胎盘早剥86例的临床表征与病因分析

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摘要 目的:分析胎盘早剥漏诊、误诊原因,提高早期确诊率,降低母儿并发症。方法:回顾性分析我院10年内胎盘早剥患者的临床资料,分析比较胎盘早剥漏诊与误诊原因。结果:过去十年内我院共检测出胎盘早剥86例,发生率为0.46%,该类孕妇临床表现主要为腰腹胀或腹痛、阴道流血、血性羊水。其中,急诊入院患者占(61.6%),有明确诱因39例,占45.3%,且以妊娠期高血压疾病、胎膜早破、外伤性因素为主。B超检出率62.8%。轻型胎盘早剥45例(52.3%),重型胎盘早剥41例(47.7%),出现症状到就诊及处理时间重型胎盘早剥均长于轻型胎盘组P<0.01。剖宫产分娩60例(69.8%),阴道分娩26例(30.2%)。结论:临床发病到临床处理时间是影响胎盘早剥轻重程度的重要因素;胎盘早剥临床表现易与早产、先兆临产或胎儿窘迫等混淆;后壁胎盘发生胎盘早剥时,超声容易漏诊。

关键词:胎盘早剥;诊断;临床表现

中图分类号:R714.4 **文献标识码**:A **文章编号**:1673-6273(2012)25-4907-03

Clinical Manifestation and Cause Analysis on 86 Cases of Placental Abruption

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ABSTRACT Objective: To analyze the cause for missed diagnosis and misdiagnosis on placental abruption and to enhance the accuracy of early diagnosis and decrease the complication of mother and fetus. Methods: The clinical data of 86 placental abruption cases from October 2001 to September 2011 in our hospital were retrospectively reviewed. Compare and analyze the missed diagnosis and misdiagnosis on placental abruption. Results: During October 2001 and September 2011, the incidence of placental abruption was 0.46%, in which emergence patients accounted for 61.6%, and 39 cases had the predisposing factors(45.3%), mainly including hypertensive disorders complicating pregnancy, premature rupture of fetal membranes, and traumatic factors. The main clinical manifestations included lower abdormen pain, vaginal hemorrhage, bloody amniotic fluid. The detection rate of ultrasonography was 62.8%. 45 cases had mild placental abruption(52.3%), and 41 cases had severe placental abruption(47.7%). The interval from the onset of the initial clinical sign to treatment for patients with severe placental abruption was longer than those with mild placental abruption (P<0.01). 60 cases had cesarean section (69.8%), and 26 cases were vaginal delivery(30.2%). Conclusions: The interval from the onset of the initial clinical sign to treatment is closely associated with the severity of placental abruption. The clinical manifestations of placental abruption are easily confused with premature delivery, threatened labor or fetal distress. Missed diagosis by ultrasonography in placental abruption would occur when the placenta is located on posterior.

Key words: Placental abruption; Diagnosis; Clinical manifestation

Chinese Library Classification: R714.4 Document code: A

Article ID: 1673-6273(2012)25-4907-03

前言

胎盘早剥是指孕20周后或分娩期,正常位置的胎盘在胎儿娩出前,部分或全部从子宫壁剥离,发生率国内外报道相似,约为4‰~21‰[1-3],围产儿死亡率可达20%~60%[4,5]。胎盘早剥发病时间短、进展迅速,难以预料,随时可危及母儿生命,因而已成为产科高致死的病症之一[6-8]。本文回顾性分析了我院近10年来诊断出的86例胎盘早剥的临床资料及结局,探讨胎盘早剥的诊断、处理及漏诊、误诊的原因,为胎盘早剥的早期诊断、及时处理,改善母儿预后方面提供临床参考。

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(收稿日期:2012-04-15 接受日期:2012-05-05)

1 资料与方法

1.1 基本资料

2001年10月1日至2011年9月30日我院分娩产妇数共18614例,其中胎盘早剥86例,发病率为0.46%。患者年龄范围19~38岁,平均年龄27岁。其中初产妇67例(77.9%),经产妇19例(22.1%)。本地户口71例(82.6%),外地户口15例(17.4%)。发病孕周≤28周3例(3.5%),28~37周21例(24.4%),≥37周62例(72.1%)。胎盘早剥分型及子宫胎盘卒中的诊断标准,依据曹泽毅主编的《中华妇产科学》(第2版)。

1.2 统计方法

本研究数据资料收集与处理采用 SPSS13.0 统计软件完成，计量资料采用 t 检验，计数资料采用 x^2 检验，以 P＜0.05 表示差异有统计学意义。

2 结果

2.1 诱因与入院时间及方式

86 例胎盘早剥患者中有明确诱因的 39 例，占 45.3%。其中妊娠高血压疾病 20 例、外伤性因素 4 例、羊水过多 1 例、水囊引产 1 例、羊膜腔穿刺 1 例、脐带因素 2 例、胎膜早破 10 例。不明原因 47 例，占 54.7%。

86 例胎盘早剥患者中 53 例入院时间在 18 时至次日 8 时，属于急诊入院者占（61.6%），首诊负责医师为一线值班医师。步行入院 62 例（72.1%），急诊救护车接送入院 24 例（27.9%），其中基层乡镇医院转诊 20 例。

2.2 临床表现

86 例胎盘早剥患者中，确诊组 54 例（62.8%）。常见的临床表现有腹痛、阴道流血、血性羊水、腰酸、腹背痛、胎心改变。严重时可出现面色苍白、冷汗、四肢冰凉、脉搏细弱、血压下降等休克表现，甚至胎心消失，胎死宫内。漏诊、误诊组 32 例（37.2%），主要表现为自发性早产、先兆临产、胎心异常。胎盘早剥常合并多种临床表现情况（表 1）。

表 1 86 例胎盘早剥临床表现 n(%)

Table 1 Clinical manifestation of the 86 cases of placenta abruption

临床表现 Clinical manifestation	组别 Groups	
	确诊组 Diagnosed (54 cases)	漏诊、误诊组 Missed or misdiagnosed (32 cases)
腰痛 / 腹痛 Lumbago/bellyache	23	10
阴道流血 Vaginal bleeding	18	8
血性羊水 Bloody amniotic fluid	3	0
自发早产 Spontaneous early preterm delivery	10	5
胎心异常 Abnormal fetal heart rate	5	2
子宫压痛 Uterine pressure	4	0
子宫张力过高 High uterine tension	15	2
休克症状 Shock	3	0

2.3 超声检查与分型

分娩前超声影像阳性 54 例，检出率 62.8%。胎盘早剥主要表现为胎盘与子宫壁之间见边缘粗糙、形态不规则的液性暗区，其内可见散在斑点状高回声、不均质低回声或杂乱回声，有时仅表现为胎盘异常增厚，呈不均质增强回声。其余 32 例无胎盘早剥超声特征性改变。86 例患者中重型胎盘早剥 41 例（47.7%），轻型胎盘早剥 45 例（52.3%）。

2.4 分娩方式及母婴结局

86 例患者中：剖宫产 60 例（69.8%），平产分娩 26 例（30.2%）。50 例术前考虑胎盘早剥行剖宫产术，其中剖宫取死胎 2 例，10 例并发子宫胎盘卒中。其中 1 例院外发现死胎，产妇失血性休克，多器官功能衰竭、导致产妇死亡。1 例死胎为入院后发生，重度子痫前期患者，出现腹痛、阴道流血表现，胎心监护出现频繁晚期减速，行急诊剖宫产娩出一死胎。

母婴结局 新生儿窒息 25 例，重度窒息 8 例，其中新生儿死亡 1 例。产妇死亡 1 例。重度胎盘早剥组首发症状至处理时限长于轻度胎盘早剥组，两者比较差异有统计学意义，P＜0.01（表 2）。重型胎盘早剥新生儿窒息率高于轻型胎盘早剥，两者比较差异有统计学意义，P＜0.01（表 3）。

表 2 86 例胎盘早剥患者的首发症状至被处理时间

Table 2 The interval from the onset of the initial clinical sign to treatment of 86 cases of placenta abruption

分型 Type	例数 Cases	出现症状到处理时间（h）The interval from the onset of the initial clinical sign to treatment
轻型 Mild	45	6.10± 2.07
重型 Severe	41	21.90± 7.51

注 轻型组与重型组比较 P＜0.01。

Note: Mild group was compared with the severe group, P＜0.01.

表 3 86 例胎盘早剥患者的妊娠结局

Table 3 Results of 86 cases of placenta abruption

妊娠结局 Pregnancy results	分型 Type		x^2 值	P 值
	轻型 Mild (45 cases)	重型 Severe (41cases)		
宫内死胎 Stillborn foetus in utero	0	2	0.61	0.43
新生儿窒息 Asphyxia neonatorum	6	19	11.34	0.001

2.5 诊断情况

根据入院时临床表现、体征及典型的B超声像即作出诊断54例，占62.8%。其余32例均为术中及产后发现，漏诊、误诊率37.2%。漏诊、误诊的病例均临床症状不典型，无明显阳性体征，B超声像无特征性改变。漏诊、误诊的病例中剖宫产分娩12例，平产分娩20例。剖宫产的病例均因其他手术指征行剖宫产术（胎儿窘迫2例、疤痕子宫临产3例、胎位异常1例、胎膜早破2例、早产1例、妊娠高血压疾病1例）。平产分娩检查胎盘母体面有凝血块及压迹20例。

3 讨论

胎盘早剥是妊娠期出血，产前出血的主要原因之一，是妊娠期的严重并发症，往往起病急，发展快，若处理不当，可威胁母儿生命[9]。早期诊断及处理是改善母儿预后的关键，漏诊、误诊可导致母儿严重的并发症、甚至母儿死亡。

胎盘早剥的漏诊、误诊原因分析 本组资料中，未能及早发现胎盘早剥的主要原因有[11-15]：①不典型的临床症状常会影响胎盘早剥的早期诊断。典型的胎盘早剥常有腹痛、阴道流血、血性羊水等，但是临床表现个体差异显著。本文12例漏诊的剖宫产分娩病例中，因胎儿窘迫、胎膜早破、疤痕子宫临产等原因行剖宫产术，术中常规检查胎盘发现胎盘早剥。轻型胎盘早剥，阴道流血少，无明显腹痛和子宫强硬。仅表现为少量阴道出血伴轻微腹痛，极易与先兆早产、先兆临产混淆。先兆早产往往保胎治疗症状无改善。对于无原因的早产，尤其治疗一段时间无明显效果时，应想到胎盘早剥的可能。②胎盘位置的影响。前壁胎盘发生胎盘早剥时，胎盘后积血的刺激，患者可表现为明显的腹痛。而位于后壁的胎盘早剥时，腹部体征常不典型，仅表现为轻微的腰痛等，容易漏诊。且后壁胎盘因超声远场分辨力差，不易诊断，容易漏诊。因此，对于后壁胎盘孕妇分娩时，如出现较强宫缩，子宫张力高，产程中应严密监测患者的体征，密切监测胎心改变，要高度警惕胎盘早剥的可能。本文漏诊、误诊的32例病例中，其胎盘附着位置有15例（占46.9%）B超提示位于后壁、后壁及侧壁，说明里胎盘附着位置与胎盘早剥的漏诊、误诊有一定的相关性。③B超检查的影响。超声检查是术前诊断胎盘早剥的重要手段。胎盘早剥时，如果以显性出血为主，血液外流或底蜕膜出血量少，B超图像可无特征性表现；如果以隐性出血为主，积血多时在胎盘后形成血肿，则B超可显示胎盘基底部与子宫壁之间出现单个或多个液暗区，胎盘异常增厚等。罗红等报道四川大学华西第二医院产前超声诊断胎盘早剥诊断符合率61.4%，漏诊率33.3%，误诊率5.3%[16]。本资料中，分娩前胎盘早剥超声声像检出率为62.8%，因此超声报告阴性并不能完全排除胎盘早剥，对可疑患者因动态B超监测了解胎盘变化情况。同时B超仪器的分辨率及操作者的经验也是影响诊断的重要因素。④首诊医师的资历与经验。本文86例病例中53例入院时间在18时至次日8时，属于急诊入院，占（61.6%），首诊负责医师为一线值班医师。漏诊、误诊病例有32例，占漏诊、误诊病例的60.4%。可见胎盘早剥的诊断与首诊年轻医师对胎盘早剥的临床征象认识不足及临床经验缺乏有关。胎盘早剥的早期诊断：①重视胎盘早剥的高危因素对发病的影响。胎盘早剥的病因目前尚不十分明确，但胎盘早剥的发生确实与一些风险因素有关，如母亲高龄产妇和产次增加、吸烟、吸毒、多胎妊娠、重度子痫前期、慢性高血压合并子痫、胎膜早破、羊水过多、脐带绕颈或过短、外伤因素，既往有胎盘早剥病史。加强对胎盘早剥发生的高危因素的认识，有利于早期诊断胎盘早剥。同时孕产妇的保健因素也对胎盘早剥的早期诊断有一定影响。本文86例病例中，外地户口15例（占17.4%）。对于我们这样流动人口不是特别多的城市，外地户口的发生概率是比较高的。因为外地户口孕产妇，由于生活习惯、经济因素等原因，接受正规产前检查次数均少于本地孕妇，对围产期的保健知识了解较少，容易发生胎盘早剥。因此，应该加强高危孕产妇的管理，加强围产期的检查次数及覆盖面积。在围产检查中应加强宣教，指导性生活，避免外伤，同时对孕妇的病史。孕产史、药物滥用病史，既往胎盘早剥病史应充分关注。②辅助检查对胎盘早剥早期诊断的价值B超检查是胎盘早剥的常规辅助检查手段。在前文已述，B超对胎盘早剥的早期诊断有一定的漏诊、误诊率[17]。当临床高度怀疑胎盘早剥，但B超声像无特征性改变时，可考虑使用其他辅助影像检查手段，包括核磁共振、CT检查。实验室血常规及凝血功能检查有重要参考意义。有可疑血红蛋白下降，凝血酶原时间、纤维蛋白原改变时间应考虑胎盘早剥的可能。还有资料显示，孕妇血清甲胎蛋白增高与胎盘早剥发生明显相关。

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