

Appendix BB: FAQ What Do Patients Need to Know?

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National Accreta Foundation's Accreta Patient FAQ

What do accreta patients need to know? National Accreta Foundation produced this patient facing FAQ based on the latest literature and evidence-based care recommendations for women with placenta accreta.

What is “Placenta Accreta Spectrum?”

Placenta Accreta Spectrum (PAS) refers to the full range of accreta diagnoses, including placenta accreta (adherent placenta) as well as increta and percreta (invasive placenta). PAS historically has had many terms, such as placenta creta, Morbidly Adherent Placenta (MAP), and Abnormally Invasive Placenta (AIP) to name a few. Placenta Accreta Spectrum has become a terminology of choice due to its inclusiveness of all forms of the condition.

Any Updates on how many women get accreta?

While once a rare diagnosis, prevalence of accreta is increasing with accreta now affecting as many as 1 in 272 pregnancies. Experts generally agree that this increase is mostly due to the increasing rate of cesarean delivery over the last 3-4 decades.

What are risk factors for developing accreta?

Women at highest risk of developing accreta are those who have a history of cesarean delivery and the presence of placenta previa (placenta located low in the uterus, covering the cervix). Level of risk increases with number of prior cesareans, for women with placenta previa and history of two prior cesareans the risk of developing accreta is as high as 40%. Here's a study that includes more detail on risk percentages. Non-cesarean risk factors include advanced maternal age, multiparity (having prior pregnancies), IVF and any prior uterine surgery or curettage. Placenta previa is an independent risk factor for accreta, with 3% of woman with previa and no prior cesareans developing accreta.

What is the mortality rate of accreta?

We get asked this a lot. Earlier studies have estimated the maternal death rate of accreta as high as 7%. A recently published study based on accreta deliveries between 1998-2011 found that while accreta was associated with as much as a 19-fold increase in adverse outcomes (including hysterectomy, transfusion and prolonged hospital stay), there were very few maternal deaths in their sample.

Here's what the recent ACOG & SMFM Accreta Care Consensus says:

“Placenta accreta spectrum is becoming increasingly common and is associated with significant morbidity and mortality ... It is worth noting that even in the most optimal setting, substantial maternal morbidity and, occasionally, mortality occur.” This is part of why it is so important to deliver at a hospital that is capable of managing accreta. More on that later.

Can blood work detect if I have accreta?

Unfortunately, there is not yet a reliable blood test for placenta accreta. Elevated maternal serum

alpha fetoprotein (AFP) and low pregnancy associated plasma protein A (PAPP-A) have been linked to an increased risk of accreta, however they are poor predictors and can be abnormal in many other scenarios. A very exciting recent study discovered “a unique and distinct plasma protein signature” in patients with placenta accreta. National Accreta Foundation is very interested in continuing to follow research on biomarkers with the possibility of accurately diagnosing accreta early in pregnancy.

Diagnosis:

Ultrasound is the primary diagnostic tool for accreta, with most cases identified in the second and third trimesters, although it’s important to know that ultrasound is not perfect. Women with higher risk of accreta – for example, two or more cesarean sections with placenta previa – still have considerable risk for accreta even without ultrasound evidence. It is important for both care teams and patients to be prepared that they may encounter accreta at delivery, regardless of ultrasound findings. It is unclear whether MRI adds additional diagnostic value beyond ultrasound, one study found that “MRI confirmed an incorrect diagnosis or incorrectly changed a diagnosis based on ultrasonography in 38% of cases.” In some situations (poor visibility due to scar tissue or obesity, posterior placenta, etc.) MRI can be helpful. Diagnosis of accreta is a critical first step in obtaining proper level care. One study at an accreta center of excellence found that outcomes in expected cases of accreta were better than in cases where accreta was unexpected, even when the diagnosed cases had more severe placental invasion

When is delivery recommended?

If no bleeding, early labor or other complications, planned cesarean delivery or hysterectomy for women with placenta previa and suspected accreta is recommended between 34 weeks and 35 weeks and 6 days. As many as 30-50% of accreta moms will deliver earlier due to bleeding or labor.

Should I be admitted to the hospital early?

Women who experience bleeding, preterm labor or rupture of membranes are most likely to benefit from hospitalization. Those who have to travel distance or have logistical considerations may be good candidates for hospitalization or local housing as well. The ACOG & SMFM Accreta Care Consensus states: “Decisions about hospitalization and activity should be based on each patient’s individual preference.”

Are some hospitals better than others at treating accreta?

Accreta literature has previously indicated that better outcomes are achieved at a placenta accreta center of excellence, or at facilities with experience and expertise in treating accreta. There currently is no official listing of accreta centers of excellence but check out this National Accreta Foundation produced article on how to assess your hospital’s capability in treating accreta. The ACOG & SMFM Accreta Care Consensus continues to support that “optimal management involves a standardized approach with a comprehensive multidisciplinary care team accustomed to management of placenta accreta spectrum.”

Care teams generally include:

- ▶ A facility with access to a blood bank that is capable in massive transfusion protocols
- ▶ Experienced Obstetricians
- ▶ Maternal-Fetal Medicine Specialists
- ▶ Gynecological Oncologists
- ▶ Urologists
- ▶ Interventional Radiologists
- ▶ Obstetric Anesthesiologists
- ▶ Critical Care
- ▶ Trauma Surgeons
- ▶ Neonatologists
- ▶ Strong Nursing Leadership

“The use of a consistent multidisciplinary team improves maternal outcomes and can drive internal continuous quality improvement as progressive experience is gained by that same group.”

National Accreta Foundation cannot stress enough the importance of delivering at a hospital that is experienced and capable in treating accreta.

Should I expect a vertical or horizontal incision?

The decision of incision type will likely be based on your main surgeon’s operating preference. A vertical incision is often preferred in accreta cases for better access and visualization, although a recent study suggests that horizontal incision for cesarean hysterectomy was associated with shorter operative times and found no difference in other factors. Talk to your care team.

Will I need a hysterectomy?

Unfortunately, most women with accreta lose their uterus due to the life-threatening potential of the condition. It is important to note that in general, accreta moms keep their ovaries and do not go into menopause from an accreta related hysterectomy.

Will I still be able to produce breast milk if I had a hysterectomy?

Yes, most women are able to produce breast milk after an accreta delivery, even if it involved a hysterectomy. For those who are interested, we recommend engaging with a lactation consultant at your hospital before delivery. Ask what resources are available and make a plan for assistance and equipment. Keep in mind that accreta moms often have many factors that can make breastfeeding more challenging (premature / NICU baby, blood loss at delivery etc.), so be kind to yourself. Note that breast milk production is triggered by hormonal changes (drop in

progesterone) after the placenta is delivered, so treatment methods that involve retained placenta many have an impact on milk supply.

What is delayed interval hysterectomy?

Interval hysterectomy is a treatment plan that involves delivering the baby and leaving placenta inside the uterus (“in situ”) with expectation to perform hysterectomy at a later time, when the risk of blood loss and tissue damage may be decreased. While still considered investigational, this approach can be a strategy for percreta cases with severe invasions.

Are there uterus preserving treatment options?

Most cases of accreta require hysterectomy. In rare and individualized cases conservative and expectant management may be considered. Conservative management is when a portion of the placenta is removed, expectant management is when the placenta is left inside the uterus. The ACOG & SMFM Accreta Care Consensus states: “Conservative management or expectant management should be considered only for carefully selected cases of placenta accreta spectrum after detailed counseling about the risks, uncertain benefits, and efficacy and should be considered investigational.” If you are going down this path, do know that current literature DOES NOT recommend use of methotrexate for placental reabsorption due to the possibility of maternal harm.

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