The increasing incidence of caesarean sections and maternal age

The increasing incidence of caesarean sections and maternal age globally predisposed more to the incidence of placenta praevia in the obstetric population (Ikechebelu & Onwusulu, 2007). Uncomplicated cases of placenta previa should be delivered by elective cesarean section between 36 and 37 weeks. Reported risk factors for placenta previa in Myles Textbook For Midwives (2014) include the history of the previous cesarean section, termination of pregnancy, advanced maternal age, high parity, previous intrauterine surgery, smoking, and multiple pregnancies. Also, the placenta previa is a risk of develivering a small-for-gestational-age.

Ultrasonography is the diagnostic modality of choice for diagnosis of placenta previa. Severe hemorrhage can occur during surgery while separating the placenta. In these cases, hysterectomy is considered the treatment of choice although conservative management has recently been proposed. Despite vast improvement in obstetric management and modern transfusion service, antepartum hemorrhage continues to be one of the leading causes of maternal morbidity and mortality. An accurate diagnosis and prompt resuscitation are the first steps in the management of antepartum hemorrhage. Cases of placenta previa and placenta accreta are increasing in numbers with the rising rate of cesarean section. It is found that higher morbidity associated a with different types of placenta previa, such as complete or partial placenta previa and it is more than marginal placenta previa or low-lying placenta.

Every institution should have a clear plan and structure a protocol for the management of cases of massive hemorrhage. This precise protocol should be regularly updated, and steps and procedures should be rehearsed. The main causes of massive obstetrical hemorrhage are placenta previa, placental abruption, and postpartum hemorrhage. These can cause serious maternal morbidity and mortality if there is a delay in the diagnosis of hypovolemia and coagulation defects.

Marinating effective circulation by more than one intravenous line to adequately and promptly pump blood products, fresh frozen plasma replacement-using crystalloids, in addition to invasive monitoring of the pulse rate and the blood pressure. Other available treatment modalities include using oxytocin and prostaglandins to keep the uterus contracted, and surgical procedures to stop bleeding by performing ligation of the uterine, ovarian or internal iliac arteries, or embolization by radiological assistance, or finally hysterectomy when indicated.

In general further education and expo-sure on placenta praevia with its possible complications

should be emphasised to ob-stetric patients, to ensure proper attitude towards the medical advice given and be compliant to medication in order to achieve optimum care for women with placenta praevia. Therefore, efforts to improve the knowledge regarding placenta praevia through quality improvement programs are very important in order to prevent avoid-able complications such as fetal mortality and maternal death secondary to uncon-trolled bleeding.