Managing Patients with Abnormal Placenta: What Are the Best Anesthetic and Transfusion Strategies?

To the Editor:

I read with interest the article by Reitman et al. describing the case scenario for a pregnant patient with placenta accreta, and wish to make several comments. Although I would concur with the authors that a neuraxial technique is a viable approach for planned cesarean section for these patients, no specific detail was provided by the authors in the “anesthetic management” section of the article about preferred modes of neuraxial anesthesia. As exemplified in recent case series of patients with abnormal placenta undergoing cesarean delivery, an epidural catheter-based technique – epidural de novo or combined spinal-epidural (as described in “surgical course”) – is advisable. For these cases, an epidural catheter allows epidural supplementation of local anesthesia to maintain adequate surgical anesthesia during an anticipated period of prolonged surgery. In addition, the epidural catheter can be employed postoperatively to provide epidural analgesia, especially as these patients often have large midline incisions. These patients may often experience moderate-severe intraoperative blood loss requiring transfusion therapy, therefore verifying that the platelet count and coagulation indices are within a normal range before postoperative epidural catheter removal is advised. Urgent cesarean delivery may also be required because of antenatal vaginal bleeding or spontaneous labor; however, the article did not include discussion of anesthesia in this setting. A general anesthetic is likely to be preferred over a neuraxial technique for cesarean cases requiring expedited cesarean delivery, as platelet count/function and coagulation indices may have been altered by the rate and magnitude of vaginal blood loss or may simply be because of pressure of time to deliver for fetal indications.

Although the authors correctly state major blood loss can occur perioperatively, the article underplays the critical importance of early availability of adequate volume of blood products for these cases. The authors imply that the transfusion requirements for placenta accreta are moderate (4–6 units erythrocytes), but transfusion requirements can vary and be substantial for all subtypes of abnormal placentation, including placenta accreta. In a recent case series describing transfusion therapy in 66 cases of abnormal placentation (accrete, increta, percreta), massive transfusion (more than 10 units erythrocytes) was necessary for 26 patients with the majority (65%) diagnosed with placenta accreta. Before scheduled and, in particular, urgent cesarean delivery for patients with placenta accreta, an adequate quantity of blood products should be made available to obstetric anesthesiologists in the operating room to avoid communication and transport delays in the ordering, receipt, and delivery of blood products. Immediate access to blood products is especially important during the perioperative period, as placenta accreta is the most common cause for emergency postpartum hysterectomy for uncontrolled bleeding. As a result, the implementation of a massive transfusion protocol can prove life-saving for cases of life-threatening obstetric hemorrhage in this setting, as this critical initiative can ensure the ongoing availability of adequate amounts of essential blood products (erythrocytes, plasma, platelets) to the operating room until surgical control of active bleeding is achieved.

The endorsement of a 1:1:1 ratio of erythrocyte:plasma:platelets for massive obstetric hemorrhage based on evidence from the trauma literature should be viewed with caution. The implication that a high plasma to erythrocyte ratio leads to improved patient outcomes during trauma resuscitation patients has been questioned, as many of the studies supporting this postulated effect are observational, apply to young, healthy males with penetrating trauma and, most importantly, are confounded by survival and probable selection biases. The article that Reitman et al. reference to justify a 1:1:1 ratio also highlights a number of these methodologic limitations, and states that the “perfect plasma-to-erythrocyte ratio may be an illusory goal.” Recent guidelines from the American Association of Blood Banks do not recommend for or against a fresh frozen plasma:erythrocyte ratio of 3 or more for massive transfusion, which indicates continuing uncertainty regarding ideal transfusion ratios for trauma resuscitation.

Lastly, the coagulopathy associated with trauma is characterized by overt activation of the anticoagulant thrombo-modulin protein C pathway and concomitant hyperfibrinolysis. However, results of recent studies of hemostatic changes during postpartum hemorrhage (PPH) suggest that decreased fibrinogen levels are significantly associated with severe PPH. Charbit et al. reported that fibrinogen, factor V, antithrombin, and protein C levels are significantly decreased in women with severe PPH compared with those with nonsevere PPH, and observed no differences in fibrinolytic parameters between severe and nonsevere PPH. As a result, therapeutic approaches for treating coagulopathy in

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trauma patients may differ from strategies for managing coagulopathy related to severe PPH. The use of point-of-care technologies, such as thromboelastography (TEG®) or rotational thromboelastometry (ROTEM®), have been advocated for optimizing the treatment of coagulopathy associated with severe hemorrhage. These technologies may prove useful for goal-directing hemoctatic therapy for obstetric patients experiencing obstetric hemorrhage and requiring massive transfusion. In this respect, I agree with the authors’ final conclusion that more research and consensus regarding transfusion therapy for PPH are needed.

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References


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In Reply:

We would like to thank Butwick for his interest in our Case Scenario. He raises several issues that we were not able to address in depth as the Case Scenario format does not allow for an in-depth review of all aspects of the field. To address each point in turn, we agree that an epidural is indicated when the surgery is likely to outlast the duration of a spinal block. Since this is almost always the case when abnormal placenta accreta is in the range of 5 units in other published series and in our experience.23 We meant to differentiate this from placenta previa, which is more likely to require massive transfusion and, depending on the evidence for placental invasion, might cause the practitioner to favor general anesthesia from the start of the procedure.

Newer protocols for massive transfusion with higher ratios of plasma have emerged from the trauma literature. However, as we stated in our manuscript, “Additional clinical trials are needed to establish the cost-benefit and risk-benefit profiles for procoagulant drugs and to establish standards for treatment of massive bleeding in pregnancy.”1 The use of more plasma in obstetrical hemorrhage seems reasonable in massive obstetrical hemorrhage, as fibrinogen levels are often found to be low and may be associated with continued oozing even when surgical bleeding is controlled. On the other hand, pregnancy is associated with enhanced procoagulant risk, making the hemotologic situation more complex. The use of thromboelastography and rotational thromboelastometry may have been advocated for management of