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B-lynch padding : A case report.

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ABSTRACT : *Delivery haemorrhage is the leading cause of maternal mortality in Morocco and many other countries, and is an obstetric and anaesthetic emergency requiring a number of procedures and resuscitation measures. If these measures fail, surgical treatment is essential, such as uterine padding and artery ligation, or radical hemostatic hysterectomy as a last resort to save the mother's life. Placenta accreta can be a cause of delivery haemorrhage, and can be managed with uterine preservation, particularly when fertility is to be preserved. We report a case of placenta accreta diagnosed intraoperatively and treated conservatively in a patient with a history of curetted abortion, caesareanized for a fully overlying hemorrhagic placenta previa.*

Keywords : B-lynch padding; delivery hemorrhage; placenta accreta; fertility preservation.

INTRODUCTION :

Delivery haemorrhage is an obstetric emergency with multiple etiologies, including placenta accreta, defined as abnormal adhesion of the placenta to the uterine wall. The placenta may extend into the myometrium (placenta increta) or through the myometrium into the uterine serosa or adjacent organs (placenta percreta). Placenta accreta is associated with considerable maternal morbidity, including severe hemorrhage, uterine rupture, infection and even maternal mortality.

The standard treatment for placenta accreta is hysterectomy. To preserve fertility, conservative surgical treatment may be attempted in some cases. Surgical uterine compression techniques are part of the therapeutic strategy adopted for delivery hemorrhage, enabling the uterus to be preserved.

CASE REPORT :

Patient aged 27, history of curettage one year ago, gravida 2, para 1, pregnancy estimated at 38 weeks' amenorrhea. An emergency caesarean section was indicated for hemorrhagic placenta previa completely covering the placenta in labor, which allowed extraction of a live newborn. Placenta delivery was incomplete, with a piece of placenta remaining measuring 3 cm/2 cm, there was profuse haemorrhage and uterine inertia. We decided to perform conservative surgical treatment to preserve the patient's fertility. A sterile field was placed in the lower segment of the uterus, opposite the accreted area, and triple ligation of the uterine arteries, round ligament arteries and utero-ovarian arteries was performed, followed by hysterography, B-lynch padding and framing of the lower segment. Intra-rectal administration of 40 IU synthocinon (oxytocin) and 4 tablets cytotec (misoprostol), exacyl (tranexamic acid), transfusion of three packed red blood cells. Hemostasis was ensured with a very good uterine safety globe. A drain was inserted. At the end of the procedure, the patient was hemodynamically stable, diuresis preserved with clear urine. A sandbag was placed on the patient's abdomen, and she was transferred to the maternal intensive care unit for monitoring, with very good progress. The placenta was sent for anatomopathologicalstudy, which confirmed the placenta accretion.

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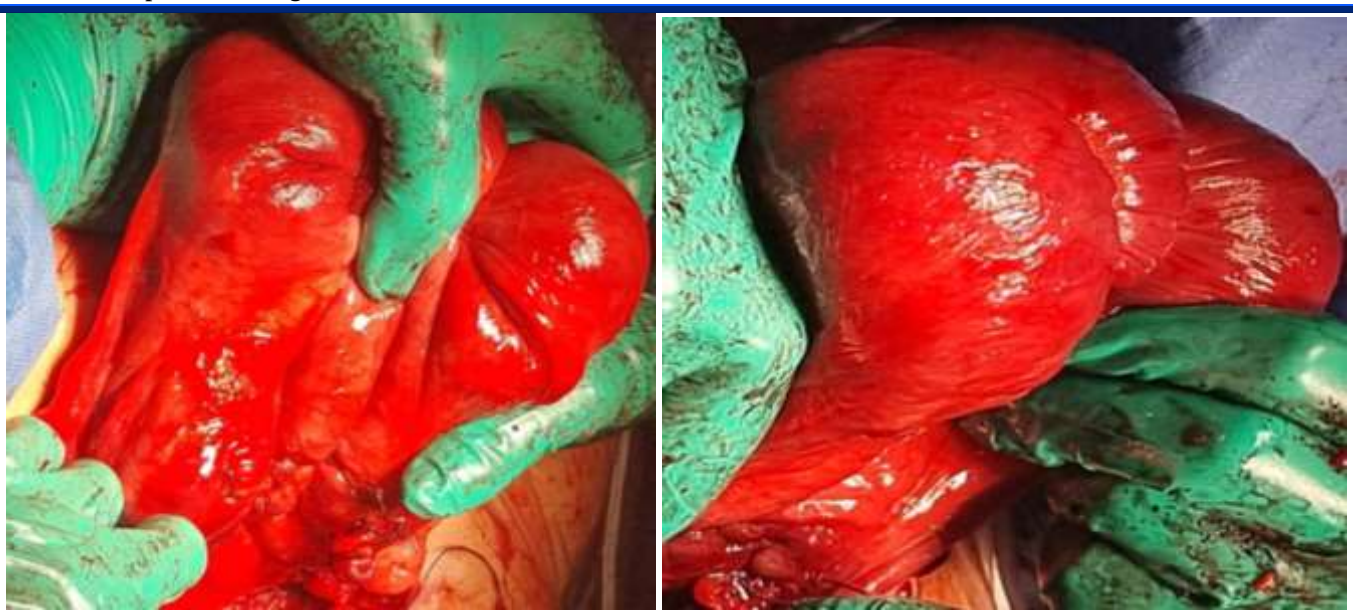

Figure 1 : *B-lynch padding.*

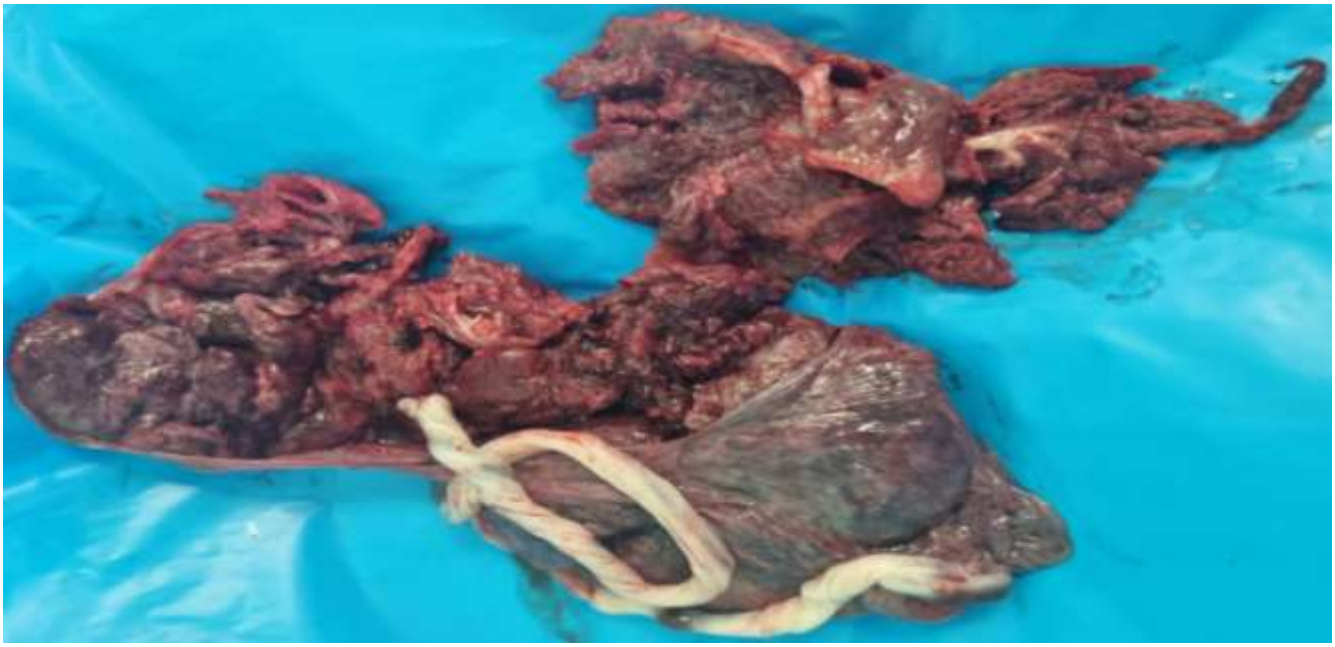

Figure 2 : *placenta accreta.*

DISCUSSION :

Delivery haemorrhage is the leading cause of maternal mortality in Morocco [1]. It is an obstetric emergency which rapidly puts the mother's vital prognosis at risk. Its classic treatment consists of a number of gestures (uterine massage, uterine revision, indwelling bladder catheterization, examination of the genital tract, infusion of oxytocin, or even prostaglandins) and resuscitation measures (vascular filling, transfusion of packed red blood cells) which should be carried out systematically before considering therapeutic escalation. If these measures fail, and/or if the patient's condition is unstable, surgical treatment is required [2]. The techniques of B-Lynch uterine plication and uterine compression or padding (Cho) appear to be an interesting alternative, especially in cases of uterine atony. They enable haemostasis to be achieved by compressing the anterior wall against the posterior wall using simple or framed transfixing stitches.

The definitive diagnosis of placenta accreta can only be made after histological study of the placenta, but a presumptive diagnosis should be made in the event of difficulty in delivering the placenta.

The incidence of placenta accreta is 1 in 111 deliveries [3]. Risk factors include previous caesarean section, advanced maternal age, multiparity, previous curettage and placenta previa [3].

Prenatal diagnosis of placenta accreta can be made by color Doppler ultrasonography [4], magnetic resonance imaging [5] and elevated serum fetoprotein levels [6]. Color Doppler ultrasound provides the most specific diagnostic criteria, such as diffuse or focal intraparenchymal placental lacunar flow, hypervascularization of the uterine bladder-serosa interphase, prominent subplacental venous complex and loss of subplacental Doppler vascular signals [4].

Hysterectomy by Caesarean section remains the standard treatment for placenta accreta. Preservation is only considered when bleeding is not excessive, hemodynamics are stable and the patient wishes to preserve her fertility.

The B-lynch padding technique is easy: we start 3 cm below the hysterotomy, to the right, from outside to inside, and take up your needle, from inside to outside, 3 cm above the hysterotomy, and 4 cm from the uterine border. The thread passes over the uterine fundus, 4 cm from the right horn. Posteriorly, the needle transfixes the uterus, from outside to inside, at the level of the insertion of the right uterosacral ligament. The needle is guided horizontally into the cavity and then externalized again, to the left, to return to the uterine fundus 4 cm from the left horn. A final entry is made into the uterine cavity, 3 cm above the hysterotomy and 4 cm from the left uterine border. Finally, the needle is inserted again, 3 cm below the hysterotomy, transfixing the lower segment from medial to lateral. The hysterotomy must be closed before the B-Lynch is tensioned and knotted, for fear of not properly controlling the incision angles. Throughout the procedure, the first assistant must exert strong bimanual compression on the uterus to ensure that the thread is placed, without traction so that it does not cut. Frame stitch padding can be used in addition to B-lynch to ensure good haemostasis.

Complications after padding are rare, and may amount to 5-7% [7, 8] : pyometry, erosion of the sling through the uterine wall, uterine ischemia, uterine necrosis, synechia.

CONCLUSION :

Delivery haemorrhage is a life-threatening obstetric and anaesthetic emergency. It can be caused by placenta accreta, a potentially fatal pathology whose incidence is increasing due to multiple risk factors, in this case a history of caesarean section. Conservative surgical treatment with B-lynch cushioning and triple ligation of the arteries is possible when indicated, enabling the patient's obstetrical future to be saved.

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