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شبكة المعلومات الجامعية

التوثيق الالكتروني والميكروفيلم

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قسم

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بالرسالة صفحات
لم ترد بالأصل

The effect of the duration between the previous caesarean section and the current pregnancy on the incidence of placenta accreta spectrum

A Thesis

Submitted for Fulfillment of Master Degree
in Obstetrics and Gynecology

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Safaa Bakr Farag Allah Elghatwary

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Abb.	Full term
AFP	Alpha-Fetoprotein
Ang-2	Angiopoietin-2
cffDNA	Cell-Free Fetal DNA
D&C	Dilatation and curettage
EMT	Epithelial-to-mesenchymal transition
EVT	Extravillous trophoblasts
INSL4	Insulin-like protein 4
IQR	Inter quarterly range
IVF	In vitro fertilization
MAP	Morbid adherent placenta
MMP	Matrix metalloproteinase
PAPP-A	Pregnancy-Associated Plasma Protein A
PAS	Placenta accreta spectrum
PPH	Post partum hemorrhage
sFlt-1	Fms-like tyrosine kinase 1
TAS	Trans abdominal US
TVS	Trans vaginal US
VBAC	Vaginal birth after caesarean
VEGF	vascular endothelial growth factor
VEGFR-2	Vascular endothelial growth factor receptor-2

PROTOCOL OF A THESIS FOR PARTIAL FULFILMENT OF MASTER DEGREE IN OBSTETRICS AND GYNAECOLOGY

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What is already known about this subject? AND What does this study add?
This study aims to provide more information about the risk factors of placenta accreta spectrum.

1. INTRODUCTION/ REVIEW

Placenta accreta spectrum (PAS) disorders are dangerous pathological conditions in which the placenta abnormally invades the myometrium **(Jauniaux and Ayres-de-Campos 2018).**

Most commonly, it is a consequence of a partial or complete absence of the compact and spongy layer known as the decidua basalis, and misdevelopment of the fibrinoid Nitabuch's layer which lies between the boundary zone of the thick endometrium and the cytotrophoblastic shell in the placenta. **(Kohn , Popek , Diaz-Arrastia et al 2016).**

The placental villi attached and are only slightly embedded into the myometrium in Placenta accreta (more than 70% cases), deeply invade into the myometrium in placenta increta (13%) and invade the perimetrium even infiltrating adjacent structures of the pelvic floor in placenta percreta (5%). **(Dankher, Bachani, Patel, Shivhare 2017).**

Placenta accreta spectrum is associated with significant maternal morbidity and mortality, in particular, major obstetric haemorrhage and peripartum hysterectomy **(Silver and Barbour, 2015).**

Diagnosis of placenta accreta prior to labor can be achieved by ultrasound (including the use of Doppler) or MRI. The major sonographic characteristics of placenta accreta are:
(1) Loss of continuity of the uterine wall;
(2) Multiple vascular lacunae within the placenta;
(3) Lack of a hypoechoic border (myometrial zone) between the placenta and the myometrium;
(4) Bulging of the placental/myometrial site into the bladder;
(5) Increased vasculature evident on color Doppler.***(Comstock 2005)***

The treatment for placenta accreta depends on the severity of penetration to the uterine wall, the clinical presentation, the woman's hemodynamic status and future pregnancy plans. When there is a high suspicion for the presence of abnormal placental implantation, an elective caesarean section with experienced obstetric team should be planned because of the high risk for intrapartum and postpartum haemorrhage and life-threatening potential **(Lin , Qin , Xu et al 2015)**

All recent studies confirm that the incidence of placenta accreta increased dramatically in the past two decades with the increasing number of caesarean sections. The number of previous caesarean sections and the presence of placenta previa exponentially increase the risk for placenta accreta. **(Eshkoli, Weintraub, Sergienko, Sheiner, 2013)**

There is a continued need to study risk factors of placenta accreta spectrum to improve the antenatal diagnosis, particularly