, total or partial. In the suspected presence of placenta previa, internal examination can be done but it is better to do it in the operating room for further action if there is bleeding that gets worse after internal examination. [5,13] The blood that comes out is fresh red, the source of the bleeding is placenta previa. torn uterine sinus due to detachment of the placenta from the uterine wall, or due to tearing of the marginal sinus from the placenta. The bleeding is unavoidable because of the inability of the lower uterine segment muscle fibers to contract to stop the bleeding, unlike the uterine muscle fibers to stop bleeding in the third stage of a normal placenta.[14,15] The patient also admitted that he did not feel intermittent abdominal pain, out of water (-), fever (-). The baby's movements are still actively felt. The patient denied a history of diabetes, hypertension, surgery and a family history of disease.

On the physical examination that needs to be done to establish the diagnosis of placenta previa include: general condition and vital signs, inspection of the external genitalia, inspection inspekulo and leopold. Examination of the general condition and vital signs can be assessed by the amount of bleeding that occurs in the patient.[3] The patient's vital condition was within normal limits. On physical examination obstetrics in the form of abdominal palpation (Leopold maneuver) often found abnormalities in the location of the fetus, low uterine fundal height because it is not enough months, it is also often found that the lower part of the fetus has not descended, if the head is located, usually the head is still swaying, floating or churning above the pelvic inlet.[3,8] On Leopold's examination the patient found the bouncy part is below, the possibility of the fetus presenting cephalad, this can be confirmed by transabdominal ultrasonography. On inspection of the external genitalia, blood clots appear around the vulva, the urethra looks calm. On examination of the external genitalia can be seen through the amount of blood that comes out through the vagina, blood clots, and so on. If a lot of bleeding is found, the mother will look pale.[5] On examination of the patient's genitals: Inspection: Vulva/Urethra is calm. Blood laboratory examination: Hemoglobin 11.5 g/dL; Hematocrit 35.0%; WBC 22.89 103/ul; Platelets 232 103/ul.

Lately, internal examination in the operating room is rarely done because transabdominal ultrasound equipment is available which provides high accuracy reaching 98-98%. [5,16,17] Ultrasound examination aims to assess the condition of the fetus, namely in the form of fetal growth which is assessed from the value of the fetus. Biparietal Diameter (BPD), Head Circumference (HC), Abdominal Circumference (AC), Femur Length (FL). Where based on biometric data, it can be concluded that intrauterine fetal growth in the form of estimated fetal weight and estimated gestational age. In addition, ultrasound examination can serve to assess whether there are intrauterine pathological conditions such as a decrease/increase in the amount of amniotic fluid above normal or an abnormal location of placental implantation. In placenta previa, implantation occurs in the lower uterine segment, which can be classified into total, partial, marginal, and low-lying placenta previa. Where, the patient found that the placenta covered the entire internal uterine os, so that it was diagnosed as total placenta previa. [4,7,15] On ultrasonography of the patient, the fetus was found in transverse position, total placenta previa, and posterior placenta.

Management of the patient is by monitoring the mother's vital signs, fetal heart rate, his, and preparing for termination of pregnancy by abdominal (section cesarean) due to continuous bleeding. Termination of pregnancy per abdominal (section cesarean) is an option in the management of placenta previa. This is because the implantation of the placenta in the lower uterine segment

that covers the OUE will prevent the birth of the fetus vaginally. Cesarean delivery for placenta previa is performed on all placenta previa totalis, live or dead fetuses, and all placenta previa marginalis due to bleeding that is difficult to control.[3,8,18]

Complications that can occur to the mother and baby are antepartum bleeding, anemia, shock, premature pregnancy, fetal distress, placental abruption, low birth weight, maternal death due to bleeding.[8,14,19] In this case the baby was born a boy with Birth weight 2600, body length 48 cm, Apgar score: 8-9.

4. Conclusion

Placenta previa is a condition where part or all of the placenta enters the lower uterine segment which is characterized by uterine bleeding that can come out through the vagina without pain and is classified based on ultrasound. The risk factors for placenta previa are not known for certain, but from several studies it has been reported that the highest frequency of placenta previa occurs in elderly mothers, multiparity, history of cesarean section and previous abortions and lifestyle that can also affect the increased risk of placenta previa. Prompt and appropriate diagnosis and treatment can prevent complications for the mother and fetus.[4,5,12]

References

[1] Cunningham FG. 2006.Obstetri William Vol. 1. Jakarta: EGC. pp:685-704.
[2] Cunningham G, Leveno KJ, Bloom SL, Hauth JC, Rouse DJ, Spong CY. Williams Obstetrics 23rd edition. United State: McGraw-Hill Medical. 2010.
[3] FaizA Sand Ananth CV. 2003. Etiology and risk factors for placentaprevia: An over view and meta-analysis of observation al studies. Journalof Maternal-Fetaland Neonatal Medicine. 13: 175–190.
[4] Hung TH, Hsieh C Cand HsuJJ. 2007. Risk factors for placentapreviainan Asian population. International Journal of Gynecology and Obstetric. 97: 26-30.
[5] Chalik, TMA. Perdarahan pada Kehamilan Lanjut dan Persalinan. Dalam: Saiudin, Abdul Bahri, editor. Ilmu Kebidanan. Jakarta: PT Bina Pustaka. 2010.
[6] Hung TH, Hsieh C Cand HsuJJ. 2007. Risk factors for placentapreviainan Asian population. International Journal of Gynecology and Obstetric. 97: 26-30.
[7] Johnson LG, Sergio Fand Lorenzo G. 2003. The relationship of placentaprevia and history of inducedabortion. International Journalof Gynaecologyand Obstetrics. 81(2): 191–198.
[8] Kay HH. 2003. Placenta previaan dabruption. In JR Scottetal. (eds). Danforth' Obstetricsand Gynecology, 9thed. Philadelphia:LippincottWilliams and Wilkins, pp: 365-379.J
[9] Usta IM, Hobeika EM, Musa AAA, Gabriel GE, Nassar AH. Placenta previa-accreta: Risk factors and complication. Am J Obstet Gynecol. 2005:193(3 Pt 2):1045-9.
[10] Tikkanen M, Stefanovic V, Paavonen J. Placenta previa percreta left in situ - management by delayed hysterectomy: a case report. Journal of Medical Case Report. 2011:5(418): 1752-1947.
[11] Fishman S. Risk factors for preterm delivery with placenta previa. J Perinat Med. 2011:16;40(1):39-42.
[12] RCOG. Placenta Praevia, Placenta Accreta and Vasa Praevia: Diagnosis and Management. 2011. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_27.pdf. Accessed 20 June 2016
[13] Bagian obstetric dan ginekologi FK Universitas Padjadjaran Bandung. Obstetri Patologi. Bandung: Penerbit dan percetakan Elstar Offset. 1984.
[14] Oyelese Y and Smulian JC. 2006. Placenta previa, placenta accreta, and vasa previa. Obstetrics and Gynecology. 107(4): 927– 941.
[15] Scearce Jand Uzelac PS.2007. Third-trimes tervaginal bleeding. In: AHDe Cherney etal. (eds). Current Diagnosisand Treatment Obstetricsand Gynecology, 10th ed. New York: McGraw-Hill, pp: 328-341.
[16] Jang DG, We JS, Shin JU, Choi YJ, Ko HS, Park IY. Maternal Outcomes According to Placental Position in Placental Previa. Int J Med Sci 2011:8(5):439-444.
[17] Hasegawa J, Nakamura M, Hamada S, Matsuoka R, Ichizuka R, Sekizawa A, et al. Prediction of hemorrhage in placenta previa. Taiwanese Journal of Obstetrics and Gynecology. 2012:51(1):3-6.
[18] Sheiner GI. Shoham-Vardi, Hallak M. Hershkowitz R.Katz Mand MajorM. 2001. Placentaprevia: Obstetricrisk factors and pregnancyoutcome. J. Matern Fetal. Med10: 414-419.
[19] Usta IM, Hobeika E. M, Musa A.A,Gabriel G.E and Nassar A.H. 2005. Placenta previa-acreta:risk factors and complications.Am.J.Obstet.Gynecol.193:50 4-1059.