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Placenta Accreta Spectrum (PAS)

(Management and Referral pathways)

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the management and referral pathways for Placenta Accreta.

This guideline is for use by the following staff groups:

- Obstetricians
- Midwives
- Ultrasonographers

Lead Clinician(s)

Dr Laura Veal

Consultant Obstetrician (Clinical Director)

Approved by *Maternity Governance Meeting* on: 17th October 2025

Approved by Medicines Safety Committee on: N/A
Where medicines are included in document.

Review Date: 17th October 2028

This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
Oct 2020	Document Approved	Maternity Governance
June 2024	Document extended for another 12 months whilst under review	Maternity Governance
Oct 2025	Document reviewed and referral pathway to Birmingham updated.	Maternity Governance

Inclusion statement

We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

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Ockenden Maternity Guidelines Assessment

Is there National Guidance Available for this guideline?	Yes
National Guidance used to inform guideline e.g. NICE/RCOG	RCOG Placenta Praevia and Placenta Accreta: Diagnosis and Management (Green-top Guideline No. 27a) RCOG West Midlands Perinatal Network Referral Pathway for Placenta Accreta Spectrum (PAS) For centres whose NHS England designated PAS centre is Birmingham Women's Hospital
Does the guideline follow National Guidance if available? <i>If no, what rationale has been used.</i>	Yes
If no national guidance available or national guidance not followed, what evidence has been used to inform guideline.	N/A
Ratified at Maternity Guidelines Forum:	17/10/2025

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1 Definition

Placenta accreta is a serious 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. 35% of placenta accreta is not diagnosed before labour.

A morbidly adherent placenta carries a significant chance 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%	0.24 in 100	3%	3 in 100
1	0.31%	0.31 in 100	11%	11 in 100
2	0.57%	0.57 in 100	40%	40 in 100
3	2.13%	2.13 in 100	61%	61 in 100
4	2.33%	2.33 in 100	67%	67 in 100
5	6.74%	6.74 in 100	67%	67 in 100

2 Antenatal care

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

- If this scan demonstrates a **major placenta praevia** in a woman that has had a previous caesarean section, then referral should be made to BWH as per the BWH pathway – Appendix 1 and 2
- If the placenta is **anterior and low**, a repeat scan (transvaginal) should be performed at 27-28 weeks with a full bladder to identify the distance from the lower edge of the placenta to the cervical os. If the placenta remains low lying at this point the woman should be referred to BWH.

Referrals to BWH should be made using the Fetal medicine Referral form (Appendix 3) which will be completed by the DAU midwives at the relevant site and should include the Woman's named Obstetrician. The Consultant on call should be added if the woman was previously low risk.

If the placenta is posterior, covering the os or anterior and low without a previous caesarean section, care should proceed with a repeat scan at 32 weeks as per the placenta praevia guideline.

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If a placenta accreta is diagnosed at BWH, care will either continue at BWH or will be joint care depending on the clinical situation. Delivery will take place at BWH.

Optimise the haemoglobin from the point of diagnosis through either oral or intravenous iron supplementation depending on the level of anaemia present. Hb should be monitored regularly through the pregnancy with a low threshold for any further treatment.

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.

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. The timing of this is likely to be decided by BWH.

3 Emergency Delivery

In cases of placenta accreta delivery is anticipated to occur in BWH and WMAS will be advised to take them to this unit.

In the unlikely event that a woman presents with an antepartum haemorrhage or another emergency necessitating delivery consideration should be given for transfer to Main Theatre for delivery if it is safe to do so and staffing allows. However, if 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.

3.1 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

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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.

3.2 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.

4 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.

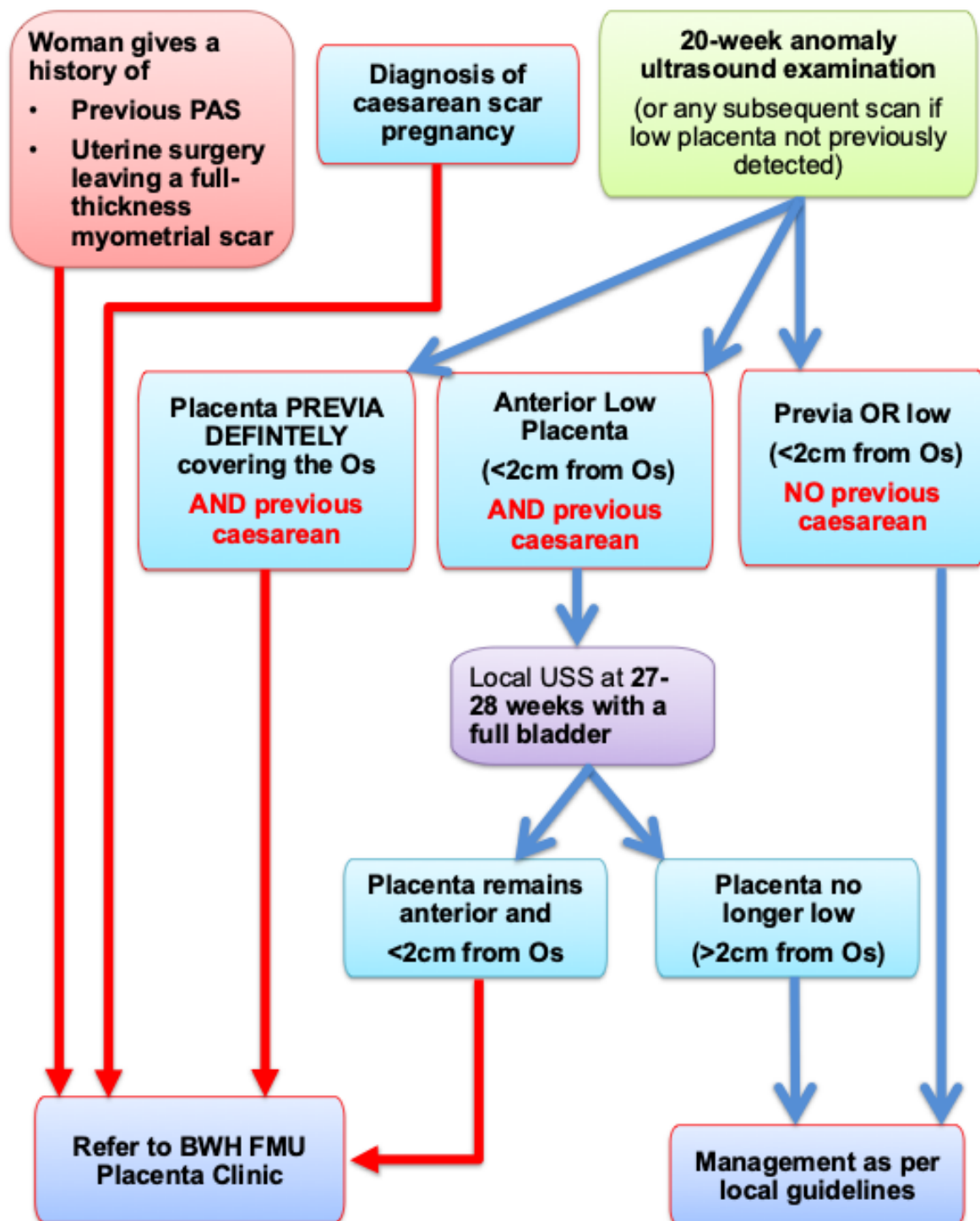
Patients should be prescribed antibiotic prophylaxis for 5 days following delivery. It is also important that patients recognise the risk of delayed infection and the need to report signs and symptoms in a timely way.

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

Interval hysterectomy can also be considered.

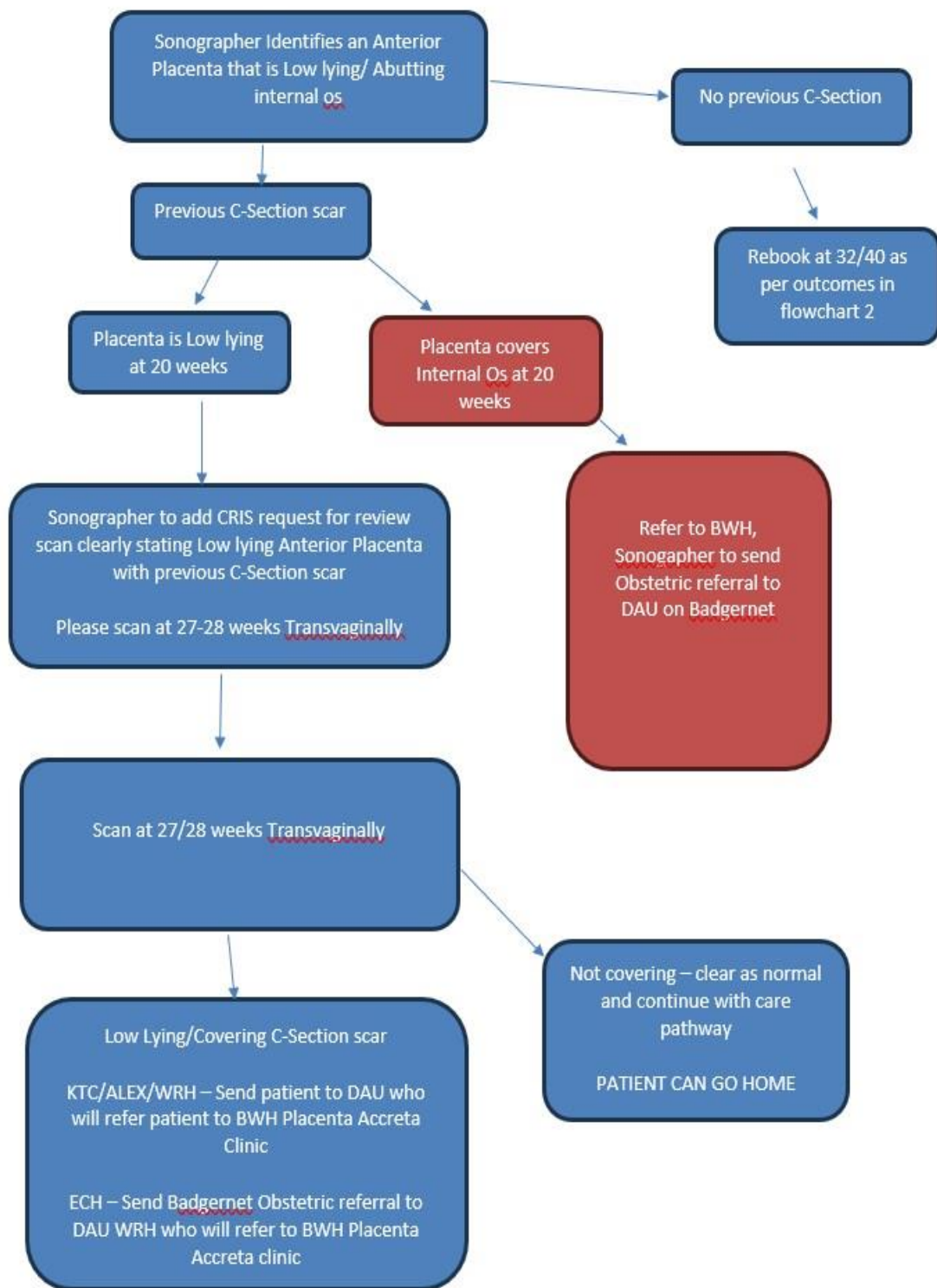
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5 Appendix 1 – BWH Pathway



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6 Appendix 2 – Referral Pathway for Women with a low lying anterior placenta and previous Caesarean section



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7 Appendix 3 – Referral form

WEST MIDLANDS FETAL MEDICINE REFERRAL FORM

SUSPECTED FETAL ANOMALY IN A SINGLETON FETUS

REFERRAL DATE		NHS TRUST NAME			
REFERRER		CONTACT NUMBER			
OBSTETRICIAN + E MAIL ADDRESS		CONTACT NUMBER			
PATIENT NAME		CONTACT NUMBER			
HOSPITAL NUMBER		ADDRESS/POST CODE			
NHS NUMBER					
DATE OF BIRTH					
GP NAME		GP ADDRESS			
HEIGHT IN CMS		WEIGHT IN KG		BMI	
FIRST LANGUAGE		INTERPRETER REQUIRED			

GRAVIDA		PARITY	
GESTATION		E.D.D. BY SCAN	
BLOOD GROUP / Rh STATUS / ANTIBODIES (ATTACH HARD COPY)		HIV, HEP B STATUS IF POSITIVE VIRAL LOAD (ATTACH HARD COPY)	
SCREENING/NIPT/KARYOTYPE RESULTS IF PERFORMED			
PREVIOUS OBSTETRIC HISTORY		RELEVANT MEDICAL HISTORY	
LIVING CHILDREN	>37 WEEKS	<37 WEEKS	
NEONATAL DEATHS	>37 WEEKS	<37 WEEKS	
MISCARRIAGES	< 12 WEEKS	<23 WEEKS	
STILL BIRTHS			CURRENT MEDICATION
TERMINATIONS			

PLEASE STATE INDICATION FOR REFERRAL, SECOND OPINION, EXAMINATION OR PROCEDURE REQUIRED (and attach also a copy of the most recent USS performed prior to referral)

Referring on the placenta accreta pathway

Include here details of previous deliveries/caesarean sections

E mail to: f.medicine@nhs.net

*****IF ANY SECTIONS ARE INCOMPLETE THEN THIS REFERRAL WILL BE REJECTED*****

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8 Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non- compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	Undiagnosed/Missed Accreta	Datix	AdHoc	Governance team	Maternity & Neonatal Safety Meeting	AdHoc

9 References

Royal College of Obstetricians and Gynaecologists (RCOG). (2018) *Placenta praevia and placenta accreta: diagnosis and management (Green-top Guideline No. 27a)*. London: RCOG. Available at: <https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/placenta-praevia-and-placenta-accreta-diagnosis-and-management-green-top-guideline-no-27a/>

10 Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
All Maternity Staff

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Maternity Governance Meeting

11 Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	No

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.