Pathway for the management of placenta accrete

Key Document code:	WAHT-TP- 094	
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Approved by:	Maternity Governance Meeting	
Date of Approval:	15th November 2019	
Updated	3rd September 2020	
Date of review:	15th November 2022	

Key Amendments

Date	Amendments	Approved by
Oct 2020	Document Approved	Maternity Governance

Definition:

Placenta accreta is an obstetric complication whereby the placenta adheres to or invades the myometrium. There is an increased incidence in women where the placenta is sited over a prior caesarean section scar. Accreta is also more likely in patients with multiple LSCS, prior myomectomy or a previous manual removal of placenta.

A morbidly adherent placenta carries an increased risk of maternal and fetal mortality secondary to massive obstetric haemorrhage at the time of delivery.

Table 1: Risk of accreta with increasing numbers of LSCS

Number previous LSCS	Chance of accreta	Chance of accreta if placenta praevia
0	0.24%	3%
1	0.31%	11%
2	0.57%	40%
3	2.13%	61%
4	2.33%	67%
5	6.74%	67%

Antenatal care:

Placental site should be confirmed at the 20 week anomaly scan.

If this scan demonstrates a low or anterior placenta with a prior history of LSCS, a repeat scan should be performed at 32 weeks to identify the distance from the lower edge of the placenta to the cervical os and to determine whether or not the placenta overlies the old scar.

Report any signs of placental invasion and if noted request specialist colour-flow Doppler ultrasound scan as a first line. These are performed by Dr Santhosh Vijay and should be requested by the patient's named Obstetric Consultant directly. An MRI may also be required at the discretion of the radiology team. MRI should not be performed in preference to or absence of a specialist ultrasound. Ideally, specialist ultrasound should be performed with a full bladder to observe potential bladder invasion.

Ensure that the woman is fully counselled about the increased risk of major haemorrhage, urological injury, need for a blood transfusion along with the increased risk of hysterectomy.

Optimise the haemoglobin from 32 weeks through either oral or intravenous iron supplementation depending on the level of anaemia present.

The patient should be referred for review with the Anaesthetic team. This should be done as soon as the placenta has been confirmed to be abnormally invasive and ideally before the MDT discussion.

Advise women to avoid sexual intercourse.

Women should be urgently reviewed in Triage if they report any vaginal bleeding, contractions, pain or supra-pubic period-like pain.

Ensure that they have a means to attend hospital as an urgent case. If they do not have support, offer in patient surveillance.

A multidisciplinary review should take place by 34 weeks to include the Consultant Obstetrician and Consultant Anaesthetist in charge of care as a minimum. Aim to include Consultant Radiologist and Haematologist where possible. This meeting should ensure that there is a plan for delivery, be that as an emergency or elective case.

A single course of steroids is recommended between 34 and 35+6 weeks for pregnant women with a low-lying placenta or placenta praevia and is appropriate prior to 34 weeks in women at higher risk of preterm birth.

Elective delivery

In the absence of risk factors for preterm delivery in women with placenta accreta spectrum, planned delivery at 35 to 36+6 weeks provides the best balance between fetal maturity and the risk of unscheduled delivery.

Plan for delivery in Main theatres. No other elective sections to be scheduled in the session and careful consideration should be given to the number/complexity of cases booked for the afternoon session. Contact the Duty Theatre Co-ordinator in Main theatres to arrange this (John Bond, Christopher Webb or Mark Butwell at time of updating this guideline)

Cross match 6 units packed cells.

Ensure cell-salvage is in place for the procedure.

Organise neonatal support.

A scan on the morning of surgery by the operating surgeon may assist with mapping of the placental site.

Consider the need for interventional radiology to insert balloons into the uterine artery as a prophylactic haemostatic measure in the instance of postpartum haemorrhage. Employ this urgently if pharmacological measures fail to control haemorrhage following delivery.

Ensure that there is HDU/ITU provision in case of need post-delivery.

There is currently insufficient data to recommend the routine use of ureteric stents in placenta accreta spectrum. The use of stents may have a role when the urinary bladder is invaded by placental tissue. Involve the urologist in the MDT discussion to plan this further.

Emergency Delivery

Once the diagnosis of placenta accreta spectrum is made, a contingency plan for emergency delivery should be developed in partnership with the woman.

Should a patient present with antepartum haemorrhage and the decision is taken for emergency delivery consider transfer to Main Theatre for delivery if it is safe to do so and staffing allows. However, it this is not possible the patient should be managed in Obstetric Theatre with appropriate scrub staff. In both instances provisions should be made for hysterectomy.

The major obstetric haemorrhage protocol should be activated.

Where feasible, institute cell salvage.

Inform neonatal team and request attendance.

Inform HDU/ITU.

There is no role for interventional radiology in extremis.

Consent

Consent must be taken by a Consultant Obstetrician and should include a discussion about blood transfusion, hysterectomy, admission to HDU/ITU in addition to routine general risks associated with all caesareans. This should be obtained well in advance of the anticipated surgery during antenatal clinic, ideally following the MDT, to ensure their genuine informed consent.

Procedure

Consultant Anaesthetist should decide on and administer the appropriate anaesthetic.

The caesarean should be performed by a Consultant Obstetrician.

Ensure that the interventional radiology compatible table is orientated the correct way round so that c-arm can pass underneath.

Ensure that an underbody warming blanket and a Belmont rapid infuser is available.

Only give tranexamic acid after delivery of the baby as it crosses the placenta.

Where interventional radiology has been used, cover the balloon catheter insertion site with blue gauze and op site dressing. This will allow the obstetrician to use standard c section drape. It is also advisable to suture balloon catheters in place as they have potential to get dislodged during surgery.

Consider vertical skin and/or uterine incisions when the fetus is in a transverse lie to avoid the placenta, particularly below 28 weeks of gestation.

If the placenta is transected during the uterine incision, immediately clamp the umbilical cord after fetal delivery to avoid excessive fetal blood loss.

Providing the placenta separates in the normal way, continue the procedure as routine.

Should the placenta remain adherent 1 of 2 options should be pursued:

1. Undertake immediate hysterectomy
2. Leave the placenta in situ and manage conservatively in the postnatal period

Do not attempt to remove a firmly adherent placenta piecemeal.

Caesarean section hysterectomy with the placenta left in situ is preferable to attempting to separate it from the uterine wall. ***There is limited evidence to support uterus preserving surgery in placenta percreta*** and women should be informed of the high risk of peripartum and secondary complications, including the need for secondary hysterectomy

When the extent of the placenta accreta is limited in depth and surface area, and the entire placental implantation area is accessible and visualised (i.e. completely anterior, fundal or posterior without deep pelvic invasion), uterus preserving surgery may be appropriate, including partial myometrial resection.

Uterus preserving surgical techniques should only be attempted by surgeons working in teams with appropriate expertise to manage such cases and after appropriate counselling regarding risks and with informed consent.

If the decision is taken to leave the placenta in situ, allow the placenta to drain itself and then tie off and divide the cord as close to the cord insertion as possible.

In the event of haemorrhage, if pharmacological measures fail to control the bleeding initiate intrauterine tamponade and/or surgical haemostatic techniques sooner rather than later, along with interventional radiology (see paragraph above).

Close the uterus in the usual way.

Postoperative Care

Women should be cared for at HDU level as a minimum, to include hourly observations, urine output and fluid balance.

Regularly assess the uterine fundus, observing carefully for signs of haemorrhage. Remember that if a placenta is left in situ and is covering the cervical os, there may be concealed bleeding within the uterine cavity.

Check FBC 6 hours post-op as a minimum.

Management when the placenta is left in situ

A retained placenta carries an additional risk of sepsis and secondary PPH. The patient must understand the importance of twice weekly hospital review, clinical assessment, blood tests to include FBS and CRP with possible additional imaging.

Patients should be prescribed antibiotic prophylaxis for 5 days following delivery. It is also important that patients recognise the risk of delayed infection and the need to report signs and symptoms in a timely way.

Placental reabsorption should be monitored on a weekly basis with serum beta-HCG levels and ultrasound.

Interval hysterectomy can also be considered.