

Placenta Previa

Abruptio Placenta

Placenta Previa

Objective

-Placenta Previa.

- CLASSIFICATIONS.

- PATHOPHYSIOLOGY.

- NSG DXs & NSG INTERVENTIONS.

-ASSESSMENT.

-COMPLICATIONS.

-MEDICAL & SURGICAL mngt...

Placenta Previa

The abnormal implantation of placenta in the lower uterine segment, partially or completely covering the internal cervical os.

Normal placenta

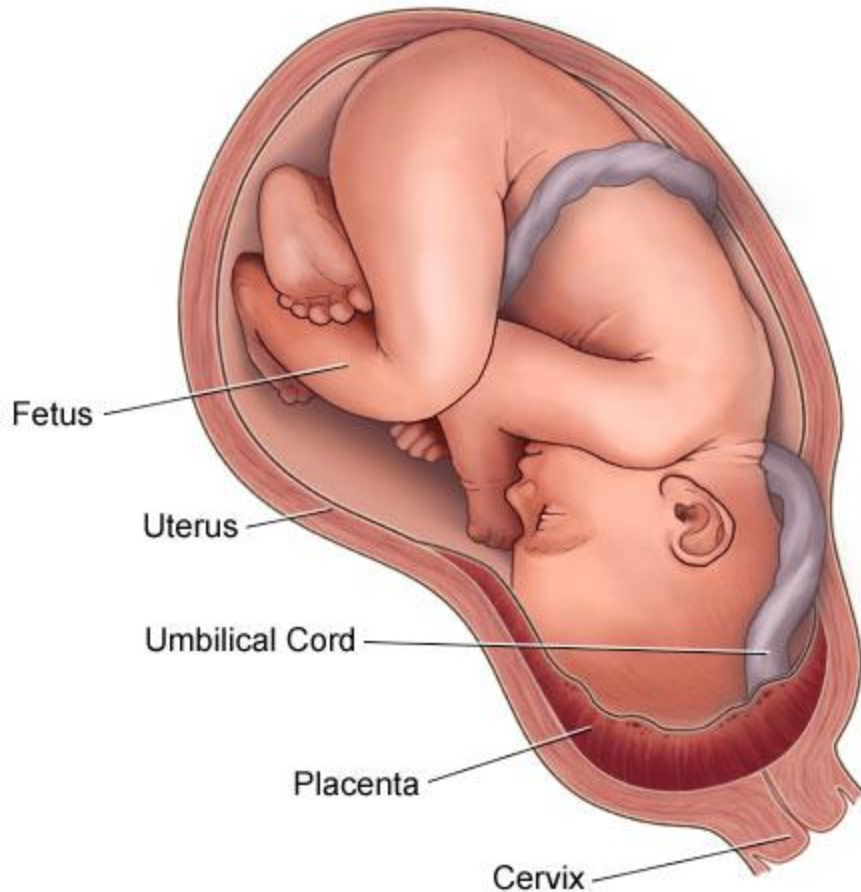


Placenta previa



CLASSIFICATIONS:

Total Placenta Previa

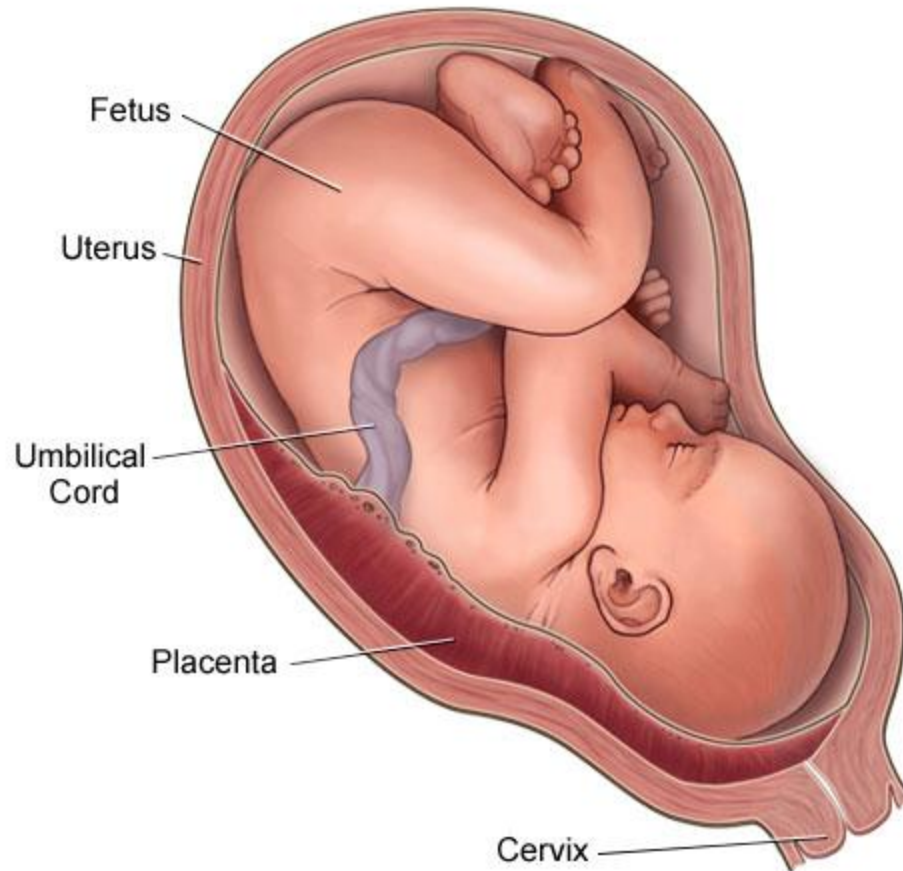


Top Placenta Previa
(Complete)

*The placenta
completely covers
the cervix*

CLASSIFICATIONS:

Partial Placenta Previa

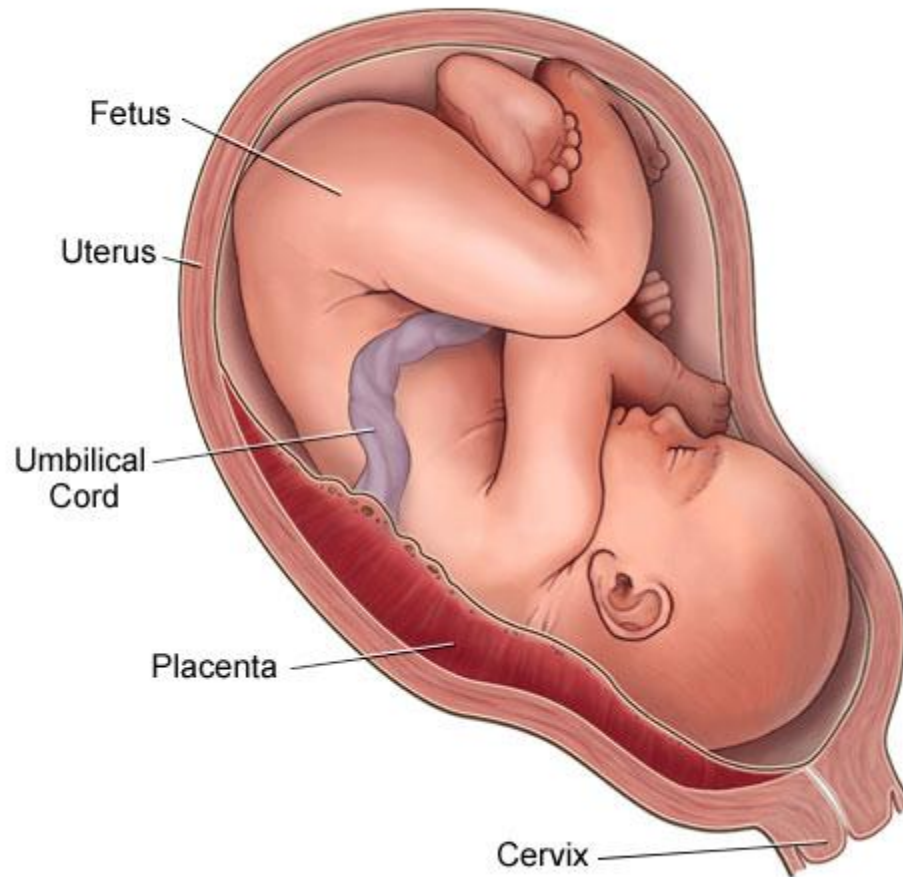


Partial Placenta Previa

*The placenta is
partially over the
cervix*

CLASSIFICATIONS:

Marginal Placenta Previa



Marginal Placenta Previa

*The placenta is
near the edge of the
cervix*

PATHOPHYSIOLOGY:

Predisposing Factors:

Age (35-40)
Race (nonwhite ethnicity)
Hereditary

Predisposing Factors:

Previous abortion
Previous placenta previa
Multiple births
Endometritis
VBAC (vaginal birth after cesarean delivery)
Lifestyle (smoking, etc.)

*Damage to
endometrium*

FOLLOWS A VICIOUS CYCLE:

*Bleeding – Contractions –
Placental separation – Bleeding*

Bright bleeding occurs when cervix dilates, resulting in painless bleeding

COMPLICATIONS

- *Placenta accreta*
- *Immediate hemorrhage, with possible shock and maternal death*
- *Increased risk for anemia secondary to increased blood loss and infection secondary to invasive procedures to resolve bleeding*
- *Intrauterine growth restriction (IUGR)*
- *Congenital anomalies*
- *Fetal mortality resulting from hypoxia in utero and prematurity*

Placenta accrete

It is a severe obstetric complication involving an abnormally deep attachment of the placenta, through the endometrium and into the myometrium, it can be exhibited as.

- a- placenta accrete- placental chorionic villi adheres to the superficial layer of the uterine myometrium.
- b- Placenta increta- placental chorionic villi invade deeply into the uterine myometrium.
- c- Placenta percreta- placental chorionic villi grow through the uterine myometrium and often adhere to abdominal structures (e.g. bladder or intestine.)

ASSESSMENT

- Determine the amount and type of bleeding
- Inquire as to presence or absence of pain in association with the bleeding
- Record maternal and fetal VS
- Palpate for the presence of uterine contractions
- Evaluate laboratory data on Hct and Hgb
- Assess fetal status with continuous fetal monitoring
- Never perform a vaginal examination when pt is bleeding

Altered Tissue Perfusion related to excessive blood loss causing fetal compromise

- *Frequently monitor mother and fetus*
- *Administer IV fluids as prescribed*
- *Position on side to promote placental perfusion*
- *Administer oxygen as facemask as indicated (8-10 per minute)*

Fluid volume deficit related to excessive blood loss

- Establish and maintain a large-bore IV line, as prescribed and draw blood for type and screen for blood replacement
- Position in a sitting position to allow weight of fetus to compress the placenta and decrease bleeding
- Maintain strict bed rest during any bleeding episode
- Prepare woman for a cesarean delivery
- Administer blood or blood products protocol per institutional policy

Risk for infection related to excessive blood loss

- *use aseptic technique when providing care*
- *Evaluate temperature q4h unless elevated; then evaluate q2h*
- *Evaluate WBC and differential count*
- *Teach perineal care and hand washing techniques*
- *Assess odor of all vaginal bleeding or lochia*

Anxiety related to excessive blood loss

- *Explain all treatments and procedure*
- *Encourage verbalization of feelings by patient and family*
- *Provide information on a CS delivery*
- *Discuss the effects of long-term hospitalization or prolonged bed rest*

*Fear related to outcome of pregnancy
after episodes of blood loss*

- *Explain all treatments and procedure*
- *Encourage verbalization of feelings by patient and family*
- *Provide information on a CS delivery*

MEDICAL MANAGEMENT

- IV access
- Laboratory examinations
- Blood typing and cross matching
- Admin. Betamethasone (Celestone)

SURGICAL MANAGEMENT

- Amniocentesis
- CS delivery

Abruptio Placenta

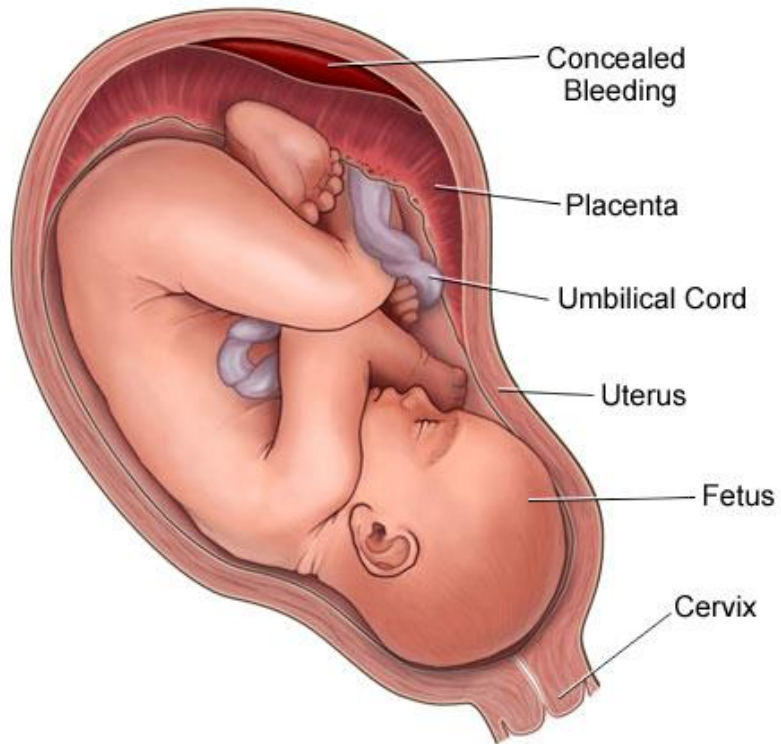
Abruptio Placenta

Is premature separation of the implanted placenta before the birth of the fetus

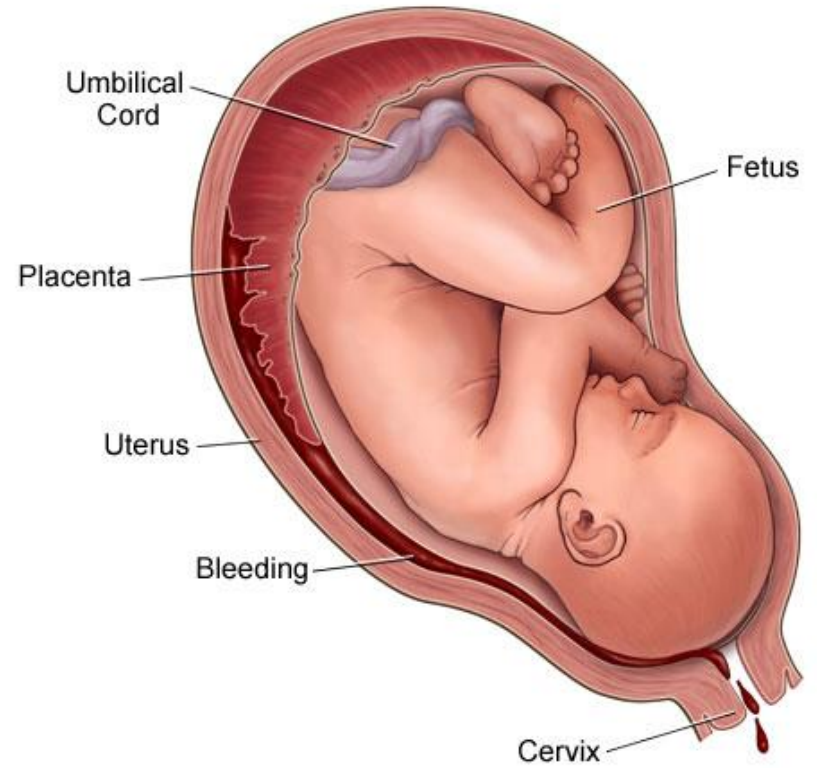
Hemorrhage can be either occult or apparent. With an occult hemorrhage, the placenta usually separates centrally, and a large amount of blood is accumulated under the placenta. When the apparent hemorrhage is present, the separation is along the placental margin, and blood flows under the membranes and through the cervix.

If the placenta begins to detach during pregnancy, there is bleeding from these vessels. The larger the area that detaches, the greater the amount of bleeding

Concealed Bleeding



Visible Bleeding



PAT#OP#YSIOLOGY:



Predisposing Factors:

Age (> 35y.o)
Hereditofamilial



Predisposing Factors:

Previous abruptio placenta
PIH
Abdominal trauma
Smoking
Cocaine use
Chorioamnionitis

Placental abruption may be classified in three types of separation.

1. Marginal/low separation .This occurs when the separation is low and is not complete; vaginal hemorrhage is evident .
2. Moderate/high separation .This occurs when the separation is high in the uterine segment. The fetus is in grave danger because of lack of oxygen. External hemorrhage will probably not be present here.
3. Severe/complete separation .This occurs when the fetus head is present in the cervical os that prevents external hemorrhage. The fetus is in grave danger, and an immediate cesarean section will probably be needed in order to save the baby's and mother's lives .

COMPLICATIONS

- Maternal shock
- Anaphylactoid syndrome of pregnancy
- Postpartum hemorrhage
- Acute respiratory distress syndrome
- Sheehan's syndrome
- Renal tubular necrosis
- Rapid labor and delivery
- Maternal and fetal death
- Prematurity

Anaphylactoid Syndrome of Pregnancy:

A rare complication of childbirth in which amniotic fluid enters the blood stream of the laboring woman through ruptured uterine veins. The condition causes hemorrhage, shock, pulmonary embolism and sometimes, maternal death. The condition can often be caused by powerful uterine contractions

Sheehan syndrome, also known as postpartum hypopituitarism or postpartum pituitary necrosis:

is hypopituitarism (decreased functioning of the pituitary gland), caused by necrosis due to blood loss and hypovolemic shock during and after childbirth.

ASSESSMENT

- Determine the amount and type of bleeding and the presence or absence of pain.
- Monitor maternal and fetal vital signs, especially maternal BP, pulse, FHR, and FHR variability.
- Palpate the abdomen
 - Note the presence of contractions and relaxations between contractions (if contractions are present)
 - If contractions are not present assess the abdomen for firmness
- Measure and record fundal height to evaluate the presence of concealed bleeding.
- Prepare for possible delivery.

Ineffective tissue perfusion (placental) related to excessive blood loss causing fetal compromise

- *Evaluate amount of bleeding by weighing all pads. Monitor CBC results and VS*
- *Position in the left lateral position, with the head elevated to enhance placental perfusion*
- *Administer oxygen through a snug face mask at 8-12L per minute*
- *Evaluate fetal status with continuous external fetal monitoring*
- *Prepare for possible CS delivery if maternal or fetal compromise is evident*

Acute Pain related to increase uterine activity

- Instruct patient on the cause of pain to decrease anxiety*
- Instruct and encourage the use of relaxation technique to augment analgesics*
- Administer pain medications as needed and as prescribed*

Fluid volume deficit related to excessive blood loss

- Establish and maintain a large-bore IV line, as prescribed and draw blood for type and screen for blood replacement*
- Evaluate coagulation studies*
- Monitor maternal VS and contractions*
- Monitor vaginal bleeding and evaluate fundal height to detect an increase in bleeding*

Risk for infection related to excessive blood loss

- *use aseptic technique when providing care*
- *Evaluate temperature q4h unless elevated; then evaluate q2h*
- *Evaluate WBC and differential count*
- *Teach perineal care and hand washing techniques*
- *Assess odor of all vaginal bleeding or lochia*

Fear related excessive blood loss and unknown outcome

- Inform the woman and her family about the status of herself and the fetus*
- Explain all procedures in advance when possible or as they are performed*
- Answer questions in a calm manner, using simple terms*
- Encourage the presence of a support person*

CHARACTERISTIC	PLACENTA PREVIA	ABRUPTIO PLACENTA
ONSET	Second trimester	Third trimester
BLEEDING	Mostly external, small to profuse in amount, bright red	May be concealed, external dark hemorrhage or bloody amniotic fluid
PAIN AND UTERINE TENDERNESS	Usually absent; uterus soft	Usually present; irritable uterus
FETAL HEART TONE	Usually normal	Maybe irregular or absent
SHOCK	Usually not present unless bleeding is excessive	Moderate to severe depending on external hemorrhage
DELIVERY	Delivery may be delayed depending on size of fetus and amount of bleeding	Immediate delivery, usually by CS delivery

Recommended Videos

Recommended Videos topic	Website Link	Video Length
The Placenta: Its Development and Function	https://www.youtube.com/watch?v=bp-ed-RVWsLk	3.58 minutes
Placenta Previa	https://www.youtube.com/watch?v=dFkloeIN_lo	27 Second
Placental Abruptio	https://www.youtube.com/watch?v=Z9dBS1xLQMc	3.32 minutes