

EBM Case Conference

植入性胎盤及胎盤滯留的處置

婦產科

R2 黃昱蒼

指導醫師: 陳鴻昇醫師 沈靜茹醫師

Clinical Scenario

- This 34 year-old female was pregnant 39+2 weeks with G4P1(NSD)A2.
- LMP: 2009/7/28 and EDC: 2010/5/4
- She had regular prenatal care at our OBS OPD.
- Tracing back to her history, during this pregnancy, no abnormal findings was found.

- Vaginal delivery was done in 99/04/29
- Male 3360g A/S 9'/10'
- Prolong labor in 3rd stage
- Placenta retained and placenta increta

Past History

- 1. Hypertension: denied
- 2. DM: denied
- 3. Asthma: denied
- 4. Heart disease: denied
- 5. Drug allergy: denied
- 6. Operation history: denied
- 7. Peptic ulcer: (+)

GYN/OBS history

- 1. Married
- 2. G4P1A2
- 3. LMP: 2009/7/28, EDC: 2010/5/4

Personal, Social and Occupational History

- Cigarette Smoking: denied
- Alcohol: denied
- Occupation history: 醫療
- Contact history: nil
- Travel history: nil
- 生育史: G4P1(NSD)A2

Review of Systems

- 《general》 fever : -
- 《skin》 jaundice : -
- 《head》 headache : -
- 《eyes》 pain : -
- 《ear》 pain : -
- 《nose》 epistaxis : -
- 《mouth/throat》 pain : -
- 《neck》 pain : -
- 《pulmonary》 dyspnea : -
- 《breast》 pain : -
- 《cardiovascular system》 chest pain : -
- 《gastrointestinal system》 vomiting : -
diarrhea : -
- 《neurological system》 fainting : -
blackouts : -
- 《musculoskeletal system》 muscle pain : -
- 《genitoreproductive system Female》 pregnancies : 39+2 weeks
- 《endocrine system》 excessive sweating : -
- 《hematologic system》 easy bruising or bleeding : -
- 《psychiatric disorder》 headache : -

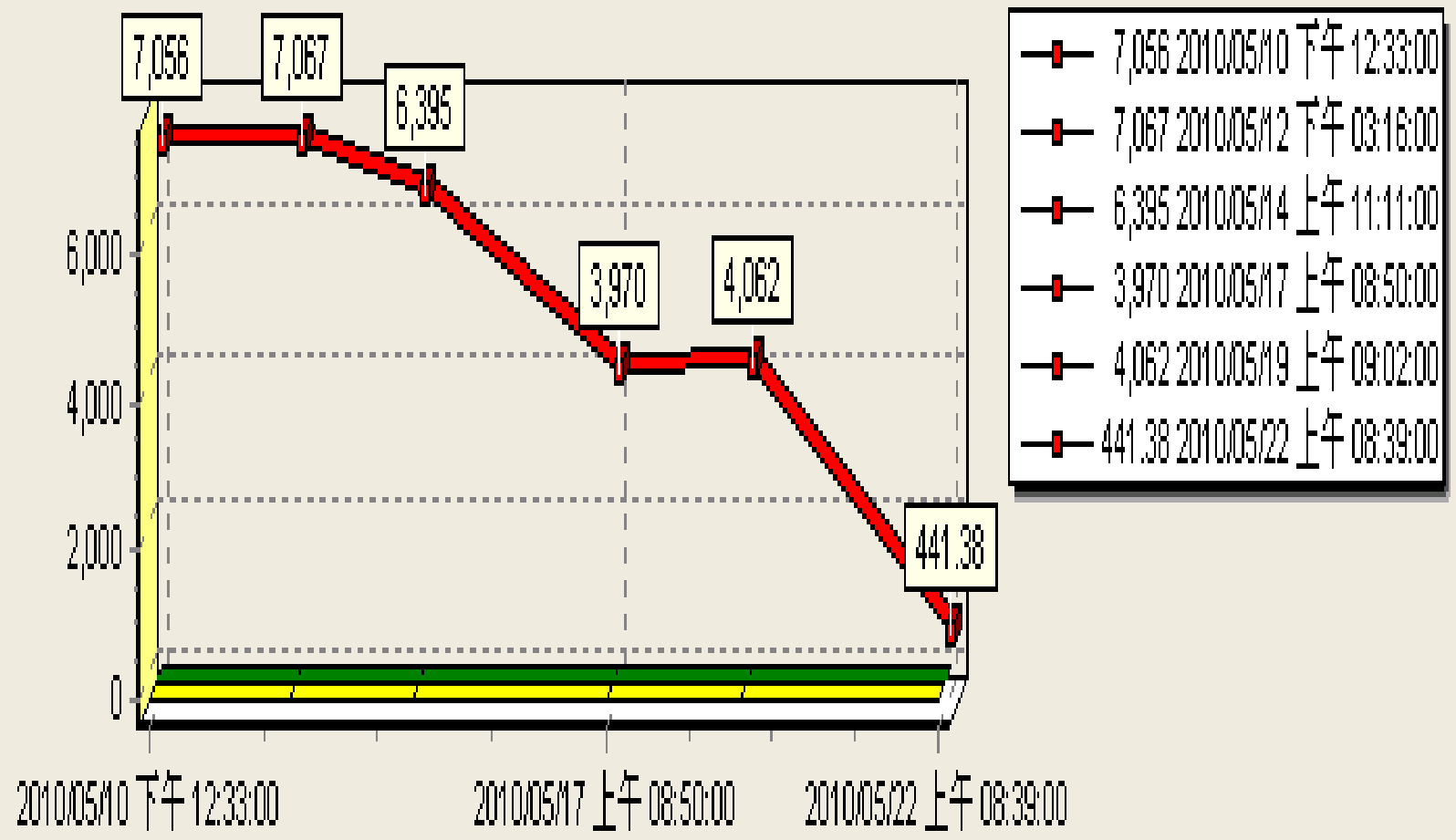
- **【Current Medicine】**

Denied

- **【Allergy History】**

Denied

- Apano (Mifepristone) #3 in 5/12
- Fever was showed form 5/7
- Nausea and vomiting was showed form 5/11
- MTX was arranged in 5/20
- Arrange hysterectomy in 5/21



Routine
Har-mid
Pwr 100 G
Cn -1
CB / M5
P4 / E2
SRI II 3



placenta increta

1 D 0.51cm
2 D 0.53cm













Search Results for "placenta accreta"

All search results | Prioritize adult topics | Prioritize pediatric topics | Prioritize patient topics

- **Diagnosis and management of placenta accreta**
- Clinical manifestations and diagnosis of placenta previa
- Management of placenta previa
- Repeat cesarean delivery
- Causes and treatment of postpartum hemorrhage
- Use of intrauterine balloon catheters for control of uterine hemorrhage
- Cesarean delivery: Postoperative issues
- Peripartum hysterectomy
- Retained products of conception
- Placental development and physiology
- Puerperal uterine inversion
- Pregnancy complications predicted by maternal serum analyte screening
- Abdominal pregnancy, cesarean scar pregnancy, and heterotopic pregnancy
- Intrauterine adhesions

Topic Outline

- INTRODUCTION
- INCIDENCE
- RISK FACTORS
- CLINICAL MANIFESTATIONS
- DIAGNOSIS
 - Ultrasonography
 - Color Doppler
 - Magnetic resonance imaging
 - Maternal serum alpha-fetoprotein
 - Histology
- COMPLICATIONS
- MANAGEMENT
 - Preoperative management
 - Balloon catheterization
 - Intraoperative management
 - Uterine conservation

Background information placenta accreta

- Placenta accreta : an abnormal placental implantation in which the anchoring placental villi attach to the myometrium, rather than being contained by decidual cells.
- More severe abnormalities of placental implantation include:
 - ✓ Placenta increta, in which the chorionic villi invade into the myometrium
 - ✓ Placenta percreta, in which the chorionic villi penetrate to or through the uterine serosa and may invade surrounding organs

RISK FACTORS

- The most important risk factor → previous uterine surgery
- The most common setting → placenta previa after a prior pregnancy delivered by cesarean

- The mechanism for the abnormal implantation → thin, poorly formed, or absent **decidua basalis** in the scarred area of the lower uterine segment.
- Does not resist deep penetration by trophoblast.

The risk of placenta accreta

- Unscarred uterus, 1 to 5 percent
- One previous cesarean birth, 11 to 25 percent
- Two previous cesarean births, 35 to 47 percent
- Three previous cesarean births, 40 percent
- Four or more previous cesarean births, 50 to 67 percent

- Maternal age greater than 35 years.
- Endometrial defects (Asherman syndrome)
- Submucous leiomyomata

Retained Placenta

- Retained placenta → a placenta that has not been expelled by 30 to 60 minutes after delivery of the baby.

Question

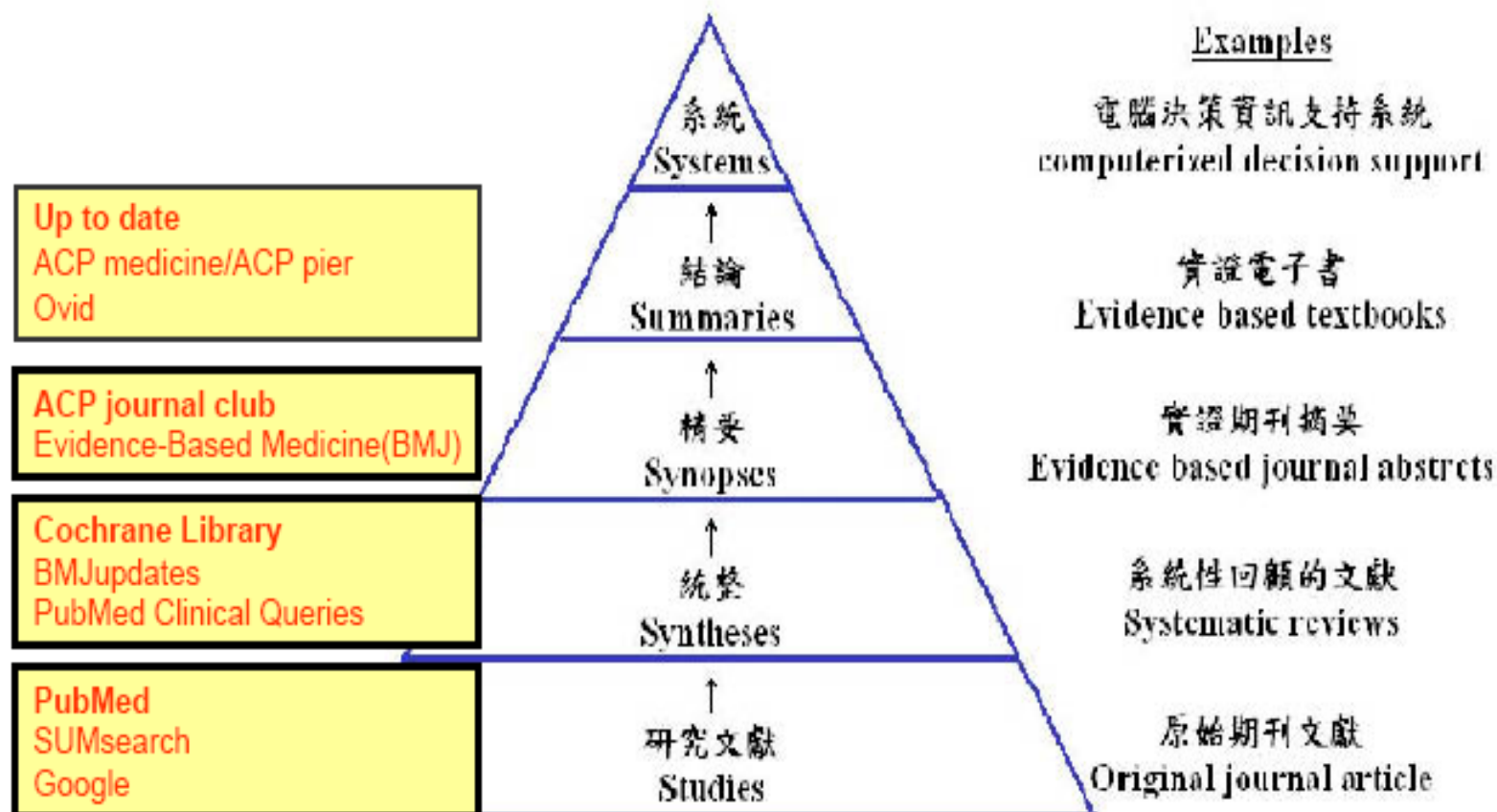
- 植入性胎盤及胎盤滯留無法手動剝離時是否需要子宮全切除？
- 當病人拒絕子宮全切除時 是否有其他治療方法？
- 其他治療方法的風險？

P I C O

Patient / Problem	Placenta increta with retained placenta
Intervention	Abdominal hysterectomy
Comparison	Conservative treatment
Outcome	Pateine's condition
Time	Post fetus delivered and try to manual remove placenta failure

- Key word : placenta accreta ,retained placenta ,conservative treatment

5S Model





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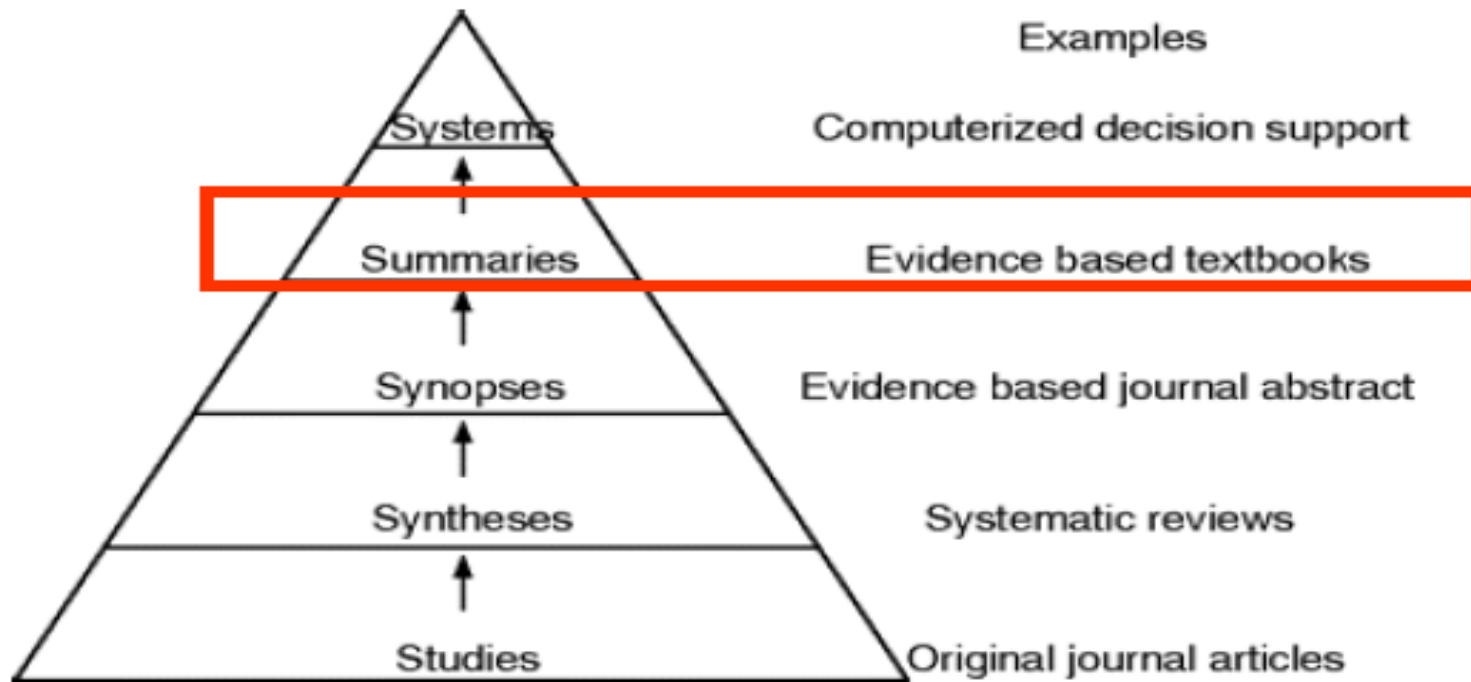
實證醫學

自學教材

Medline

- 1 [ACP Journal Club](#) (Journal) American College of Physicians, 2000- [UC](#) [WebOPAC](#)
- 2 [Bandolier](#) (Journal) Bandolier, 1994- [UC](#) [WebOPAC](#)
- 3 [Cochrane Library](#) [實證醫學資料庫](#) (Database) Wiley InterScience
- 4 [DynaMed](#) [臨床實證醫學資料庫](#) (Database) EBSCO
- 5 [EBMR: ACP Journal Club](#) [實證醫學資料庫](#) (Database) OVID, 1991-2003/10
- 6 [EBMR: Cochrane Central Register of Controlled Trials](#) [實證醫學資料庫](#) (Database) OVID, 1991-2003/Q4
- 7 [EBMR: Cochrane Database of Systematic Reviews](#) [實證醫學資料庫](#) (Database) OVID, 1991-2003/Q4
- 8 [EBMR: Database of Abstracts of Reviews of Effectiveness](#) [實證醫學資料庫](#) (Database) OVID, 1991-2003/Q4
- 9 [Evidence Based Dentistry](#) (Journal) Nature Publishing Group, 1998- [UC](#) [WebOPAC](#)
- 10 [Evidence-Based Medicine](#) (Journal) BMJ, 2000- [UC](#) [WebOPAC](#)
- 11 [Evidence-Based Mental Health](#) (Journal) BMJ, 限1年前 [UC](#) [WebOPAC](#)
- 12 [Evidence-Based Nursing](#) (Journal) BMJ, 限1年前 [UC](#) [WebOPAC](#)
- 13 [Journal of Evidence-Based Dental Practice](#) (Journal) SDOS, 2001- [UC](#) [WebOPAC](#)
- 14 [Lippincott's Nursing Procedures and Skills \(LNPS\)](#) (Database) Lippincott Williams & Wilkins

System- **uptodate**



Management of the third stage of labor

TOPIC OUTLINE

INTRODUCTION

THIRD STAGE PHYSIOLOGY

- Normal placental separation
- Duration
 - Influence of gestational age

MANAGEMENT

- Expectant versus active management
- Drugs used for active management
 - Oxytocin
 - Ergot alkaloids
 - Ergometrine-oxytocin
 - Prostaglandins
 - Oxytocin agonists

Retained placenta — Retained placenta is variously defined as a placenta that has not been expelled by 30 to 60 minutes after delivery of the baby [56]. It occurs in 1:100 to 1:200 deliveries and is an important cause of PPH. A retained or partially detached placenta interferes with normal uterine contraction and retraction, which leads to bleeding. For this reason, a retained placenta should be removed, usually manually, in an operating room, under anesthesia or with conscious sedation. Although there is a small risk of uterine trauma or introducing infection; these risks should be weighed against risks of bleeding and infection with prolonged expectant management.

Sonographic scanning is appropriate when the third stage of labor is prolonged and the etiology is uncertain. If the placenta is already detached, as demonstrated sonographically, further traction on the umbilical cord is warranted. If the placenta is partially or totally adherent, one may perform a manual removal with or without ultrasonic guidance, if bleeding is not brisk.

Manual removal — Manual removal is performed by using one hand to follow the path of the umbilical cord through the vagina, cervix, and lower uterine segment, while the other hand holds the uterine fundus. If the placenta is free in the lower segment, it is removed. If it has not separated, the fingers are used to gently develop a space between the placenta and uterus and shear off the placenta. The placenta and membranes are then grasped and removed manually. There are no data

Manual removal

- Manual removal is performed by using one hand to follow the path of the umbilical cord through the vagina, cervix, and lower uterine segment, while the other hand holds the uterine fundus.
- If the placenta is free in the lower segment, it is removed. If it has not separated, then the fingers are used to gently develop a space between the placenta and uterus and shear off the placenta.
- General anesthesia may be required to relax the uterus and because manual removal is painful.

Pharmacologic interventions

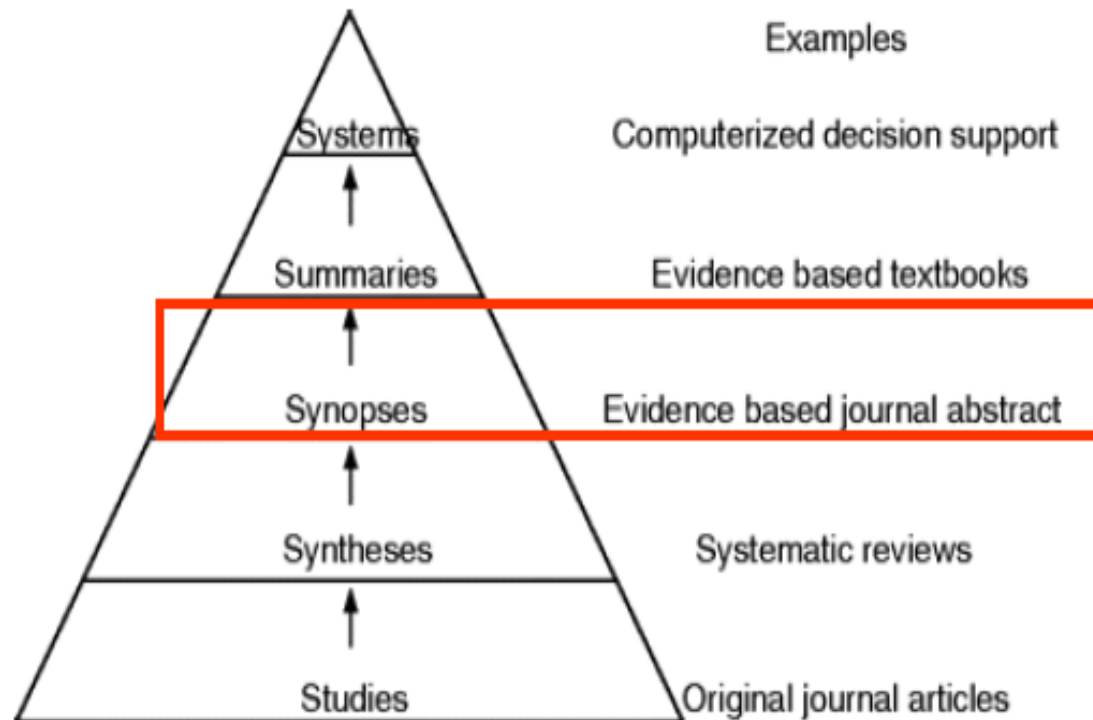
- Oxytocin : Administration of oxytocin oxytocin is a major component of standard management of the third stage of labor.
- Oxytocin is usually infused into a maternal vein .
- A solution of 10 to 20 units of oxytocin in 500 or 1000 mL 0.9 percent saline is commonly used.
- Other routes for administering oxytocin include umbilical vein injection (20 units) or intramuscular administration of up to 10 units .
- Intraumbilical injection of a solution of oxytocin in saline has been used as an alternative to manual removal in stable patients

- Prostaglandins — Although promising, more data on the safety and efficacy of prostaglandins in management of retained placenta are needed before this therapy can be recommended.

- Uterine artery embolization
- Methotrexate
- Mifepristone and Misoprostol

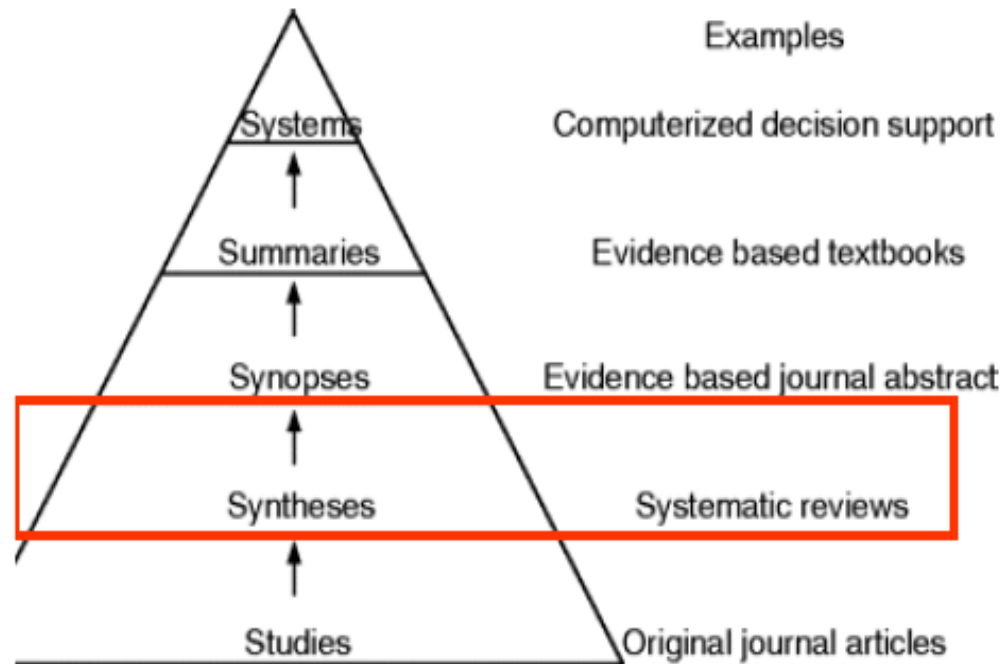
Synopses- **ACP journal club**

- 搜尋結果：none

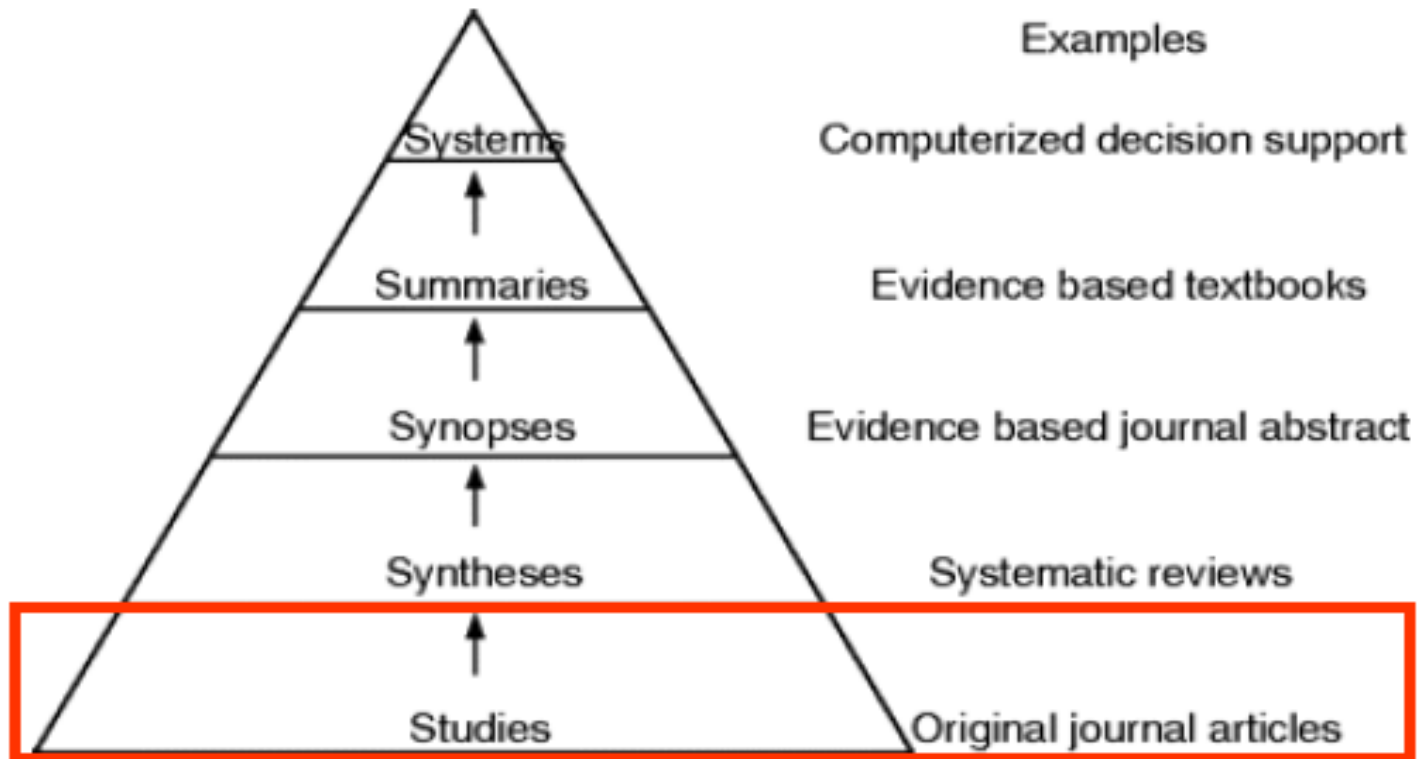


Syntheses- **Cochrane Library**

NONE



Studies- NCBI



[Maternal outcome after conservative treatment of placenta accreta.](#)

1. Sentilhes L, Ambroselli C, Kayem G, Provansal M, Fernandez H, Perrotin F, Winer N, Pierre F, Benachi A, Dreyfus M, Bauville E, Mahieu-Caputo D, Marpeau L, Descamps P, Goffinet F, Bretelle F.

Obstet Gynecol. 2010 Mar;115(3):526-34.

PMID: 20177283 [PubMed - indexed for MEDLINE]

[Related citations](#)

[Laparoscopic management of placenta percreta.](#)

2. Ochalski ME, Broach A, Lee T.

J Minim Invasive Gynecol. 2010 Jan-Feb;17(1):128-30.

PMID: 20129349 [PubMed - indexed for MEDLINE]

[Related citations](#)

[Transcatheter endovascular techniques for management of obstetrical and gynecologic emergencies.](#)

3. Salazar GM, Petrozza JC, Walker TG.

Tech Vasc Interv Radiol. 2009 Jun;12(2):139-47. Review.

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4. El-Hamamy E, Wright A, B-Lynch C.

J Obstet Gynaecol. 2009 May;29(4):278-83. Review.

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[Failure of conservative treatment for placenta increta.](#)

5. Liao CY, Ding DC.

Taiwan J Obstet Gynecol. 2009 Sep;48(3):302-4. No abstract available.

PMID: 19797026 [PubMed - indexed for MEDLINE]

[Related citations](#)



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Obstet Gynecol. 2010 Mar;115(3):526-34.

Maternal outcome after conservative treatment of placenta accreta.

Sentilhes L, Ambroselli C, Kayem G, Provansal M, Fernandez H, Perrotin F, Winer N, Pierre F, Benachi A, Dreyfus M, Bauville E, Mahieu-Caputo D, Marpeau L, Descamps P, Goffinet F, Bretelle F.

Department of Obstetrics and Gynecology, Angers University Hospital, Angers, France. loicsentilhes@hotmail.com

Abstract

OBJECTIVE: To estimate maternal outcome after conservative management of placenta accreta. **METHODS:** This retrospective multicenter study sought to include all women treated conservatively for placenta accreta in tertiary university hospital centers in France from 1993 to 2007. Conservative management was defined by the obstetrician's decision to leave the placenta in situ, partially or totally, with no attempt to remove it forcibly. The primary outcome was success of conservative treatment, defined by uterine preservation. The secondary outcome was a composite measure of severe maternal morbidity including sepsis, septic shock, peritonitis, uterine necrosis, fistula, injury to adjacent organs, acute pulmonary edema, acute renal failure, deep vein thrombophlebitis or pulmonary embolism, or death. **RESULTS:** Of the 40 university hospitals that agreed to participate in this study, 25 institutions had used conservative treatment at least once (range 1-46) and had treated a total of 167 women. Conservative treatment was successful for 131 of the women (78.4%, 95% confidence interval [CI] 71.4-84.4%); of the remaining 36 women, 18 had primary hysterectomy and 18 had delayed hysterectomy (10.8% each, 95% CI 6.5-16.5%). Severe

Related citations

- ▶ [Conservative treatment of placenta accreta. *J Gynecol Obstet Biol Reprod (Paris)*]
- ▶ Management of placenta accreta: morbid outcome. *[Eur J Obstet Gynecol Reprod Biol]*
- ▶ Optimal management strategies for placenta accreta. *[BMC Pregnancy Childbirth]*
- ▶ **Review** Placenta previa, placenta accreta, vasa previa. *[Obstet Gynecol]*
- ▶ **Review** Conservative management of placenta accreta with selective arterial embolization. *[Fertil Steril]*

» See reviews... |

Recent activity

Turn On



Obstetrics & Gynecology

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Maternal Outcome After Conservative Treatment of Placenta Accreta

Sentilhes, Loïc MD; Ambroselli, Clémence MD; Kayem, Gilles MD, PhD; Provansal, Magali MD; Fernandez, Hervé MD, PhD; Perrotin, Franck MD, PhD; Winer, Norbert MD, PhD; Pierre, Fabrice MD, PhD; Benachi, Alexandra MD, PhD; Dreyfus, Michel MD, PhD; Bauville, Estelle MD; Mathieu-Caruto, Dominique MD, PhD; Marneau, Loïc MD, PhD; Descamps, Philippine MD, PhD

Maternal Outcome After Conservative Treatment of Placenta Accreta

- **OBJECTIVE:** To estimate maternal outcome after conservative management of placenta accreta.

- **METHODS:** This retrospective multicenter study sought to include all women treated conservatively for placenta accreta in tertiary university hospital centers in France from 1993 to 2007.
- Conservative management was defined by the obstetrician's decision to leave the placenta in situ, partially or totally, with no attempt to remove it forcibly.

- **RESULTS:** Of the 40 university hospitals that agreed to participate in this study, 25 institutions had used conservative treatment at least once and had treated a total of 167 women.
- Conservative treatment was successful for 131 of the women (78.4%); of the remaining 36 women, 18 had primary hysterectomy and 18 had delayed hysterectomy.

- Severe maternal morbidity occurred in 10 cases .
- One woman died of myelosuppression and nephrotoxicity related to intraumbilical methotrexate administration.

- Spontaneous placental resorption occurred in 87 of 116 cases (75.0%), with a median delay from delivery of 13.5 weeks (range 4–60 weeks).

- **CONCLUSION:** Conservative treatment for placenta accreta can help women avoid hysterectomy and involves a low rate of severe maternal morbidity in centers with adequate equipment and resources.
- **LEVEL OF EVIDENCE: II**

- The three primary options for managing placenta accreta are the **cesarean hysterectomy**, and the **extirpative** and **conservative approaches**.

- The extirpative approach involves forced manual removal of the placenta in an attempt to obtain an empty uterus.
- It should be avoided because it is associated with higher rate of massive postpartum hemorrhage than either cesarean hysterectomy or the conservative approach.

- The cesarean hysterectomy is generally considered the standard treatment for placenta accreta.
- Conservative treatment may be applied for some women who want to be able to have more children.
- In this approach, the placenta adhering either partially or totally to the myometrium is left in situ, either after the failure of a prudent manual attempt at placental removal or no attempt at all.

- The conservative approach may also be safest in cases of **placenta percreta**, in particular when the bladder is involved.
- It may reduce severe maternal morbidity, such as ureteral injury, cystotomy, and urinary fistula, in comparison with cesarean hysterectomy.
- It nevertheless remains controversial for it may expose the patient to the risk of intraabdominal infection and especially major bleeding.

- At the obstetrician's discretion and depending on the circumstances and course.
- additional treatment could include uterotonic drugs (oxytocin or sulprostone or both).
- prophylactic antibiotic therapy.
- Methotrexate.
- preoperative ureteric stent placement.
- balloon catheter occlusion, and uterine devascularization
- pelvic arterial embolization, surgical vessel ligation (uterine or hypogastric artery ligation, stepwise uterine devascularization)
- uterine compression sutures (B-Lynch and Chosutures).

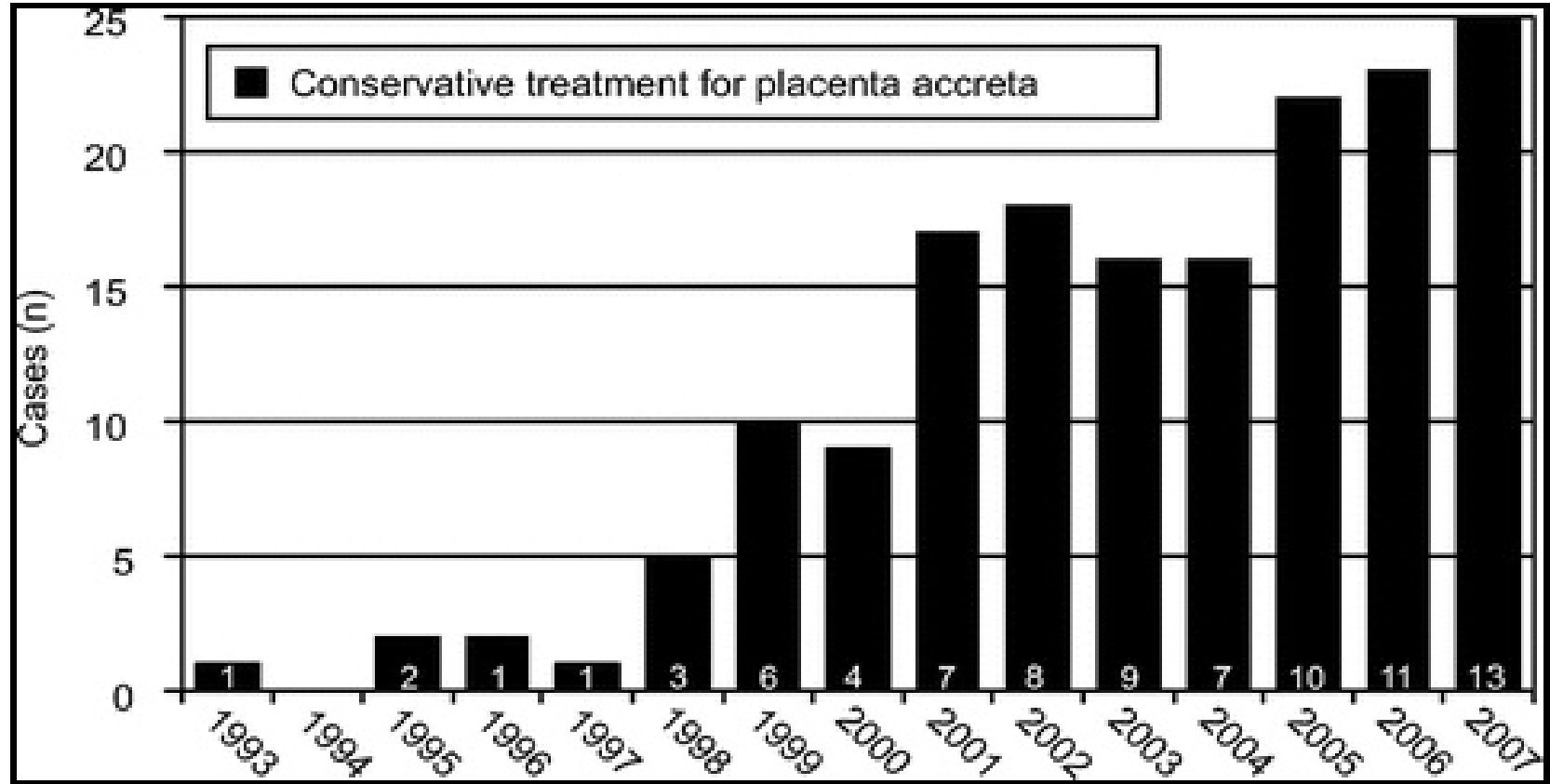


Table 1. Risk Factors for Placenta Accreta

Risk Factor	Placenta Accreta (n=167)
Previous abortion or miscarriage	66 (39.5)
One curettage	54 (32.3)
Two or more curettages	12 (7.2)
Previous uterine surgery	33 (19.8)
Myomectomy*	11 (6.6)
By hysteroscopy	6 (3.6)
By laparotomy	5 (3.0)
Polypectomy*	4 (2.4)
Endometrectomy*	1 (0.6)
Synechia*	5 (3.0)
Metroplasty*	5 (3.0)
Previous cesarean delivery	90 (53.8)
One	48 (28.7)
Two or more	42 (25.1)
Previous accreta	6 (3.6)
Previous endometritis	3 (1.8)
Age 35 y or older	64 (38.3)
Placenta previa	87 (52.1)
At least one risk factor	160 (95.8)

Data are n (%).

* The total number of previous uterine surgical procedures exceeds the number of patients because some patients had more than one uterine surgery.

Table 2. Patients' Demographic and Obstetric Characteristics

Characteristic	Placenta Accreta (n=167)
Age (y)	33.15±4.78
Geographic origin	
European	122 (73.0)
Sub-Saharan Africa	23 (13.8)
North Africa	18 (10.8)
Asia	4 (2.4)
Parity	1 (0–8)
Number of pregnancies	3 (1–12)
Twin pregnancy	6 (3.6)
Pregnancy termination	5 (3.0)
Gestational age at delivery (wk)	34.5±4.75
Less than 24	8 (4.8)
24–31	34 (20.4)
32–36	39 (23.3)
37 or more	86 (51.5)
Mode of delivery	
Planned cesarean	113 (67.6)
Emergency cesarean due to hemorrhage	27 (23.9)
Cesarean during labor	26 (15.6)
Vaginal	28 (16.8)

Data are mean±standard deviation, n (%), or median (range).

Table 3. Peripartum Management and Modalities of Conservative Treatment for Patients With Placenta Accreta, Including Placenta Percreta

Characteristic	Placenta Accreta, Including Percreta (n=167)
Hysterotomy (n=139)	
Fundal	71 (51.1)
Low transverse	68 (48.9)
Placenta left in situ	167 (100)
Partially	99 (59.3)
Entirely	68 (40.7)
Preoperative ureteric stent placement	6 (3.6)
Uterotonic administration	167 (100)
Primary postpartum hemorrhage	86 (51.5)
No additional uterine devascularization procedure	58 (34.7)
Additional uterine devascularization procedure	109 (65.3)
Pelvic arterial embolization*	62 (37.1)
Vessel ligation*	45 (26.9)
Stepwise uterine devascularization	15 (9.0)
Hypogastric artery ligation	23 (13.8)
Stepwise uterine devascularization and hypogastric artery ligation	7 (4.2)
Uterine compression suture*	16 (9.6)
Balloon catheter occlusion	0
Methotrexate administration	21 (12.6)

Data are n (%).

*The total number of additional uterine devascularization procedures exceeds the number of patients because some patients had more than one such procedure.

Table 4. Maternal Morbidity After Conservative Treatment for Placenta Accreta, Including Placenta Percreta

Characteristic	Placenta Accreta, Including Percreta (n=167)
Primary hysterectomy	18 (10.8)
Cause of primary hysterectomy	
Primary postpartum hemorrhage	18/18 (100)
Postpartum prophylactic antibiotic therapy more than 5 d	54 (32.3)
Transfusion patients	70 (41.9)
Units of packed RBCs transfused more than 5	25 (15.0)
Transfer to intensive care unit	43 (25.7)
Duration of stay in intensive care unit (d)	2.36 ± 1.93
Acute pulmonary edema	1 (0.6)
Acute renal failure	1 (0.6)
Adjacent organ injury	1 (0.6)
Septic shock	1 (0.6)
Sepsis*	7 (4.2)
Infection	47 (28.1)
Endometritis	15 (9.0)
Wound infection	8 (4.7)
Peritonitis	2 (1.2)
Pyelonephritis	2 (1.2)
Vesicouterine fistula	1 (0.6)
Uterine necrosis	2 (1.2)
Isolated postpartum fever higher than 38.5°C for 24 h	17 (10.2)

Deep vein thrombophlebitis or pulmonary embolism	3 (1.8)
Secondary postpartum hemorrhage stopped after	18 (10.8)
Uterotonics	2/18 (11.1)
Manual exploration of the uterus	2/18 (11.1)
Hysteroscopy and curettage	2/18 (11.1)
Pelvic arterial embolization	4/18 (22.2)
Delayed hysterectomy	8/18 (44.5)
Delayed hysterectomy	18 (10.8)
Median interval from delivery to delayed hysterectomy (d)	22 (9–45)
Cause of delayed hysterectomy	
Secondary postpartum hemorrhage	8/18 (44.4)
Sepsis	2/18 (11.1)
Secondary postpartum hemorrhage and sepsis	3/18 (16.7)
Vesicouterine fistula	1/18 (5.6)
Uterine necrosis and sepsis [†]	2/18 (11.1)
Arteriovenous malformation	1/18 (5.6)
Maternal request	1/18 (5.6)
Death	1 (0.6)
Success of conservative treatment	131 (78.4)
Severe maternal morbidity	10 (6.0)

DISCUSSION

- Follow-up information about the subsequent outcome of the placenta was available for 116 of the 131 (88.5%) women with successful conservative treatment.
- In 75% (95%) of the cases (87/116), spontaneous placental resorption was observed on follow-up examination, at a median of 13.5 weeks (range 4–60 weeks) after delivery.

- Methotrexate has been proposed as adjuvant treatment to improve the success rate of conservative treatment.
- Nevertheless, no standard dosing regimen exists, and the mode of administration (in situ, intramuscular, or intraumbilical) varies widely according to author.
- Methotrexate-related pancytopenia and nephrotoxicity are possible adverse effects .

- Some practitioners performed additional **uterine devascularization procedures** in absence of any hemorrhage to improve the maternal outcome and decrease the risk of secondary postpartum hemorrhage.
- Several authors advocate the preoperative placement of **ureteric stents** or **occlusive balloon catheters** or both in the internal iliac arteries to reduce, respectively, the rate of ureteric injury and the volume of blood loss.

對找到的文章進行
critical appraisal

- 證據等級 :2A

AAMPICOT model

- AAMPICOT
 - Answer: Yes
 - Authors: *the Departments of Obstetrics & Gynecology*
- Method: meta-analysis and decision analysis
- Population:
 - Representative: Yes
 - Relative: Yes
 - Random: Yes
 - Blind: No all

- Intervention: Yes
- Comparison: Yes
- Outcome: conservative treatment can improved placenta accreta and retained placenta outcome
- Time:
 - 測量時間點是否合宜? Yes
 - 追蹤時間是否夠長? yes
 - 文獻發表時間? March 2010

使用work sheet嚴格評讀

Should these valid, potentially important results of a critical appraisal about a harmful treatment change the treatment of your patient?	
Can the study results be extrapolated to your patient?	我們的病人符合實驗中病人的條件。
What are your patient's preferences, concerns and expectations from this treatment?(病人的期望、喜好、關心)	Patient want to try conservative treatment to avoid hysteteretomy
What alternative treatments are available?	cesarean hysterectomy, conservative approaches

Thank for your attention