Management of women diagnosed with Placenta Praevia and Placenta Accreta

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Target Audience:

People who need to know about this document in detail	All Obstetric, Anaesthetic, Midwifery and any other staff responsible for providing care to women within maternity services at CTM UHB
People who need to have a broad understanding of this document	As above
People who need to know that this document exists	As above

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Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

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Management of women diagnosed with Placenta Praevia & Placenta Accreta

Rationale

The rates of placenta praevia and accreta continue to rise as a result of increasing rates of caesarean sections, increased maternal age and use of assisted reproductive technology (ART). Antenatal diagnosis is key to reducing maternal and neonatal complications.

Definitions

Placenta praevia is defined as “placenta developing directly over the internal os of the uterine cervix”. The estimated incidence at term is 1 in 200.

- In pregnancies greater than 16 weeks the placenta should be reported as:
  - ‘Low lying’ when the leading edge is less than 20 mm from the os
  - ‘Normal’ when it is 20 mm or more from the internal os on TAS or TVS.

Placenta accreta a is a spectrum disorder ranging from abnormally adherent to deeply invasive placental tissue. Depending on the depth of villous tissue invasion, it is subdivided into ‘creta’ or ‘adherenta’ where the villi adhere superficially to the myometrium without interposing decidua; ‘increta’ where the villi penetrate deeply into the uterine myometrium down to the serosa; and ‘percreta’ where the villous tissue perforates through the entire uterine wall and may invade the surrounding pelvic organs, such as the bladder. Placenta accreta can also be subdivided into total, partial or focal according to the amount of placental tissue involved and the different depths of accreta can be found to co-exist.
The estimated incidence varies from 1 in 300 to 1 in 2000.

Scope

Healthcare professionals involved in the care of women identified with a placenta praevia & accreta.

Aim

Identification and management of placenta praevia & accreta antenatallywhile optimizing outcome for both mother and baby.

Objectives

- Accurate diagnosis of placenta praevia & accreta in the antenatal period using transabdominal (TAS) or transvaginal (TVS) ultrasound scanning and for identified women to have appropriate care under a consultant.
- Safely manage women who present to the clinic or ward with undiagnosed placenta praevia or accreta.

Risk factors

Risk factors for placenta praevia are:-

- Previous placenta praevia, previous caesarean section, advanced maternal age, multiple pregnancies, previous uterine surgery including repeated curettage, ART, smoking and use of other narcotics.

Risk factors for placenta accreta are,

- Previous caesarean section, advanced maternal age, multiparity, previous uterine surgery including repeated curettage, placenta praevia, ART including IVF.

Antenatal diagnosis

The mid-pregnancy routine fetal anomaly scan should include placental localization.
If the placenta is thought to be low lying or praevia at the routine fetal anomaly scan in the absence of previous caesarean section, a follow-up ultrasound scan including a TVS is recommended at 32 weeks of gestation to diagnose persistent low-lying placenta and/or placenta praevia.
TVS for the diagnosis of placenta praevia or a low-lying placenta is superior to transabdominal and transperineal approach and is safe.
Women with a persistent low-lying placenta or placenta praevia at 32 weeks of gestation who remain asymptomatic, must undergo an additional TVS at 36 weeks to aid in the discussion about mode of delivery.

NOTE: Cervical length measurement may help with management decisions in asymptomatic women with placenta praevia. A short cervical length on TVS before 34 weeks increases the risk of preterm delivery and PPH at caesarean section. This information must be used in the forming of a contingency plan for the patient's delivery.

When conducted by an experienced operator, ultrasound imaging is highly accurate for diagnosing placenta accreta spectrum.

Women with a previous caesarean section who have an anterior low-lying placenta or placenta praevia detected during the routine fetal anomaly scan should undergo specific screening for placenta accreta spectrum (PAS).

MRI can be used alongside ultrasound imaging to evaluate the depth and lateral extent of myometrial invasion, particularly in cases of posterior placentation and/or when ultrasound indicates parametrial invasion.

Diagnostic value of MRI and ultrasound scan in detecting placenta accreta spectrum is similar when performed by experts.

Management of asymptomatic women with persistent low-lying placenta or praevia. (See flowchart Appendix 1)

These women should be encouraged to ensure they have safety precautions in place, including having someone available to help them as necessary and ready access to the hospital.

For women presenting with uncomplicated placenta praevia, delivery should be considered between 36+0 and 37+0 weeks of gestation.

Women with asymptomatic low-lying placenta the mode of delivery should be based on the clinical background, the woman's preferences, and supplemented by ultrasound findings, including the distance between the placental edge and the fetal head position relative to the leading edge of the placenta on TVS.

Patients with placenta praevia should have weekly G&S to detect antibodies and have readily available blood in the lab in case of emergency delivery.

Management of women with persistent low-lying placenta or praevia who had recurrent bleeding. (See flowchart Appendix 1)

Tailor antenatal care, including hospitalisation, to individual woman's needs and social circumstances, e.g. distance between home and hospital and availability of transportation, previous bleeding episodes, haematology laboratory results, and acceptance of receiving donor blood or blood products.

Patients with placenta praevia should have weekly G&S to detect antibodies and have readily available blood in the lab in case of emergency delivery.

Where hospital admission has been decided, an assessment of risk factors for venous thromboembolism in pregnancy should be performed.

Late preterm (34+0 to 36+6 weeks) delivery should be considered for women presenting with placenta praevia or a low-lying placenta and a history of vaginal bleeding or other associated risk factors for preterm delivery.

Management of women with placenta accreta spectrum disorder. (See flowchart Appendix 1)

For women with placenta accreta spectrum who do not have risk factors for preterm delivery, planning delivery between 35+0 and 36+6 weeks of gestation offers an optimal balance between ensuring fetal maturity and minimizing the risk of unscheduled delivery.
It is crucial to develop an emergency delivery plan in collaboration with the woman including a plan of management of PPH including counseling on the need for hysterectomy.
Weekly G&S is indicated from third trimester.

Cervical cerclage and antenatal corticosteroids.

The use of cervical cerclage to reduce bleeding and prolong pregnancy is not recommended.

It is recommended that pregnant women with a low-lying placenta or placenta praevia receive a single course of antenatal corticosteroid therapy between 34+0 and 35+6 weeks of gestation.
For women with symptomatic low-lying placenta or placenta praevia, this therapy is also suitable before 34+0 weeks of gestation.

Consenting

Women suspected of having placenta praevia or placenta accreta spectrum disorder should meet with a senior consultant obstetrician and discuss the risks and treatment options, leading to a clear plan documented in the consent form and her notes.

Discussion must include the caesarean section procedure and whether to opt for conservative placenta management or proceed directly to a hysterectomy if increta or percreta is confirmed during surgery.

Choice of anaesthesia

Anaesthesia for caesarean sections in women with placenta praevia or placenta accreta spectrum should be made by the consultant anaesthetist after discussion with the woman before surgery. The woman should be informed that while the procedure can be safely conducted with regional anaesthesia, it might be necessary to switch to general anaesthesia if required, and her consent for this should be obtained.

Operative considerations for women with placenta accreta spectrum

Caesarean section hysterectomy with the placenta left in situ is often preferred to avoid severe bleeding that can occur when trying to separate the adherent placenta from the uterine wall.

Uterus preserving surgery including partial myometrial resection can be an option when the extent of placenta accreta is limited and the entire implantation area is accessible.

Documentation

All records should be filed in the All-Wales Maternity Handheld Record, Labour and Delivery Record, and other Health Board documentation. Maternal consent must be recorded on the relevant Consent Form.

The use of HDU chart is indicated for all major Antepartum Haemorrhages (APHs) and Modified Early Obstetric Warning Score (MEOWS) for all women diagnosed with APH or Postpartum Haemorrhage (PPH). Care plan must be entered into Welsh Patient Administration System (PAS) for women with risk factors for placenta praevia or low-lying placenta or accreta.

Undiagnosed placenta accreta spectrum disorder at delivery

If, during an elective caesarean section, placenta percreta is discovered upon opening the abdomen, the caesarean section should be postponed until the appropriate staff and resources are available and sufficient blood products are ready. This may require closing the maternal abdomen and urgently transferring the patient to a specialist unit for delivery.

If placenta accreta spectrum is suspected after delivery of the baby, the placenta should be left in place, senior help sought immediately and consideration for an emergency hysterectomy to be performed if the clinical situation allows.

Communication

Pregnant women diagnosed with placenta praevia or low-lying placenta must receive accurate and accessible information about the associated risks.

Maternal wishes and concerns should be thoroughly discussed and documented.

During antenatal appointments discuss the following with the patient and her partner.

- The possibility of preterm delivery and ensuing complications.
- The importance of staying close to the hospital and having support throughout labor and delivery.
- The risk of postpartum hemorrhage, including the potential need for blood transfusions.
- The need for hysterectomy or interventional radiology procedures.
- Assessment by a consultant anaesthetist.

References:

Royal College of obstetricians and Gynaecologists (RCOG): Placenta Praevia and Placenta Accreta: Diagnosis and Management

Greentop guideline No 27a September 2018

Appendix 1: Pathway For Management Of Suspected Or Confirmed PP/PAS