

PREGNANCY AFTER B-LYNCH SUTURE AND UTERINE ARTERY LIGATION IN CASE OF PLACENTA INCRETA

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ABSTRACT

This case report describes successful pregnancy outcome following B-Lynch suture & bilateral uterine artery ligation to control bleeding from placental bed in case of placenta increta.

Key Words: *Pregnancy, B-Lynch suture, uterine artery ligation, Placenta increta.*

This case report may be cited as: Shaheen S, Akhtar S. Pregnancy after B-Lynch suture and uterine artery ligation in case of placenta increta. J Postgrad Med Inst 2013; 27(4):459-60.

INTRODUCTION

B-Lynch suturing technique is used for massive postpartum hemorrhage, Christopher B-Lynch was the first to highlight this revolutionary principle¹. The suture aims to exert continuous vertical compression on the vascular system.

A laparotomy is always necessary to exteriorize the uterus. A transverse incision is made on the lower segment to check the cavity for retained placental fragments and to swab it out. The suture is now carried over the top of the uterus and to the posterior side. As the needle pierces the uterine cavity side of the posterior wall, it is placed over the posterior wall, bringing the suture over top of the fundus and onto the anterior right side of the uterus. The needle re-enters the cavity exactly in the same way as it did on the left side that is 3 cm above the upper incision and 4 cm from the lateral side of the uterus through the upper incision margin, into the uterine cavity and then out again through 3 cm below the lower incision margin². It acts as uterine compression suture.

Because of its simplicity of application, Life saving potential, relative safety & capacity for preserving the uterus & subsequent fertility, It present an alternative to hysterectomy^{2,3}. We applied B-Lynch brace suturing to the uterus after bilateral uterine artery ligation to control bleeding from the placental bed in case of placenta increta. Placenta increta is defined as an abnormal adherence, either in whole or in part, of the afterbirth to the underlying uterine wall. Placenta increta occurs when the placenta invades deeply into the myometrium and it is a life threatening condition⁴.

CASE REPORT

A 23 years old primigravida presented to us with 39 weeks gestation and labour pains for 2 days. On abdominal examination her fundal height was corresponding to the period of gestation, lie was longitudinal & fetal heart sounds were audible. Ultrasound examination showed normal average size and absent liquor. CTG showed severe bradycardia & emergency caesarean section was decided.

On caesarean section after delivery of baby. Placenta was found adherent to the fundus of the uterus. It was removed manually & patient went into severe postpartum hemorrhage (PPH). Sutures were taken at the placenta site. There was still bleeding from placental bed. Bilateral uterine artery ligation was done to control haemorrhage but she was still bleeding from the placental bed. So B-Lynch brace suture was finally applied to control the bleeding from the uterus. The patient conceived subsequently and had successful pregnancy following the procedure.

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Date Received: February 23, 2013

Date Revised: July 23, 2013

Date Accepted: September 13, 2013

DISCUSSION

The first case of successful pregnancy after hypogastric artery ligation and B-Lynch suturing technique was reported by Api et al in 2005⁴.

One of the leading cause of pregnancy related deaths which also results in significant morbidity is massive uncontrolled hemorrhage after childbirth while uterine atony is the most common cause of primary postpartum hemorrhage. When simple massage of the uterus and uterotonics such as oxytocins, syntometrine and prostaglandins fail to manage the condition, surgical solutions including uterine artery ligation, devascularization of the uterus, internal iliac artery ligation and ultimately hysterectomy are employed. These procedures require above average surgical skill. However, in contrast, B-Lynch suturing technique (brace suture) is particularly useful because of its simplicity of application and relative safety.

Homeostasis can be assessed both before and immediately after application of the B-Lynch suture. So, radical surgical methods can be considered, once it fails.

Another advantage of this technique is its potential to present as an alternative to procedures for controlling pelvic arterial pulse pressure or hysterectomy^{3,5,6}.

A case of placenta increta managed by unilateral uterine artery and ovarian artery ligation followed by B-Lynch brace suturing of the uterus to control bleeding from the placenta bed has been reported by Chaudhary et al⁷.

REFERENCES

1. Price N, Whitelaw N, B-Lynch C. Application of the B-Lynch brace suture with associated intrauterine balloon catheter for massive hemorrhage due to placenta accrete following a second-trimester miscarriage. *J Obstet Gynaecol* 2006;26:267-8.
2. Wohlmuth CT, Gumbs J, Quebral-Ivie J. B-Lynch suture: a case series. *Int J Fertil Womens Med* 2005;50:164-73.
3. Price N, B-Lynch C. Technical description of the B-Lynch brace suture for treatment of massive postpartum hemorrhage and review of published cases. *Int J Fertil Womens Med* 2005;50:148-63.
4. Api M, Api O, Yayla M. Fertility after B-Lynch suture and hypogastric artery ligation. *Fertil Steril* 2005;84:509.
5. Allam MS, B-Lynch C. The B-Lynch and other uterine compression suture techniques. *Int J Gynaecol Obstet* 2005;89:236-41.
6. Holtsema H, Nijland R, Huisman A, Dony J, van den Berg PP. The B-Lynch technique for postpartum haemorrhage: an option for every gynecologist. *Enr J Obstet Gynaecol Reporte Biol* 2004;115:39-42.
7. Chaudhary P, Sharma S, Yadav R, Dhaubhadel P. B-Lynch brace suture: an effective method of conservative surgical management for placenta increta. *Kathmandu Univ Med J (KUMJ)* 2004;2:149-51.