National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Diagnosis and Management of Placenta Accreta Spectrum

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with Placenta Accreta Spectrum (PAS).

Following a comprehensive literature review a number of evidence-based recommendations for management of Placenta Accreta Spectrum were agreed upon.

Key Recommendations

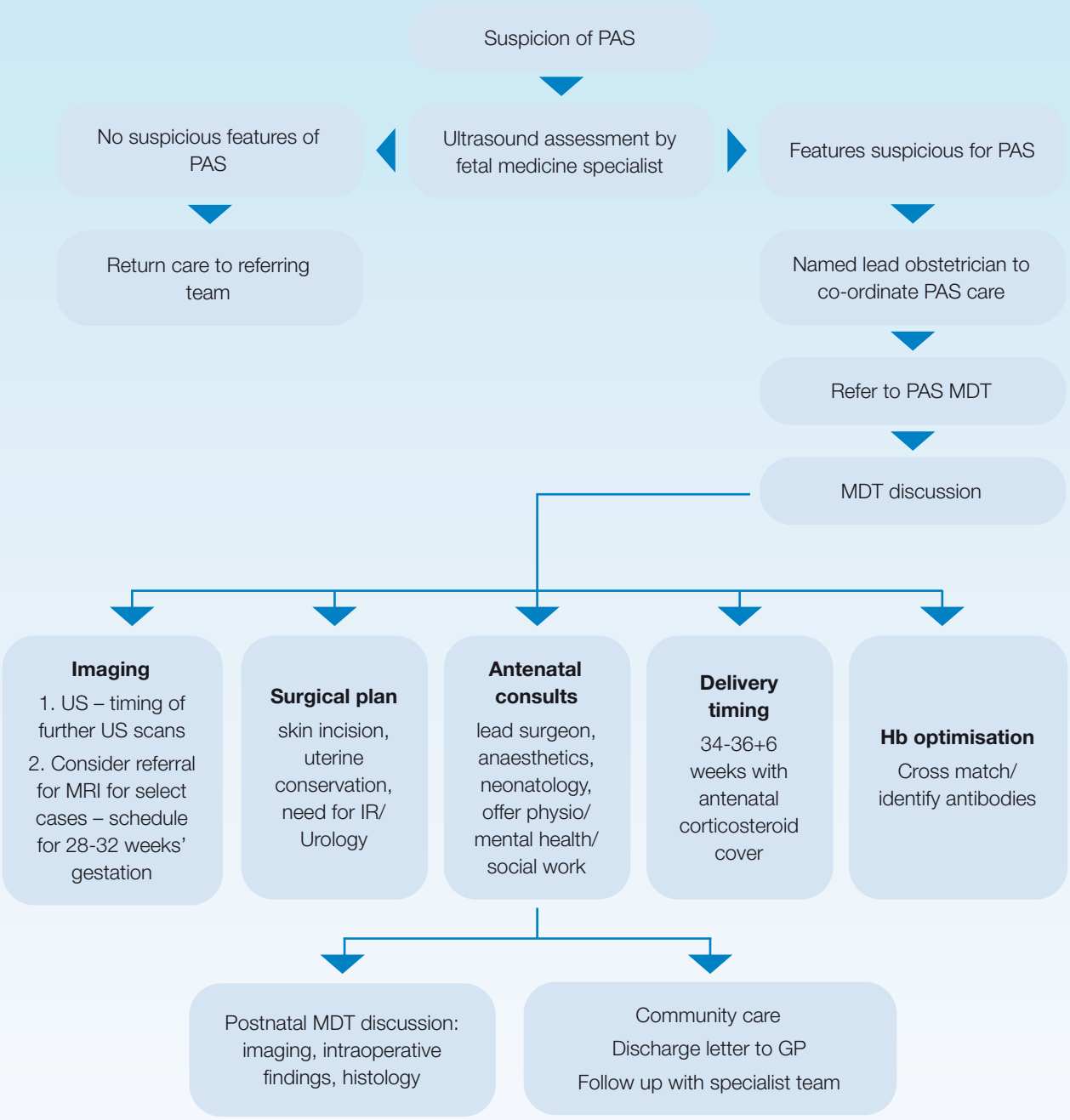
1. We suggest that all women with a previous caesarean section should have placental location clearly documented at the fetal anatomy scan. *Grade 2A*
2. We suggest where features suspicious for Placenta Accreta Spectrum (PAS) are identified, a further ultrasound assessment by a fetal medicine specialist should be performed. If this is not available locally, tertiary referral for further assessment is recommended. *Grade 2B*
3. We recommend that women with a placenta praevia and a previous caesarean section where no features of PAS are identified on ultrasound by a skilled operator, can be managed as per usual obstetric care for women with placenta praevia. Healthcare providers should be aware of the limitations of ultrasound and that PAS cannot be completely excluded on imaging. *Best practice*
4. We recommend prenatal ultrasound to assess for PAS is performed with a partially filled bladder, using both a transabdominal and transvaginal approach. *Best practice*
5. We recommend ultrasound reporting of the features of PAS should be standardised to ensure consistency in reporting of these features. A proforma in Appendix 3 summarises the ultrasound and MRI features which should be marked as either present or absent. *Best practice*
6. We recommend the limitations of ultrasound and MRI in definitively ruling out PAS should be considered when counselling women as to the risk of PAS based on imaging findings. *Best practice*
7. We recommend women diagnosed with PAS should have a named lead consultant obstetrician and be cared for by a multi-disciplinary team with expertise in the diagnosis and management of women with PAS. *Best practice*
8. We suggest where this is not available locally, a referral should be made to a tertiary centre. *Grade 2B*
9. We recommend the multi-disciplinary team should include, at a minimum, clinicians with expertise in diagnosis of PAS, to include fetal-maternal medicine specialists, consultant anaesthesiologist, and surgeons with expertise in complex pelvic surgery, usually a gynaecological-oncologist. *Best practice*
10. We recommend that at each MDT meeting, the following key elements should be discussed: medical, surgical, and obstetric history, all available imaging performed in the current pregnancy, most recent blood results and any relevant events in this pregnancy such as bleeding. A summary of the MDT discussion and recommendations should be clearly documented in the woman's medical file after each meeting. *Best practice*
11. We recommend that women with suspected PAS prior to 24 weeks should be reviewed by 24 weeks' gestation, while those referred after 24 weeks should be reviewed in a tertiary centre within 7 working days from referral, where possible. Some women will warrant more urgent review depending on gestation and clinical circumstances. *Best practice*
12. We recommend women with a diagnosis of PAS are usually suitable for outpatient monitoring unless other clinical factors, such as bleeding, necessitate inpatient management. *Best practice*

13. We recommend where a diagnosis of PAS is suspected, clear documentation should be made in the woman's chart describing the plan for care. *Best practice*
14. We recommend women with PAS should have a full blood count performed in line with routine antenatal care to diagnose anaemia. Women with haemoglobin measurements outside of the normal range should supplement with iron. *Best practice*
15. We recommend women with a diagnosis of PAS should be referred to physiotherapy antenatally and be reviewed postnatally both while in hospital, as well as being offered a follow up visit after discharge. *Best practice*
16. We recommend women are provided with antenatal educational resources specifically addressing PAS in a format most acceptable to them (website, video, printed information). *Best practice*
17. We recommend women should be offered review by the social work counselling team, particularly where women experience a prolonged hospital admission or delivery away from their local hospital is anticipated. *Best practice*
18. We recommend a perinatal mental health referral should be offered to all women with a diagnosis of PAS during pregnancy and again in the postnatal period. Where referral is declined, clear instructions on how to contact the service in the future should be provided. *Best practice*
19. We recommend women with PAS who have an antepartum haemorrhage should be admitted to hospital for a period of observation in a tertiary centre. Where women experience recurrent bleeding, we suggest admission until delivery is advisable. *Best practice*
20. We recommend admission criteria for women with PAS are considered on an individual basis, as these will be influenced by other factors such as distance from hospital and social circumstances and should be decided on a case-by-case basis. *Best practice*
21. We recommend where women with PAS are admitted to hospital, that cross matched blood is available for them. *Best practice*
22. When deciding to administer pharmacological thromboprophylaxis to women with PAS, we suggest a risk assessment should be made to determine the women's individual risk of VTE which will need to be carefully balanced against the risk of bleeding and timing of birth. *Best practice*
23. We suggest delivery for women with suspected PAS should be considered from 34 weeks' gestation in selected cases, and not delayed beyond 37+0 weeks. Each case should be discussed at the MDT meeting to finalise the most appropriate gestation, taking into consideration individual clinical factors. *Grade 2C*
24. We recommend that in selected individual cases, an elective Caesarean birth prior to 34 weeks' gestation may be indicated. *Best practice*
25. We suggest women with PAS who will give birth prior to 34+6 weeks' gestation should have antenatal timed corticosteroids administered for fetal lung maturity. *Grade 2A*
26. We recommend specialist centres providing care to women with PAS should have 24-hour availability of a multi-disciplinary team including consultant obstetrician, anaesthesiologist, surgeon with advanced pelvic skills, haematology, and neonatology. *Best practice*
27. We recommend an anaesthesiology consultation should be arranged as early as possible following suspicion of PAS to facilitate discussion around anaesthetic options available and identify any potential challenges with anaesthesia. *Best practice*
28. We suggest suitable approaches for anaesthesia for PAS include neuraxial, neuraxial + general anaesthesia, and general anaesthesia. The most suitable approach will take into consideration individual clinical factors as well as the woman's preference. *Best practice*

29. We recommend several good practice points which units caring for women with PAS can consider intraoperatively: position woman in dorsal lithotomy, ensure adequate exposure using self-retaining retractors, incise the uterus away from the placenta. *Best practice*
30. We recommend attempts at manual removal of the placenta are avoided where intraoperative findings confirm PAS. *Grade 2C*
31. We recommend units caring for women with PAS should provide education for theatre staff regarding the preparation and intraoperative management for PAS cases. *Best practice*
32. We recommend that decisions regarding hysterectomy and uterine conservation should be made at the MDT meeting and take into consideration disease severity, the woman's preferences, and available surgical expertise. *Best practice*
33. We recommend informed consent should be obtained by a senior obstetrician who can counsel women on the possible associated risks, particularly caesarean hysterectomy, blood transfusion, damage to local organs including bladder and ureters, need for HDU/ICU admission and death. *Best practice*
34. We recommend the use of Interventional Radiology (IR) techniques in PAS should be decided on a case-by-case basis at the PAS MDT meeting. *Best practice*
35. We recommend where a decision has been made to use interventional radiology, decisions regarding which IR technique to use will be determined by the expertise available and the MDT. *Best practice*
36. We recommend the use of an aortic balloon, which when inserted using intravascular ultrasound has the advantage of being performed in a standard operating theatre, with no radiation exposure to the woman or staff and possible improved haemostasis over bilateral iliac artery occlusion. *Best practice*
37. We recommend that in keeping with recommendations for all postnatal women, women with PAS should have an individual VTE score calculated to determine the dose and duration of thromboprophylaxis. *Grade 2C*
38. We recommend that women who were anaemic antenatally or are diagnosed with anaemia postnatally, should be prescribed iron supplementation for at least six weeks postnatally. *Grade 2C*
39. We recommend women have a clear management for postnatal analgesia documented and charted in the woman's health record. *Best practice*
40. We recommend that women should be offered referral to physiotherapy and social work services in the postnatal period, if this has not already been done or the referral was not followed through during the antenatal period. *Best practice*
41. We recommend that women should be offered referral to perinatal mental health in the postnatal period, if this has not already been done or the referral was not followed through during the antenatal period. *Best practice*
42. We suggest a postnatal visit with the specialist care team should be arranged at six weeks postnatally for women and their support partners, where a debrief and discussion of the pregnancy is facilitated. *Best practice*
43. We recommend all relevant clinical information relating to the antenatal course and intraoperative findings should be included so that they are available to the pathologist when requesting histological assessment for PAS specimens. *Best practice*
44. We recommend specimens sent for pathological assessment of PAS should be reported according to the FIGO classification. *Best practice*
45. We recommend in order to facilitate ongoing learning and education within PAS MDTs, the final histology should be presented at the MDT meeting once available. *Best practice*

Algorithm

Referral Pathway for Placenta Accreta Spectrum (PAS)



Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. Number of women with a previous caesarean section who have placental location documented at fetal anatomy scan
2. Number of women with PAS who were diagnosed antenatally
3. Number of women with PAS managed within an MDT
4. Number of women with PAS who had clear documentation of an antenatal care plan, birth plan and consent in the woman's medical notes
5. Number of women with PAS who have an elective section
6. Number of women with PAS who received a blood transfusion
7. Number of women with PAS who have histopathological confirmation of accreta

Recommended reading:

1. Jauniaux E, Bhide A, Kennedy A, Woodward P, Hubinont C, Collins S; FIGO Placenta Accreta Diagnosis and Management Expert Consensus Panel. FIGO consensus guidelines on placenta accreta spectrum disorders: Prenatal diagnosis and screening. Int J Gynaecol Obstet. 2018 Mar;140(3):274-280 DOI: 10.1002/ijgo.12408
2. Collins SL, Ashcroft A, Braun T, Calda P, Langhoff-Roos J, Morel O, Stefanovic V, Tutschek B, Chantraine F; European Working Group on Abnormally Invasive Placenta (EW-AIP). Proposal for standardized ultrasound descriptors of abnormally invasive placenta (AIP). Ultrasound Obstet Gynecol. 2016 Mar;47(3):271 DOI: 10.1002/uog.14952
3. Bartels HC, Rogers AC, O'Brien D, McVey R, Walsh J, Brennan DJ. Association of Implementing a Multidisciplinary Team Approach in the Management of Morbidly Adherent Placenta With Maternal Morbidity and Mortality. Obstet Gynecol. 2018 Nov;132(5):1167-1176 DOI: 10.1097/AOG.0000000000002865
4. Collins SL, Alemdar B, van Beekhuizen HJ, Bertholdt C, Braun T, Calda P, Delorme P, Duvekot JJ, Gronbeck L, Kayem G, Langhoff-Roos J, Marcellin L, Martinelli P, Morel O, Mhallem M, Morlando M, Noergaard LN, Nonnenmacher A, Pateisky P, Petit P, Rijken MJ, Ropacka-Lesiak M, Schlembach D, Sentilhes L, Stefanovic V, Strindfors G, Tutschek B, Vangen S, Weichert A, Weizsäcker K, Chantraine F; International Society for Abnormally Invasive Placenta (IS-AIP). Evidence-based guidelines for the management of abnormally invasive placenta: recommendations from the International Society for Abnormally Invasive Placenta. Am J Obstet Gynecol. 2019 Jun;220(6):511-526 DOI: 10.1016/j.ajog.2019.02.054
5. Jha P, Põder L, Bourgioti C, Bharwani N, Lewis S, Kamath A, Nougaret S, Soyer P, Weston M, Castillo RP, Kido A, Forstner R, Masselli G. Society of Abdominal Radiology (SAR) and European Society of Urogenital Radiology (ESUR) joint consensus statement for MR imaging of placenta accreta spectrum disorders. Eur Radiol. 2020 May;30(5):2604-2615 DOI: 10.1007/s00330-019-06617-7

Authors

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https://www2.healthservice.hse.ie/organisation/national-pppgs/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/