

Pathway for the management of placenta accreta

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Key Amendments

Date	Amendments	Approved by

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 LSCS	previous	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 either Dr Rob Johnson or 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.

Counsel the patient regarding the potential risk of massive postpartum haemorrhage and hysterectomy at the time of delivery.

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.

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.

Elective delivery

Plan to deliver no later than 37 weeks

Ensure that steroids have been given 1 week prior to date for LSCS to reduce the risk of neonatal respiratory distress.

Plan for delivery in Main theatres. No other elective sections to be scheduled in the session.

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 femoral artery as a prophylactic haemostatic measure in the instance of postpartum haemorrhage.

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

Emergency Delivery

Should a patient present with antepartum haemorrhage and the decision is taken for emergency delivery, the patient should be managed in main theatres with appropriate scrub staff and equipment to include provision 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 there 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.

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.

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.

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.