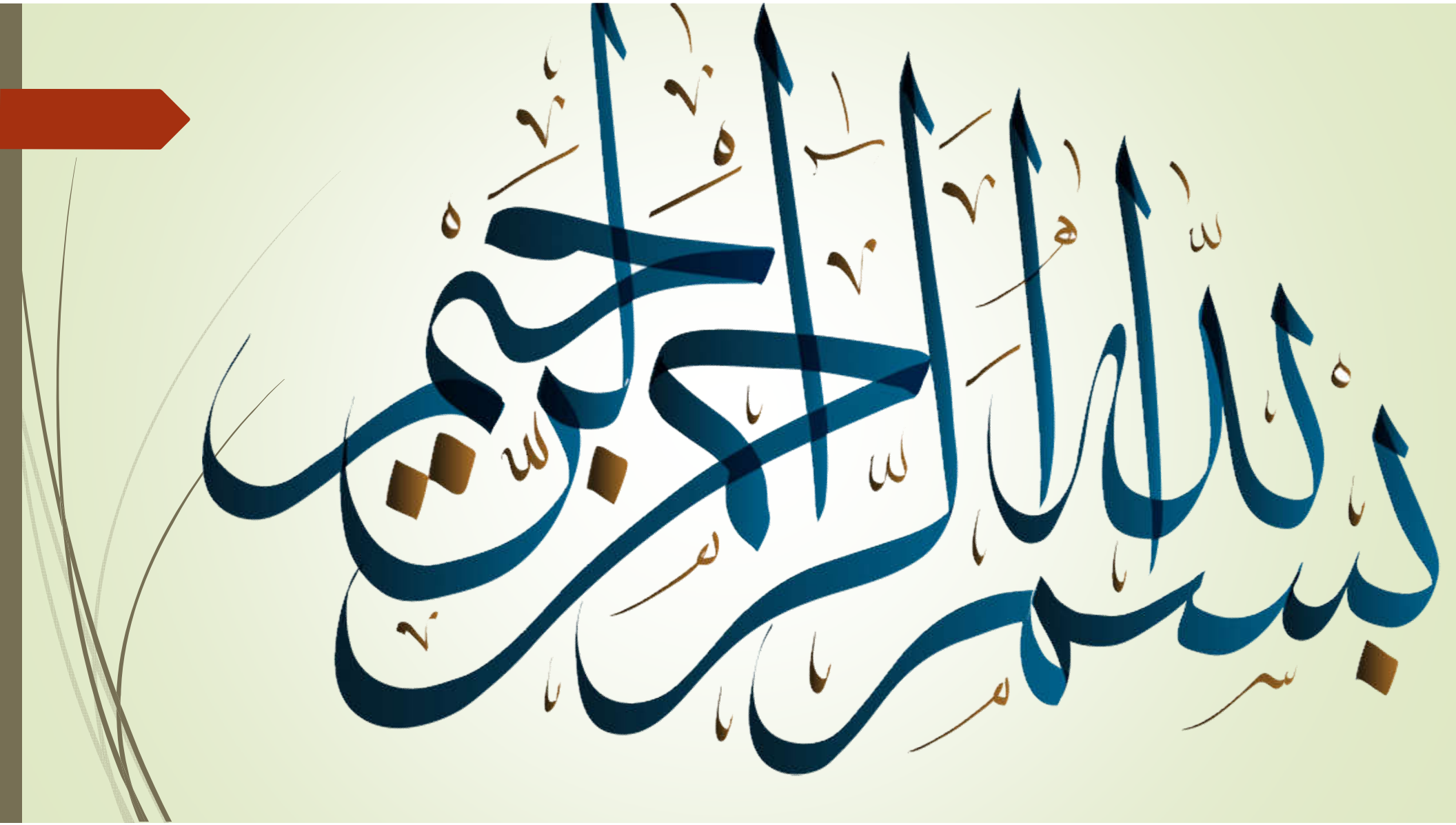
بسم الله الرحمن الرحيم

Maternal mortality

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- 37 year old woman
- G5 P4 Ab1L2D2
- BMI 28.9
- PH: PIH - hyperthyroidism -IUFD
- LMP 1400/06/30
- number of visit : 8
- visit 1400/8/10 until 1401/2/20
- weight 74____89
- BP 10/6_____12/75
- drug: ASA

- 140 /2/26. مراجعه به بیمارستان
- از شب قبل سرگیجه، تاری دید
- BP 170/90
- GA:34w,2d
- علائم بیمار در بدو ورود به بیمارستان
- ساعت14
- PR:92.
- BP:149/100
- RR:18
- FHR:147
- ساعت۱۶
- BP:160/98.

- تاری دید
- سرم سولفات ،هیدرالازین، بتامتازون، آمپی سیلین ,آزمایشات PIHومانیتورینگ قلب جنین
- BP:14/90-13/80
- به مدت دوساعت احساس جرقه زدن ودل درد که بهبود یافته
- Hb:12 PTL:214000
- AST:17. ALT:14 ALP:292
- UA: Neg
- درخواست مشاوره داخلی

- ۱۴۰۰/۲/۲۷

- سونو: 33 w / 2D
- ادامه سولفات
- مشاوره داخلی
- قطع سولفات وانتقال بیمار به بخش مامایی
- BP:135/85
- Uric acid:5
- AST:14 ALT:12 ALP:288
- LDH:379

- ۲/۲۸/
- درخواست مشاوره قلب DC
- گلو درد:PCR
- تستNST
- فشار:۱۲۰/۸۰
- پروتئین ادرار۲۴ ساعت:۲۵۰

- ۱۴۰۰/۲/۲۹
- مانیتورینگ بیمار
- BP: ۱۴/۸

- ۱۴۰۰/۲/۳۰

- ساعت ۱۱:۲۵ بصورت ناگهانی بی قراری , درد شدیدناحیه کمر ,استفراغ صفراوی, تاری دید وتنگی نفس
- T:36/8. BP:130/75. PR:90 O2sat:97 FHR: no
- در معاینه :شکم نرم بدون تندرنس
- وسرویکس ext باز
- جهت C/S انتقال به اتاق عمل
- بدلیل شک به آمبولی عدم C/S وانتقال به لیبر

- بيمار بدليل بي قراري ,تاكي پنه و كاهش هوشياري انتقال به اتاق عمل
- در اتاق عمل بيمار هيپوترم,سيانوتيك عدم لمس نبض وفشار خون
- اينتوبه ،عمليات احيا ،دريپ لئوفدواپي نفرين وسزارين انجام مي شود
- نوزاد دختر با آپكار4/10 متولد ميشود

- بیمار کاملا paleوعلائم کلاپس قلبی عروقی
- خونریزی زمان C/Sکم بوده
- عدم دکولمان
- سوند ادراری عدم خونریزی
- در NGتیوب عدم خونریزی
- رکتال examمنفی
- اکو EF:25 %
- میدریاز فیکس
- برادیکاردی وارست

تشخیص







Acute abdominal pain in pregnancy

- abruption of the placenta
- uterine rupture
- spleen rupture
- pulmonary embolism
- Abdominal artery dissection or aneurism
- visceral artery thrombosis
- myocardial infarction
- perforated ulcer
- urolithiasis

Rupture of the internal iliac artery

Spontaneous Rupture of the internal iliac artery is a rare complication in pregnancy, but has to be considered as a differential diagnosis of abdominal pain.

Ruptures of other visceral branches of the internal iliac artery have also been described as a very rare complication of pregnancy, their cause being mostly unknown.

Predisposing factor of IILA

- Endometriosis
- congenital diseases of connective tissue that result in less valuable artery walls, such as Ehlers-Danlos syndrome type IV or **collagen vascular diseases**
- congenital malformations of blood vessels such as aneurysm, including aneurysm of the internal iliac artery, may cause arterial rupture in pregnancy or in non-pregnant patients .
- Pregnancy
- Infection
- Trauma
- Atherosclerosis

There is an ongoing debate as to whether pregnancy may contribute to the pathogenesis of vascular disease.

Cardiovascular changes during pregnancy may enhance the stress on the arterial wall.

High levels of female hormones during pregnancy alter the histological structure of the arterial wall, thereby resulting in a predisposition to aneurysmal dilatation. Pregnancy may be an initiator of arterial degeneration, which is additive with multiple pregnancies and changes may be permanent

Incidence

IIAAs are uncommon, representing 0.9–2 % of all abdominal aneurysms.

Diagnosis

- computed tomography angiography, MRA
- abdominal/ transvaginal (A detailed evaluation of the kidneys)
- A specific description of fluid collections (free fluid, hematoma, serous, mucinous etc.)
- use of color flow mapping

Treatment in pregnancy

The majority are asymptomatic and are usually incidental findings not requiring therapy in the absence of symptoms or growth.

Many centers use a diameter measurement of > 3 cm as the indication for treatment.

given the increased risk of rupture associated with aneurysms of this size, and that rupture is associated with high morbidity and mortality

Primary embolization of a unilateral IILA in pregnancy is reported.

After the procedure no alterations of cardiotocography were seen and Doppler of the umbilical artery remained normal in the fetus, the fetus did not show any signs of hypoxia, assuming collateral blood flow can ensure enough circulation for continuation of pregnancy.