中大出血的成效。

C40 Abnormal placentation with unexpected profuse peripartum hemorrhage-Case report

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Background: Over the past 30 years, due to the growing number of cesarean deliveries, the frequency of abnormally invasive placentation has increased at least 10-fold (Obstetrical & Gynecological Survey 62; 2007,pp 529-39). The importance of a proper management plan in case of abnormally invasive placentation is obvious. The most important complication of abnormally invasive placentation is massive hemorrhage. This is often a result of attempted manual placental separation from its poorly formed decidual bed, which opens up large-caliber spiral vessels and sinuses. In intractable bleeding, emergency hysterectomy is usually required.

Report of a case: A case of 34-year-old gravida 2 para 1, without any systemic disease, was admitted due to preterm premature rupture of membrane and planed for elective cesarean section due to breech presentation with decreasing amniotic fluid and right posterior laying placenta previa, Grade II. Obstetrician failed to control the bleeding during the surgical intervention. The patient developed hemorrhagic shock and acute drop of hemoglobin level. Treatments with uterotonic drugs, suturing, ligation of internal iliac arteries, packing of the pelvis, and blood transfusion failed to control diffuse pelvic and vaginal bleeding. Aortic compression was performed as a final attempt to control the bleeding. After bleeding was successfully slow down, as well as gained time for later transcatheter arterial embolization of bilateral internal iliac arteries, but finally subtotal hysterectomy ensued. Although short period of acute anemia was noted (Hb 4.6 mg/dl) during the operation, but no any sequela. The remainder of the patient's hospital course was unremarkable. She was discharge from hospital a week later with completely recovery.

Conclusion: Always looking for the risk of abnormal placentation, especially for those posterior positioned placenta. Well prepared for massive hemorrhage, keep aggressive fluid management and follows the guidelines of massive transfusion will bring good result in critical case. A close team work to patient care is also very important and can reduce maternal mortality and morbidity.

胎盤構造異常合併週産期大量出

血之病例報告

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前言: 過去三十年臨床剖腹生產的數量愈來愈多，胎盤構造異常(abnormal placentation)的發生率亦隨之增加(Obstetrical & Gynecological Survey 62; 2007,pp 529-39)。這一類病人在醫療上需特別注意及小心，最嚴重的併發症就是於周產期大量出血，乃因胎盤根部生長異常及血管畸形造成出血的機會增加。對於難以處理的大量出血最終還需作子宮切除才能善後。

病例報告: 一位三十四歲經產一次，沒有系統性疾病的女性病患，因羊膜早期破水住院，且因胎位不正、羊水減少、後位性邊緣性前置胎盤，故安排作剖腹生產。術中產科醫師無法經由外科手術進行止血，病人血紅素急速下降，並且演變成出血性休克。經過子宮收縮藥物的使用、子宮縫合、動脈結紮、紗布填塞、輸血等治療都無法控制持續性的出血，最後以主動脈壓迫暫時性降低出血量，並馬上爭取時間做經導管主動脈栓塞，以及最後作部分子宮切除。手術過程中大量出血時雖然血紅素最低降至4.6 毫克，麻醉按據治療原則作積極處理，慶幸病人最後並沒有任何後遺症出現，於一星期後，病人完全康復出院。

結論:我們必須經常留意胎盤構造異常的風險，尤其是後位性的胎盤，爲大量出血做好準備，按照大量輸血的指引原則，積極作輸液處理，始能帶給重症患者較好的預後。緊密的團隊合作也是照顧患者十分重要之一環，並可有效降低死亡率及致病率。

C41 Iatrogenic Left Internal Iliac Artery Perforation during Lumbar Discectomy

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Iatrogenic intra-abdominal vascular injury can result from lumbar discectomy via a posterior approach. Although it is well known and documented in the literature, few anesthesiologists have had personal experience with this life-threatening instance. We report a patient who sustained left internal iliac artery perforation during posterior lumbar discectomy at the L_{4-5} level. The patient suffered from refractory hypotension with tachycardia at the end of surgery even with utmost fluid resuscitation and medical treatment. Besides, abdominal distension and tenderness of left lower abdominal quadrant were also complained by the patient. Emergent laparotomy was performed by vascular surgeon and the vascular injury was successfully repaired. It is important for anesthesiologists to be aware of this potentially fatal complication. Rapid diagnosis and immediate laparotomy for control of hemorrhage can result in a favorable outcome.

腰部椎間盤手術中併發左髂動脈破裂之病例報告