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OUR EXPERIENCE WITH DELAYED CESAREAN SCAR NEGATIVE OUTCOMES

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НАШ ОПЫТ С ОТРИЦАТЕЛЬНЫМИ ИСХОДАМИ ОТСРОЧЕННОГО КЕСАРЕВА СЕЧЕНИЯ

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РЕЗЮМЕ

Мы считаем, что ПАС является скорее следствием рубцового дефекта, чем реальными агрессивно-инвазивными случаями плаценты. Это означает, что при определенных обстоятельствах и при определенной осторожности беременность может быть продлена до III триместра и возможна операция с сохранением матки, что улучшает как материнские, так и неонатальные исходы. Действительно, в случае CSP необходима тщательная оценка данных и показаний. Решение о прерывании или продлении данной беременности до сих пор основывается на многих параметрах, включая согласие пациентки. Для различения CSP и нижней плаценты вблизи рубца требуется дальнейшая дифференциация и заключение эксперта по УЗИ.

INTRODUCTION. Abnormal placentation in the scar on the uterine wall following previous cesarean section is one of the actual problems of modern obstetrics and gynecology. This described in textbooks as very serious (since it can be live threatening) but rare pathologic condition nowadays has become not infrequent. Its increased incidence as well as pathogenesis is explained by negative consequences of abdominal delivery which was transformed to alternative to natural labor to the beginning of our century [1,2].

MATERIAL AND METHODS. This is a descriptive study of clinical and ultrasound criteria in uence on decision to prolong pregnancy and how to terminate it if such necessity was accepted by specialists and patients with participation of their families. 53 pregnancies with placentation in scar area and below suspected as “scar pregnancy” (CSP) or placenta accreta spectrum (PAS) were included (group 1 – PAS (32 pts), group 2 – “scar pregnancy” (21 pts)). All patients were admitted, followed and operated at the Baku Health Center (Bakı Sağlamlıq Mərkəzi) academic hospital of Baku Sechenov University between 2019 -2023.

Ultrasound criteria used for prenatal diagnosis and classi cation of gestational sac/placenta localization and severity prognosis were based on recommendations of:

- Cali et al., 2017 [3] and Lin et al., 2018 [4] – for CSP
- Collins et al., 2016 [5] and Cali et al., 2019 [6] – for PAS

Surgery for scar pregnancy:

- hysteroscopic approach involved use of resectoscopy with or without activation of bipolar electrode.
- laparoscopic assistance consisted of permanent or temporally occlusion of hypogastric or uterine arteries.
- laparoscopic treatment was in form which combined temporarily or permanent devascularization, broad dissection of “pregnancy in scar” area, resection and resuturing of uterine wall with total laparoscopic hysterectomy was performed according to routine steps.

Surgery for PAS (all pregnancies were terminated between 32 and 37 weeks of gestation) included cesarean section with uterine devascularization as in case of PAS -0 or Tripple -P intervention (in one patient with Covid 19 placenta was left in situ and total laparoscopic hysterectomy was performed 3 weeks after cesarean section).

RESULTS. Our results for CSP and PAS management were shown at the tables 1 and 2. We had only one emergency case with ruptured scar pregnancy located on the level of internal cervical ostium which ended with TLH which was indicated and discussed with the patient and her family in advance.

TABLE 1 Date of termination and sonographic type of CSP

	Number	Date of termination	Indication	Sonographic type
HS	4	6-7 weeks	planned	Grade 1|COS 2
HS (LS assistance)	3	7- 8 weeks	planned	Grade 1|COS 2
LS	13	6- 8 weeks	planned	Grade 2|COS 1
		8-10 weeks		+ Grade1|COS 1
TLH+BSO	1	12-14 weeks	emergency	Grade 3-4*

Note: Grades were diagnosed according to Lin SY et al., 2018, COS –"crossover sign" was proposed by Cali et al, 2017. Both systems were described in details in relevant publications.

We performed only 3 hysterectomies in pregnants with PAS (Table 2). In one case of prenatal diagnosed PAS 3 we performed resection of bladder but uterus was saved (Table 2). There was no case of severe placenta percreta [1] in this group of patients. Transient intraoperative and post operative outcomes are as follows: shortening of surgery duration from approx. 180-220 min to 90-120 min, decrease in cases with ICU stay – only 2 patients, shortening of stay in ICU to 12-24 hours, diminishing of PRBC and FFP infusion to 1-2 units

TABLE 2

Sonographic degree	number	CS+DV	CS+DV+MP	CS+DV+HE
PAS 0	11	11		-
PAS 1	6	-	5	1*
PAS 2	7	-	7	-
PAS 3	5	-	3	2

Note: DV – pelvic devascularization, MP – metroplasty, HE – hysterectomy

* - patient with acute COVID-19 at the time of CS; placenta was left in situ and TLH performed three weeks afterwards

DISCUSSION and CONCLUSION. We consider PAS is rather a consequence of scar defect than real aggressively invasive placenta cases. This opinion was previously supposed and published by Einerson BD et al., 2020 [7]. This means that under certain circumstances and with certain cautiousness pregnancies can be prolonged to the III trimester and uterus conserving surgery is possible which improves both maternal and neonatal outcomes [8]. Indeed, thorough evaluation of data and indications are needed in case of CSP. Decision to terminate or prolong the given pregnancy is so far based on many parameters including patients consent Further differentiation and expert ultrasound report is required to distinguish between CSP and lower placentation near the scar [9].

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ჩვენი გამოცდილება საკეისრო კვეთის დაგვიანებული ნაწიბურის უარყოფითი შედეგებით

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რეზიუმე

ჩვენ მიგვაჩნია, რომ PAS უფრო ნაწიბურის დეფექტის შედეგია, ვიდრე რეალური აგრესიულად ინვაზიური პლაცენტის შემთხვევა. ეს ნიშნავს, რომ გარკვეულ გარემოებებში და გარკვეული სიფრთხილით ორსულობა შეიძლება გაგრძელდეს III ტრიმესტრამდე და შესაძლებელია საშვილოსნოს შენარჩუნების ოპერაცია, რომელიც აუმჯობესებს როგორც დედის, ასევე ახალშობილთა შედეგებს. მართლაც, CSP-ის შემთხვევაში საჭიროა მონაცემთა და ჩვენებების საფუძვლიანი შეფასება. მოცემული ორსულობის შეწყვეტის ან გახანგრძლივების გადაწყვეტილება ჯერ-ჯერობით ეფუძნება ბევრ პარამეტრს, მათ შორის პაციენტების თანხმობას. საჭიროა დამატებითი დიფერენციაცია.

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SUMMARY

We consider PAS is rather a consequence of scar defect than real aggressively invasive placenta cases. This means that under certain circumstances and with certain cautiousness pregnancies can be prolonged to the III trimester and uterus conserving surgery is possible which improves both maternal and neonatal outcomes. Indeed, thorough evaluation of data and indications are needed in case of CSP. Decision to terminate or prolong the given pregnancy is so far based on many parameters including patients consent. Further differentiation and expert ultrasound report is required to distinguish between CSP and lower placentation near the scar.

Keywords: Delayed cesarean scar, negative outcomes