Case Study: Placenta Accreta Spectrum

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BACKGROUND

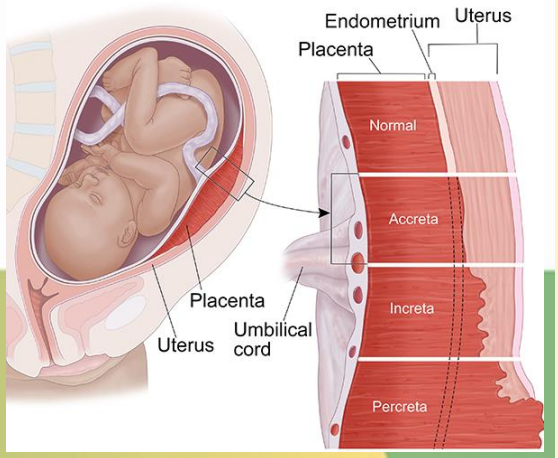

Figure 1. Placenta Accreta Spectrum [2]

Placenta accreta spectrum (PAS) refers to degrees of pathologic invasion of placenta into the myometrium and/or beyond the serosa and is associated with significant maternal and neonatal morbidity and mortality due to the potential for life-threatening pre-term haemorrhage. [1] Management focuses on early multi-disciplinary team (MDT) planning of preterm surgical delivery and prompt clinical response to unprovoked haemorrhage.

CASE

A 38-year-old G4P1 female presented to her booking-in antenatal visit. She previously had an emergency caesarean section for chorioamnionitis and was deemed unsuitable for trial of vaginal delivery. Morphology ultrasound identified a markedly abnormal placenta appearing to invade into the anterior segment and bladder. She was subsequently transferred to a tertiary hospital with a gynae-oncology PAS MDT who planned for caesarean-hysterectomy k34-37. At k31+2, she presented with painless antepartum haemorrhage. After a total loss of 1400mLs, an emergency caesarean-hysterectomy and bilateral salpingectomy were performed at k31+3 with one preceding dose of steroids.

RESULTS

Intra-operatively, placental projection to the serosa and right broad ligament were identified with no bladder invasion. Total blood loss was 2700mLs (1360mLs returned via cell-saver). The patient was admitted to the intensive-care-unit before discharge from the ward one week later. Histopathology confirmed no abruption but PAS grade 3A.

DISCUSSION

The clinical diagnosis of PAS according to FIGO classification describes placenta accreta, increta or percreta. [1] PAS grade 3A indicates abnormal invasion (percreta) limited to uterine serosa. [1]

This case highlights the importance of risk factor screening, routine antenatal imaging and timely specialist input. Previous caesarean is the biggest risk factor for PAS subsequently. PAS MDT planning is crucial in ensuring optimisation of all antenatal aspects, including monitoring haemoglobin/iron levels, ensuring blood and cell-salvage availability, creating referrals to relevant specialties and planning steroids/delivery timing. Prompt clinical response to preterm antepartum haemorrhage also improves maternal outcomes.

REFERENCES

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