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LETTER TO THE EDITOR

## Stuck on you: The increasing challenge of morbidly adherent placenta in obstetric practice

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Dear Sir,

The rising rate of morbidly adherent placenta (MAP), attributed to the increase in caesarean section (CS) deliveries (Wu et al. 2005), can lead to massive obstetric haemorrhage and its sequelae (blood transfusions, coagulopathy, sepsis and multi-organ failure), as well as complications such as peripartum hysterectomy. Indeed, there were two maternal deaths due to placenta accreta in a recent Confidential Enquiry into Maternal Death (2006–2008) (Norman 2011) and MAP is implicated in at least 40% of all recent peripartum hysterectomies in the UK (Knight et al. 2008). Due to its vascular anastomoses, traditional surgical measures for postpartum haemorrhage such as compression sutures, uterine balloon tamponade and selective devascularisation are likely to be ineffective and as such, the practising obstetrician now needs to develop a different set of multidisciplinary specialist skills. First, a high index of suspicion is required in women with concomitant low lying placenta and previous CS (as they have a 500-fold increase in risk!): in these cases, magnetic resonance imaging (Palacios Jaraquemada and Bruno 2005) and ultrasound colour Dopplers (Warshak et al. 2006) can help correctly identify this condition. Optimisation of haemoglobin and preoperative multidisciplinary involvement of the haematologist, anaesthetist, urologist and interventional radiologist, together with planned delivery by an experienced obstetrician, is crucial. The inclusion of a gynaecological oncologist can also help reduce surgical morbidity and blood loss, particularly when there is parametrial invasion (Acton et al. 2014).

Prophylactic pelvic balloon placement/inflation and bilateral ureteric stenting can reduce early complications by a factor of 2.5 (18% vs 55%;  $p = 0.02$ ) (Eller et al. 2009). The baby is delivered by classical CS, avoiding any placental incision in order to reduce the likelihood of bleeding and this is planned for between 36 and 37 weeks to avoid labour and to enable scheduling of the multidisciplinary team. While it is generally accepted that the clinician should not try to separate the placenta (women who underwent attempted removal had greater morbidity; 67% vs 36%;  $p = 0.04$ ) (Eller et al. 2009), it is unclear if conservative treatment (intentional retention of placenta awaiting spontaneous autolysis) or radical surgery (elective hysterectomy with intact placenta) is best, as both options are associated with increased morbidity; the former for example, has an up to 30% risk of subsequent bleeding (Eller et al. 2009; Fitzpatrick et al. 2013). More recently, uterine conservation surgery utilising the principle of deliberate placental

non-separation with myometrial excision of the adherent placental segment has been shown to be a safe and less morbid alternative to elective peripartum hysterectomy (Palacios Jaraquemada et al. 2004; Chandrachan et al. 2012).

The authors would like to share their experience of a recent case of placenta increta, which had invaded the serosa in close proximity with the bladder (with a 10 litre blood loss), where they had to proceed to peripartum hysterectomy. A layer of placental tissue adherent to the bladder dome had to be left attached in order to avoid the risk of inadvertent bladder resection. This continued to ooze and as the patient started developing coagulopathy, the placental remnant was oversewn and the pelvis packed with  $4 \times 3$  swabs. This simple life-saving technique is commonly practised by trauma surgeons ('pack and then go back') – the abdomino-pelvic packing must be 'airtight' in order to generate sufficient tamponade (Figure 1) and the patient then transferred to intensive care for blood replacement and correction of any coagulopathy before removing the packs 24–36 h later (Hallak et al. 1991).

While there are placenta accreta teams based in tertiary referral units in the UK, the authors argue that all accreta patients should have access to them; whether these should be 'mobile', travelling from tertiary centres or whether the expertise should actually be developed at local units, is unclear. The latter option should be seriously considered however, as there are now at least 12 maternity units delivering more than 5,000 babies per year and it is predicted from retrospective data that clinicians can expect 12 MAP cases per 10,000 deliveries (Eller et al. 2009). The need



Figure 1. Pelvic packing to produce 'airtight' tamponade on a placental segment left *in situ* following peripartum hysterectomy.

for input from interventional radiologists cannot be overemphasised, particularly in cases with lateral placental extension to the parametrium, which is usually associated with exceptionally high surgical morbidity. These cases often require multiple transfusions, and early liaison with blood transfusion specialists prevents overwhelming an unprepared blood bank.

The true risk associated with MAP has not been quantified (as most data are still based on retrospective studies), nor is there a universal agreement about the optimal diagnostic and management techniques. This condition remains one of the most formidable challenges for the obstetrician; thankfully, recent data submitted from the 221 obstetric units in the UK over a 1 year duration to United Kingdom Obstetric Surveillance System (UKOSS) placenta accreta database, will help increase knowledge for the betterment of patient care (Fitzpatrick et al. 2013).

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