Guideline No: 77  Placenta Praevia, Placenta Accreta - Diagnosis and Management

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<table>
<thead>
<tr>
<th>Version</th>
<th>Review Date</th>
<th>Reviewed By</th>
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</thead>
<tbody>
<tr>
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<td></td>
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</tr>
</tbody>
</table>
MONITORING COMPLIANCE WITH THE GUIDELINE

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Auditable Standards – See below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process for monitoring</td>
<td>Audit of Guideline</td>
</tr>
<tr>
<td>Responsible individual/group/committee</td>
<td>Risk Management Department</td>
</tr>
<tr>
<td>Frequency of monitoring</td>
<td>3 yearly</td>
</tr>
<tr>
<td>Responsible individual/group/committee for review of results</td>
<td>Obstetric &amp; Gynaecology Audit Meeting</td>
</tr>
<tr>
<td>Responsible individual/group/committee for development of action plan</td>
<td>Audit Lead</td>
</tr>
<tr>
<td>Responsible individual/group/committee for monitoring of action plan</td>
<td>Clinical Governance Steering Group</td>
</tr>
</tbody>
</table>

COMPLIANT WITH:

1. RCOG Green-Top Guideline No. 27 (Jan 2011) – Placenta Praevia, Placenta preavia accrete and vasa praevia : diagnosis and management
2. NICE CG132 : Caesarian Section (Nov 2011)
3. CEMACH, Saving Mother Lives Chapter 4, 2007

AUDITABLE STANDARDS

1. All women should have a 34 week USS to determine placental localisation if shown to be low lying at 20 weeks
2. All women with a persistently low lying placenta at 34 weeks should be referred to a Consultant led antenatal clinic
3. All women with a previous CS and a placenta that is anterior and low at 34 weeks should have a colour Doppler USS.
4. Women should be offered MRI if colour flow Doppler suggests morbidly adherent placenta
5. Consultant presence at Caesarian section in cases of placenta praevia or accreta
CONTENTS

1.0 INTRODUCTION .............................................................................................................. 4
2.0 GUIDELINE REGIME ........................................................................................................ 4
2.1 Diagnosis .......................................................................................................................... 4
2.2 Antenatal Management .................................................................................................... 4
2.2.1 Location ....................................................................................................................... 4
2.2.2 VTE Risk Management for Inpatients ................................................................. 5
2.2.3 Availability of Blood during Inpatient Care ...................................................... 5
2.3 Preparation for delivery ................................................................................................. 5
2.3.1 Mode of Delivery ....................................................................................................... 5
2.3.2 Timing of Delivery ..................................................................................................... 5
2.3.3 Blood .......................................................................................................................... 6
2.3.4 Staffing ......................................................................................................................... 6
2.3.5 The Care Bundle for Suspected Placenta Accreta ............................................. 6
3.0 REFERENCES .................................................................................................................. 6
4.0 RELATED DOCUMENTS ................................................................................................. 6
1.0 INTRODUCTION

This guideline encompasses diagnosis, antenatal management and delivery planning for patients with placenta praevia and placenta accreta. It has been developed so as to comply with recent NICE and RCOG guidance. It is deliberately concise setting out broad pathways only.

2.0 GUIDELINE REGIME

2.1 Diagnosis

- Routine ultrasound scanning at 20 weeks gestation should include placental localisation.

- If at 20 weeks gestation the placenta covers or overlaps the cervical os then follow up ultrasound will be required at 34 weeks.

- The timing of ultrasound scans for women who bleed should be managed on an individual patient basis.

- Women with a low lying placenta at 34 weeks should be referred to a Consultant led antenatal clinic.

- If a low-lying placenta is confirmed at 34 weeks in women who have had a previous caesarean section then a referral to the Fetal Medicine Unit (FMU) should be made as well as to a Consultant led antenatal clinic.

- FMU will offer colour-flow Doppler ultrasound as the first diagnostic test for morbidly adherent placenta. If a colour-flow Doppler ultrasound scan result suggests morbidly adherent placenta:
  - discuss with the woman the improved accuracy of magnetic resonance imaging (MRI) in addition to ultrasound to help diagnose morbidly adherent placenta and clarify the degree of invasion
  - explain what to expect during an MRI procedure
  - inform the woman that current experience suggests that MRI is safe, but that there is a lack of evidence about any long-term risks to the baby
  - offer MRI if acceptable to the woman.

2.2 Antenatal Management

2.2.1 Location

Women with placenta praevia in the third trimester should be counselled about the risks of preterm delivery and obstetric haemorrhage, and their care should be tailored to their individual needs.
Any home-based care after 34 weeks requires close proximity to the hospital, the constant presence of a companion and full informed consent by the woman. Any proposed home based care should be discussed with a Consultant.

It should be made clear to any woman being managed at home that she should attend immediately if she experiences any bleeding, contractions or pain (including vague suprapubic period-like aches).

Any woman experiencing recurrent bleeding in the third trimester needs long term admission and have iv access.

2.2.2 VTE Risk Management for Inpatients

Continue all standard methods of VTE risk reduction such as mobilization, TED stockings and adequate hydration. Prophylactic anticoagulation in women at high risk of bleeding can be hazardous and the decision to use it should be taken on an individual basis considering the risk factors for thromboembolism. Limit anticoagulant thromboprophylaxis to those at high risk of thromboembolism.

2.2.3 Availability of Blood during Inpatient Care

Ensure women have an up to date group and save. Women with atypical antibodies form a particularly high-risk group and discussions in these cases should involve a haematologist and the blood bank.

2.3 Preparation for delivery

2.3.1 Mode of Delivery

The decision should be based on clinical judgement supplemented by sonographic information. A woman with a placental edge less than 2 cm from the internal os in the third trimester is likely to need delivery by caesarean section.

As the lower uterine segment continues to develop beyond 36 weeks of gestation a trans vaginal scan should be offered if the fetal head is engaged prior to an otherwise planned caesarean section.

2.3.2 Timing of Delivery

Elective delivery by caesarean section in asymptomatic women is not recommended before 38 weeks of gestation for placenta praevia, or before 36–37 weeks of gestation for suspected placenta accreta.

If delivery is before 39 weeks steroids should be given.
2.3.3 Blood

When women have atypical antibodies, direct communication with the blood bank should enable specific plans to be made to match the individual circumstance.

2.3.4 Staffing

As a minimum requirement during a planned procedure for placenta praevia, a consultant obstetrician and anaesthetist should be present within the delivery suite. When an emergency arises consultant staff should be alerted and attend as soon as possible.

2.3.5 The Care Bundle (as below) for Suspected Placenta Accreta

This should be applied in all cases where there is a placenta praevia and a previous caesarean section or an anterior placenta underlying the old caesarean scar: -

- consultant obstetrician planned and directly supervising delivery
- consultant anaesthetist planned and directly supervising anaesthetic at delivery
- blood availability discussed with blood bank
- discussion and consent includes possible interventions (such as hysterectomy, leaving the placenta in place etc…)
- consider use of cell saver
- consider discussion with interventional radiology

3.0 REFERENCES

NICE Clinical Guideline 132, ‘Caesarean section’, (November 2011)

RCOG Green Top Guideline Number 27, ‘Placenta praevia, placenta praevia accrete and vasa praevia : diagnosis and management’ (January 2011)

4.0 RELATED DOCUMENTS

- Local guideline: (74) Emergency or urgent caesarean section
CARE PATHWAY FOR PLACENTAL LOCALISATION AT WIRRAL UNIVERSITY TEACHING HOSPITALS NHS TRUST

All women - placental localisation at 20 weeks

Placenta low lying

Placenta localisation at 34 weeks

Placenta low lying

Placenta anterior and previous caesarean section

Colour flow doppler

Suggestive of morbidly adherent placenta

Offer MRI

Placenta accreta

Deliver after 36 weeks if asymptomatic

Continue obstetric management as appropriate

Continue obstetric management as appropriate

Refer to consultant clinic

Discuss inpatient versus OPD management

Deliver after 38 weeks if asymptomatic

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