CLINICAL GUIDELINE

Placenta Praevia and Placenta Accreta, Obstetrics

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	2
Does this version include changes to clinical advice:	No
Date Approved:	12th September 2022
Date of Next Review:	30th September 2027
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Approval Group:	Obstetrics Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Placenta Praevia and Placenta Accreta: Diagnosis and Management

Applicable unit policies:

- Women who require caesarean section
- Postpartum haemorrhage
- Postpartum haemorrhage checklist
- Women refusing blood products
- Caesarean section
- Cell salvage and Autotransfusion record
- Invasive Placental Disease
- Placental Assessment Ultrasound Guideline

Introduction:

Maternal and fetal morbidity and mortality from placenta praevia are considerable and are associated with high demands on health resources. With the rising incidence of caesarean section operations combined with increasing maternal age, the numbers of cases of placenta praevia and its complications are increasing. The estimated incidence of placenta praevia is 1 in 200 pregnancies (1).

Identification and assessment of evidence

This is an updated guideline following the 2018 Green-top guideline release of *"Placenta Praevia and Placenta Accreta: Diagnosis and Management."*

Definition

The 2018 RCOG Placenta Praevia and Accreta Guideline recommends using the following terminology:

- For pregnancies > 16 weeks, the term **low lying placenta** should be used when the placental edge is less than 20mm from the internal os on transabdominal or transvaginal scans.
- For pregnancies > 16 weeks, the term **placenta praevia** should be used for the placenta which lies directly over the internal os.

Management decisions for women with placenta praevia are based on clinical and ultrasound findings.

Screening and diagnosis

Clinical acumen remains vitally important in suspecting and managing placenta praevia. The definitive diagnosis of most low-lying placentas is by ultrasound imaging. Clinical suspicion should be raised in any woman with vaginal bleeding and a high presenting part or an abnormal lie, irrespective of previous imaging results.

Risk Factors:

- Previous caesarean delivery. This risk rises as the number of previous caesarean sections increases.
- Assisted conception
- Increased maternal age
- Cigarette smoking
- Previous uterine surgery

Ultrasound Imaging

Transvaginal ultrasound (TVS) is safe in the presence of placenta praevia and is more accurate than transabdominal ultrasound (TAS) in locating the placenta.

The routine anomaly scan should look at placental localisation and pick up any low lying placentas (LLP) or concerns with low lying placentas. Women should be counselled that there is a high chance of false positives as the lower uterine segment is still unformed in the second trimester, and that not all LLP will persist.

Routine FAS scan:

If the placental edge is less than 20mm from the internal os or covering the os, a follow-up ultrasound +/- a **TVS** should be performed at 32 weeks to diagnose a persistent LLP or placenta praevia. Patients should be given an information leaflet titled "Low Placenta at 20 Week FAS"

32-week scan:

A transabdominal +/- transvaginal scan should be carried out at 32 weeks if the placenta was found to be low-lying at routine FAS.

Consider a cervical length measurement whilst performing a TVS at 32 weeks if the placenta is still low lying and the patient is asymptomatic.

A short cervical length increases the risk of preterm labour and may aid management options

The RCOG suggests reclassifying patients as normal if their placenta measures >2cm from the internal os at 32 weeks. Please see the GGC Ultrasound guideline on Placental Assessment for guidance on how to manage patients whose placenta measures between 2cm and 5cm from the internal os.

36-week scan:

An additional 36 week scan is recommended if the placenta is still low-lying at the 32 weeks scan. This will help aid discussion regarding mode of delivery.

Low anterior placenta at FAS with previous Caesarean section scar

All women with a CS scar and a low anterior placenta should have a repeat scan and antenatal clinic review at **30 weeks.** If the placenta remains low they should have a medical scan < 32 weeks to assess for signs of an abnormally invasive placenta (AIP)

Suspicion of scar ectopic pregnancy in first trimester

All women with a suspicion of scar ectopic in the first trimester scan should have a scan at **30 weeks** with a consultant to exclude AIP

Antenatal management

Women who are found to have a low-lying placenta or placenta praevia at 32 weeks need to be fully counselled on the risks of bleeding, and preterm delivery, as well as the importance of urgency of transfer into hospital should any bleeding occur in the community.

Prior to delivery, all women with placenta praevia and their partners should, where possible, be seen at their consultant antenatal clinic and document discussions regarding:

- Delivery
- Haemorrhage
- Possible blood transfusion
- Cell salvage
- Major surgical interventions, such as hysterectomy
- Anaesthetic options covering both elective and emergency delivery plans

Asymptomatic women

Care should be tailored on an individual basis and based on their needs. If managed as an outpatient, it should be made clear that she should attend hospital immediately if she experiences:

- Any bleeding (including spotting)
- Any contractions
- Any other pain (including vague suprapubic period-like aches)
- Any combination of the above.

New RCOG guidelines suggest a single course of antenatal corticosteroids between 34 and 35+6 weeks of gestation for **asymptomatic** patients with a LLP or PP. The course should be brought forward <34 weeks, for women at increased risk of preterm labour (2).

In women with uncomplicated placenta praevia, admission may be offered from 34 weeks, and delivery should be tailored towards symptoms and considered between 36 and 37^{+0} weeks.

Symptomatic Women:

Antenatal care, including hospitalisation should be tailored to each patient. A frank discussion regarding haemorrhage, possible hysterectomy, collapse and cardiovascular compromise to both mother and baby should be documented before managing patients as an outpatient.

The following should be taken into consideration when deciding on outpatient versus inpatient management:

- Distance between home and hospital
- Availability of transport
- Previous bleeding episodes
- Haematology and blood transfusion investigations
- Acceptance of receiving donor blood/ blood products.

If the patient is being admitted, ensure to complete a VTE assessment and consider the use of either compression stockings, or LMWH if high risk. Full disclosure of the risks of LMWH should be discussed including advice to stop if any signs of PVB, or labour pains.

A course of corticosteroids should be issued for any symptomatic patient when they first present.

Anti-D should be prescribed for rhesus negative women, and a Kleihaur taken for any woman with placenta praevia who presents with PVB.

A Group and save sample should be obtained every 72 hours whilst an inpatient to ensure immediate availability of blood in event of emergency delivery

The new RCOG guidelines state that tocolysis can be considered for symptomatic women to allow administration of antenatal corticosteroids but this should be discussed with a consultant obstetrician on a case by case basis. Tocolysis should not be considered if there are any maternal or fetal concerns.

In symptomatic women, or women who have risk factors for preterm delivery, admission may be offered from 34 weeks, and delivery should be considered between 34- 36+6 weeks of gestation with steroid cover.

Optimising Delivery

Pre-Delivery:

1. *Women with atypical antibodies*:

   Blood availability during inpatient antenatal care is informed by clinical factors relating to individual cases, as well as local blood bank services. Women with atypical antibodies form a particular high risk group and discussion in these cases should involve the local haematologist and blood bank. A group and save specimen should be obtained every 72 hours.

Routine cross matching is not required if no significant atypical antibodies (see above).

Blood should be readily available for the peripartum period. When women have atypical antibodies, direct communications with the local blood bank should enable specific plans to be made to match the individual circumstances.

2. *Anaemia*

Anaemia should be treated antenatally in order to optimize the haemoglobin level for delivery

3. *Anaesthetic*

The choice of anaesthetic technique for caesarean section for placenta praevia must be made by the anaesthetist, in consultation with the obstetrician and mother. There is increasing evidence to support the safety of regional blockade. All women with major PP should be reviewed by an anaesthetist after 34 weeks.

Women with an anterior placenta praevia/ low lying placenta should be advised that it may be necessary to convert to a general anaesthetic and asked to consent to this in their antenatal consultation.

Delivery:

- Standard Placenta Praevia cases should be cross-matched 2 units.
- Rapid infusion and fluid warming devices should be immediately available
- Cell salvage should be considered in all cases of placenta praevia
- Tranexamic acid (1Gram IV) should be considered in all cases of placenta praevia as per PPH prevention and prediction guideline (link to guideline),
- Patient should receive a superactive third stage consisting of 5IU sytocinon IV, followed by 15IU of syntocinon in 500mls over at least 30minutes, and syntometrine 1ml IM.
- If the patient is hypertensive, the superactive 3rd stage should OMIT the syntometrine but once the15 units infusion of Syntocinon completed, a further 40 units Syntocinon in 500mls crystalloid at 125 ml/hr for 2 hours should be given and then reviewed. 250mcg Hemabate IM could also be considered here (link to PPH predication and prevention guideline).
- All Placenta Praevia Caesareans require Consultant presence - both Obstetric and anaesthetic.
- A junior doctor should not be left unsupervised when caring for these women. When an emergency case arises, consultant staff should be alerted and should attend as soon as possible.
- For delivery's <28 weeks, consider a vertical skin/ uterine incision to avoid the placenta.
- Consider using preoperative and intra-operative USS if this is going to aid decision of where to incise.
- False negative and false positive diagnoses of placenta accrete can occur.
- Seek assistance before incising a suspicious looking uterus.
- If the placenta is transected during delivery, immediately clamp the cord following delivery in order to avoid excessive fetal blood loss.

- Initiate uterine tamponade ASAP if unable to control bleeding with pharmacological measures.
- Early recourse to hysterectomy should always be remembered in women with uncontrollable bleeding on a background of PP.

Major obstetric Haemorrhage

If there is a significant PPH or MOH please refer to guideline: *Postpartum haemorrhage Guideline and Postpartum Haemorrhage Checklist*

References:

1. Silver RM. Abnormal placentation: placenta praevia, vasa praevia and placenta accrete. Obstet Gynecol 2015; 126:154-68
2. 2. RCOG green-top: Placenta Praevia