PLACENTA ACCRETA SPECTRUM (PAS)\(^1\)

**Clinical Risk Factors\(^4\)**
- Placenta previa or low-lying placenta in the setting of previous cesarean delivery(ies) or uterine surgeries\(^3\)
- Prior uterine surgeries (e.g., myomectomy, curettage, endometrial ablation)\(^6\)

**Ultrasound Findings\(^2\)**
- Placental lacunae with turbulent vascular flow
- Loss of the normal hypoechoic zone between placenta and myometrium
- Interruption of the uterine serosal-bladder interface
- Thin retroplacental myometrial thickness (<1mm)
- Bridging vessels
- Cesarean scar pregnancy

**Level II Ultrasound**

**Suspected PAS\(^1\)**

**Maternal-Fetal Medicine Consultation/Transfer of Care to Level III-IV Maternal Center\(^5\)**

- Consultation(s) with Multidisciplinary PAS Care Team\(^*\)
  - BMZ course 48 hours prior to planned delivery
  - Identification of planned delivery location (main vs L&D OR)
  - Delivery timing 34 0/7 – 35 6/7 weeks of gestation\(^8\)

- Serial transabdominal ultrasounds q3-4 weeks proximal to delivery
- Transvaginal ultrasound
- May consider MRI in select cases\(^7\) but not as initial evaluation

- Counsel re: risk of maternal morbidity/mortality
- Optimize antenatal Hgb

- If previable, discuss option of TOP\(^6\)

\(*\) Multidisciplinary PAS Care Team

- Maternal-Fetal Medicine
- OB Anesthesiology
- GYN Oncology
- L&D RN-OB
- Transfusion Medicine
- Neonatology
- †Interventional Radiology
- †Urology
- †Trauma or General Surgery

\(^1\)As clinically indicated for select high-risk cases
References

   • Placenta accreta spectrum (PAS), formerly known as morbidly adherent placenta, refers to the range of pathologic adherence of the placenta, including placenta accreta, increta, and percreta.
   • The absence of ultrasound findings does not preclude a diagnosis of PAS. Clinical risk factors remain equally as important as predictors of PAS by ultrasound findings.

   • Obstetric ultrasound in the second or third trimester is the mainstay of antenatal diagnosis of PAS. Sensitivity and specificity of ultrasound for diagnosis of PAS is ~80-90%, with a PPV of ~65% and a NPV of ~98%.

   • In this study, placenta accreta was present in 15 (0.24%), 49 (0.31%), 36 (0.57%), 31 (2.13%), 6 (2.33%), and 6 (6.74%) women undergoing their first, second, third, fourth, fifth, and sixth or more cesarean deliveries, respectively.
   • In women with placenta previa, the risk for placenta accreta was 3%, 11%, 40%, 61%, and 67% for first (primary cesarean), second, third, fourth, and fifth or more repeat cesarean deliveries, respectively.

   • In this population-based study, women with a history of prior invasive gynecologic procedures were more likely to develop PAS, and the risk increased with increasing number of prior procedures.

   • Maternal outcomes in cases of suspected PAS are optimized when delivery occurs at a level III/IV maternal care facility before the onset of labor or bleeding and with avoidance of placental disruption.

   • Consider discussion of pregnancy termination in cases of PAS with high index of suspicion given the significant risk of maternal morbidity and mortality, although there are currently no data to support the magnitude of risk reduction, if any.

   • It is unclear whether MRI improves diagnosis of PAS beyond what is achieved by ultrasound alone. In this study of 78 women with suspected PAS, MRI confirmed an incorrect diagnosis or incorrectly changed a diagnosis based on ultrasound in 38% of cases.

   • This decision analysis suggested that delivery at 34 weeks of gestation is optimal given the ability of most large centers to handle late preterm infant complications while considering the increased risk of maternal catastrophic bleeding after 36 weeks.
   • SMFM recommends planned delivery no later than 35 6/7 weeks of gestation, or earlier as clinically indicated in the setting of persistent bleeding or other complications.