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Management of Morbidly Adherent Placenta

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What is Morbidly Adherent Placenta?

Disorders of placentation can be classified into two groups – placenta praevia, which refers to an abnormally sited placenta, and morbid adherence (placenta accreta, increta and percreta), which refers to abnormal placental invasion into the uterine wall.

Placenta praevia refers to a placenta partially or completely lying in the lower segment of the uterus, with an overall incidence at term of around 0.4-0.8%. Incidence increases with maternal age, smoking, multiple pregnancy, parity, previous caesarean sections. (CSs) and previous uterine instrumentation [1], Morbidly adherent placenta (MAP) encompasses a group of disorders: placenta accreta (placenta abnormally adherent to the inner half of the myometrium), placenta increta (placenta invading into the outer half of the myometrium) and placenta percreta (placenta penetrating through the myometrium and the uterine serosa). MAP may be associated with placenta praevia. but can also occur in a normally sited placenta. In fact, any factor that damages the uterine decidua can lead to a morbidly adherent placenta.

The site of placental implantation is determined by the position of the trophoblast at 8–10 weeks' gestation. If this is initially 'low lying', the leading edge of the placenta often appears to migrate upwards as the lower segment of the uterus develops. It is thought that scar tissue in the lower segment of the uterus may prevent the normal growth that usually leads to the placenta 'migrating' upwards, resulting in a higher incidence of placenta praevia in women with a previous CS. In particular, previous CS increases the likelihood of a low-lying placenta detected at the 20–22 week anomaly scan to become a placenta praevia at term from 11% to 50% [2]. The risk of abnormal placentation increases with every uterine operation, such that after four or more CSs, the risk of placenta praevia in any subsequent pregnancies is 10% while the risk of placenta accreta at the fourth CS is 2.13% [3].

What Causes MAP?

Morbidly adherent placentae are a result of excessive penetration of the trophoblast through the endometrium (i.e. decidua of pregnancy). The decidua basalis may be deficient in the lower segment or in the presence of scarring from previous operations. This increases the risk of trophoblast invading to the myometrium and beyond [4], especially in cases of damage secondary to previous CS, uterine curettage, endometritis, resection of submucous leiomyoma, endometrial ablation [5] and uterine artery embolization [6].

Why is MAP Important?

Morbidly adherent placenta is associated with severe maternal and fetal morbidity and mortality. The maternal morbidity is largely secondary to massive obstetric haemorrhage and the surgical complications of removing a placenta that may be invading other pelvic organs. The average blood loss is 3000-5000 ml [7] and around 90% of cases require blood transfusion. Morbidity includes hysterectomy, ureteric, bladder, bowel and neurovascular injury at laparotomy, intensive care admission and the risks associated with massive transfusion. Major obstetric haemorrhage is also known to be associated with psychological sequelae, including post-traumatic stress disorder (PTSD) as well as intensive care admission. As the frequency of these conditions increases, the long-term mental health implications are likely to become more significant. Maternal mortality is reported to be in the range of 7-10% of

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