23. NORMALLY INSERTED PLACENTA ABRUPTION. RISKS AND COMPLICATIONS.

Author: Guțul Cătălina

Co-author: Catrinici Rodica

Scientific adviser: Catrinici Rodica, MD, Associate Professor, Discipline of Obstetrics, Gynecology and Human Reproduction, Department of Obstetrics and Gynecology, *Nicolae Testemitanu* State University of Medicine and Pharmacy of the Republic of Moldova.

Introduction. Abruption of normally inserted placenta (ANIP) is an obstetric emergency and one of the most serious complications of pregnancy, with an incidence of 0.5-1.5% worldwide. ANIP has a negative impact on the condition of the mother and fetus with a high level of maternal and fetal morbidity and mortality. Risk factors that can cause ANIP are: hypertension, trauma, IVF pregnancy, polyhydramnios, thrombophilia, etc. Common maternal complications are: posthemorrhagic anemia, hemorrhagic shock, CID syndrome, polyorganic insufficiency and hysterectomy. Fetal complications can be: severe hypoxia, prematurity and death. These complications depend on the severity and degree of detachment of the placenta. ANIP management requires prompt action by a team of professionals at a high level of perinatal care.

Case presentation. The 37 y.o. pregnant woman, 17-18 weeks pregnant, was hospitalized in the Department of Pregnancy Pathology and Obstetric Emergencies in August 2021, with the accusations: pain in the lower abdomen, bloody elimination from the genital tract.

Discussion. The patient is registered from 10 w.p., previously hospitalized twice: 13-14 w.p. and 16-17 w.p. with the diagnosis of imminent abortion. From the anamnestic data, the patient had 4 pregnancies, 1 birth (cesarean section) and 2 miscarriages, is known as syringomyomy cyst with inferior paraparesis, hereditary thrombophilia, autoimmune thyroiditis. On physical examination: eccentric cervix, shortened 2.0 cm/, moderate bloody vaginal discharge. At the para-clinical examination: genetic tests confirmed hereditary thrombophilia, USG denotes pregnancy 18-19 w.p. imminent late abortion, retroamnational hematoma excluded, cervical length 27 mm, opening 4 mm. After a day, a repeated USG was performed and was found that: Monofetal pregnancy in evolution, imminent late abortion. Cervix length 27 mm, i/o5 mm, in the region i/o of the cervix retrocorial hematoma 17x10x8 mm. On the 3rd day bloody eliminations reappear, Ps 74 bpm, BP 110/70 mmHg, total hemorrhage 70 ml, at USG a massive retroamnational hematoma is identified d = 100x91x94mm, volume of 448 ml, the placenta located on the anterior wall to the bottom and the left lateral wall. An enlarged consilium decided to terminate the pregnancy urgently by small caesarean section. Postoperative hemorrhage amounted to 2600 ml, ineffective hemostasis measures let to performing a relaparotomy with total hysterectomy without bilateral appendages, intraoperatively was detected uterine hypotonia. The total hemorrhage was 3600 ml. The patient was in intensive care for postoperative recovery for 3 days, then transferred to the aseptic gynecology department, on the 8th day the patient was discharged at home. The actions taken were performed according to the clinical situation and the clinical protocol in ANIP. An important factor that contributed to the irreversibility of the massive hematoma was confirmed hereditary thrombophilia. The final decision of relaparotomy with total hysterectomy without bilateral appendages led to the rescue and stabilization of the patient's condition.

Conclusion. The patient's pregnancy progressed to a morbid background of hereditary thrombophilia, autoimmune thyroiditis, retroplacental hematoma that aggravated the evolution of the current pregnancy. Pathological insertion of the placenta (placenta increta), confirmed pathomorphological, led to the appearance of hypotonic hemorrhage after cesarean section, requiring total hysterectomy. The preconception of hereditary thrombophilia and the administration of specific treatment would have prevented the development of ANIP.