**C-Section Ups Placenta Previa, Abruption Risk**

**BY KATE JOHNSON**

**Montreal Bureau**

TORONTO — Women whose first babies are delivered by cesarean section face an elevated risk of placenta previa and placental abruption in their second pregnancies. And with two previous cesarean deliveries, the risk of placenta previa is increased further in the third pregnancy, according to a study by Dr. Darios Getahun of the Robert Wood Johnson Medical School in New Brunswick, N.J., and his colleagues.

The study, which was recently published (Obstet. Gynecol. 2006;107:771-8), was presented as a poster at the annual meeting of the Society for Gynecologic Investigation.

Although cesarean section has previously been reported as a risk factor for placenta previa, it has not been previously associated with abruption, Dr. Getahun said in an interview at the meeting. “Cesarean section causes scarring of the uterine wall, with the result that placation may not be optimal. That’s why it may be leading to abruption,” he explained.

The study included a cohort of women from the Missouri longitudinal linked live birth and fetal death data files. Singleton births were analyzed for 156,475 women whose first two consecutive births occurred within the study period of 1989-1997, and 31,102 women whose first three consecutive births occurred within that period.

Among 40,472 women whose first delivery was by cesarean section, the relative risk of placenta previa was 1.5, and that of placental abruption was 1.3 in the second pregnancy, compared with women whose first delivery was vaginal.

There was a dose response noted for the risk of placenta previa, but not for placental abruption risk. Therefore, when both the first and second deliveries were by cesarean section, the risk for placenta previa doubled in the third pregnancy, but the risk of placental abruption did not increase further, compared with women whose first two deliveries were vaginal.

The interval between pregnancies also was analyzed, and the study found that for cesarean deliveries, but not vaginal ones, an interval of less than 1 year was associated with a relative risk of 1.7 for placenta previa and 1.5 for placental abruption.

**Ultrasound’s Value for Diagnosing Abnormal Placenta Previa Confirmed**

**BY SHARON WORCESTER**

**Southeast Bureau**

MIAMI BEACH — Pelvic ultrasound is accurate for ruling out placenta accreta, and should be used as the primary screening tool in patients at high risk for this condition, Dr. Carri Warshak said at the annual meeting of the Society for Maternal-Fetal Medicine.

Magnetic resonance imaging also should be considered in the evaluation of all suspected cases, she added.

A historical cohort study of 413 patients with placenta previa who underwent ultrasound showed that this screening modality accurately predicted placenta accreta (which for the purposes of this study also included placenta increta and percreta) in 23 of the 32 women whose diagnosis was confirmed by pathologic examination, for a sensitivity of 0.78. Ultrasound ruled out the condition in 397 of 401 patients, for a specificity of 0.99; MRI ruled out the condition in the remaining 4 patients, said Dr. Warshak of the University of California, San Diego.

Of an additional 58 women who were referred for evaluation based on abnormal ultrasound findings, 39 were shown on pathologic examination to have placenta accreta. MRI accurately predicted the condition in 35 of the 39 patients for a sensitivity of 0.90, and ruled out the condition in the remaining 19 patients for a specificity of 1.

Information for the study was obtained from a perinatal database for patients screened by ultrasound between January 2000 and June 2005 and for patients screened by MRI between January 1992 and June 2005.

The findings are important because they confirm the accuracy of ultrasound and MRI for detecting a condition that requires accurate prenatal diagnosis for optimal management, she said.

Furthermore, the incidence of abnormal placenta previa has increased 10-fold over the past decade, largely due to the increased cesarean section rate. An estimat ed 9% of pregnancies are affected, she noted.

The findings confirm those from the three largest studies of ultrasound diagnosis for placenta accreta; pooled data from those studies and the current study show pelvic ultrasound has a sensitivity and 98% specific for diagnosis, she said.

MRI has been less studied, and results have been conflicting, but the findings of the current study suggest it may play an important role in optimizing diagnostic accuracy, particularly in patients with equivocal findings on ultrasound, she concluded.

**Drugs, Pregnancy, and Lactation**

**Gastrointestinal Agents: Part III**

**BY GERALD G. BRIGGS, PHARM.D.**

The final part of this series covers non-steroidal anti-inflammatory drugs (NSAIDs) and antacids. NSAIDs are commonly prescribed for treating pain and inflammation, and may be used during breastfeeding. However, the safety of these agents is controversial.

**NSAIDs**

NSAIDs are a group of drugs that work by inhibiting the production of prostaglandins, which are substances that cause inflammation, pain, and fever. They include aspirin, ibuprofen, naproxen, ketoprofen, and diclofenac.

**Antacids**

Antacids are used to neutralize stomach acid and relieve symptoms of heartburn and acid reflux. They include aluminum hydroxide, calcium carbonate, and magnesium hydroxide.

**H2 blockers**

H2 blockers are drugs that work by blocking the production of stomach acid. They include cimetidine, famotidine, and nizatidine.

**Proton pump inhibitors**

Proton pump inhibitors are drugs that work by inhibiting the production of stomach acid. They include omeprazole, lansoprazole, and pantoprazole.

**Other gastrointestinal agents**

Other gastrointestinal agents include antibiotics, antiemetics, antidiarrheals, and probiotics. These agents are used to treat specific gastrointestinal conditions, such as infections, diarrhea, and constipation.

**References**


**Images**

- Image of Teratology Information Specialists
- Image of Infliximab (Remicade)