



# PLACENTA ACCRETA SPECTRUM- AN EVIDENCE-BASED MANAGEMENT

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*Over the past few decades, placenta accreta spectrum (PAS) has emerged as a major obstetric challenge, with a current incidence of approximately 1 in 270 births. The condition has become more manageable with the availability of standardized guidelines from RCOG, ACOG, and FIGO.*

### *Risk Factors and Aetiology*

*Key risk factors include iatrogenic endometrial defects, placenta previa, prior caesarean delivery, history of PAS, previous uterine surgeries (e.g., curettage), manual removal of the placenta, endometritis, and Asherman syndrome. Caesarean scar pregnancy (CSP) and PAS are considered parts of the same pathological spectrum.*

### *FIGO Classification of PAS (2019)*

*Grade 1: Abnormally adherent placenta (placenta adherenta/accreta)*

*Grade 2: Abnormally invasive placenta (increta)*

*Grade 3: Abnormally invasive placenta (percreta)*

- ☞ 3a: Limited to uterine serosa*
- ☞ 3b: With bladder invasion*
- ☞ 3c: With invasion of other pelvic organs*

### *Diagnosis*

*Prenatal diagnosis is crucial for optimizing outcomes. Prior caesarean delivery combined with an anterior low-lying placenta account for more than 80% of PAS cases. Patients may be asymptomatic or may present with antepartum hemorrhage.*

*Ultrasonography is the primary diagnostic tool. Typical findings include placenta previa, multiple placental lacunae, loss of the retroplacental hypoechoic zone, myometrial thickness <1 mm, abnormal serosa-bladder interface, and turbulent blood flow on Doppler imaging. Serial ultrasound examinations are often required.*

*MRI is useful for difficult cases, particularly posterior placenta previa, and for assessing the depth and lateral extent of invasion.*

### *Management*

*Management should occur in a tertiary care centre (Level III or IV) with a multidisciplinary team. Planned delivery between 35+0 and 36+6 weeks balances fetal maturity and minimizes emergency delivery risk. Corticosteroids are recommended when delivery is anticipated before 37 weeks.*

### *Cesarean Hysterectomy*

*For obvious increta or percreta, cesarean hysterectomy with the placenta left in situ is the most accepted approach. Preoperative planning includes optimization of hemoglobin, coagulation status, counseling regarding risks, anticipated blood loss, transfusion needs, and the likelihood of hysterectomy. Interventional radiology and ureteric catheterization may be considered.*

*A vertical skin incision is preferred. After abdominal entry, the upper margin of the placenta is identified, and the uterine incision is placed above it. The placenta is not removed; the cord is clamped and returned to the uterus before closing the incision. Total hysterectomy is performed with ovarian preservation but removal of the fallopian tubes. Tranexamic acid is used, and uterotonics are avoided. Bladder injury may require repair and prolonged drainage.*

#### *Other Approaches*

*Delayed hysterectomy or expectant management with the placenta left in situ may be considered in select cases with extensive invasion, though these methods require careful follow-up.*

#### *Outcome*

*Historically associated with high morbidity (40–50%) and mortality rates up to 7%, outcomes have significantly improved (mortality only .05%) with routine prenatal diagnosis and standardized management.*

#### *Take-home messages:*

- ☞ PAS has emerged as a major obstetric challenge, with severe morbidity and high mortality*
- ☞ Increase incidence is related to is increasing Caesarean section rate*
- ☞ The availability of standardized guidelines has streamlined the management with dramatic decrease of morbidity and mortality*
- ☞ Cesarean hysterectomy remains the gold standard for managing severe PAS.*