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Title: An Overview of Placenta Accreta Spectrum Management in a Tertiary Care Centre Hospital, over a period of One Year

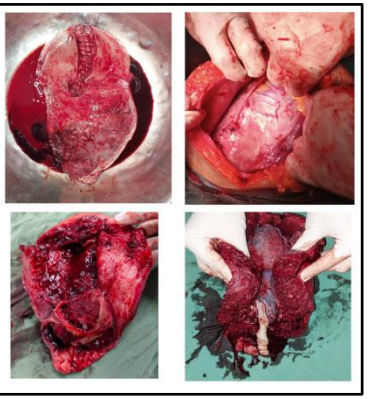
- Placenta Accreta Spectrum (PAS) is a rare but increasingly observed condition in tertiary care settings.
- This study reviews the management of 42 PAS patients at Lok Nayak Hospital, New Delhi, over one year (01/Dec/2023 – 30/Nov/2024)
- Sonography was the primary diagnostic tool, with MRI aiding complex cases.
- A multidisciplinary approach resulted in no maternal mortality during this period for these PAS cases.

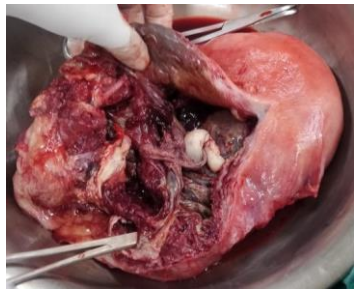
CASE SHEETS REVIEWED ON THESE PARAMETERS

- Age
- Parity
- Gestation Period
- Prev LSCS, other uterine surgeries
- Co-morbidity
  - Anaemia
  - Hypertension
  - Diabetes
  - others
- Diagnosed PAS
- Undiagnosed PAS
- Elective Surgery
- Emergency Surgery
- Blood loss
- Transfusions
- Post op
- ICU admission
- HDU stay
- Hospital stay
- Baby outcome
  - APGAR
  - weight
  - maturity
  - NICU stay
  - mortality

Typical PAS patients:

- Previous 2 to 3 LSCS
- 34 to 37 weeks
- Adequate multi speciality support
- Elective and well planned surgery
- Blood loss – in control
- Transfusions – good blood bank support
- ICU stay – fewer days
  - electively kept on ventilator
- Baby outcome - good

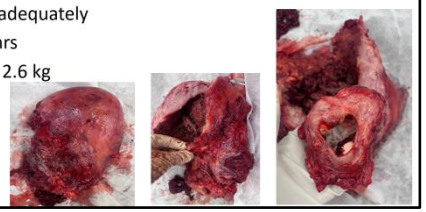


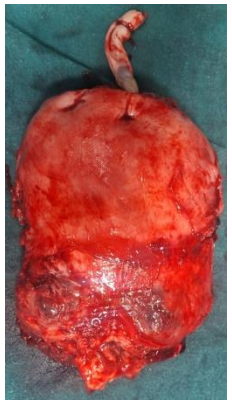


Atypical PAS Cases:

G5P3L2A1 with 35 weeks gestation with PAS admitted for elective surgery:

- Patient started trickling blood vaginally but no pain
- Taken for emergency classical caesarean with PAS protocol
- Bled severely due to cervical dilatation and partial placental separation
- Cervical dilatation around 3 cms and 80% effaced
- Bled 3.5 litres and transfused adequately
- Electively extubated after 24 hrs
- Baby born with APGAR 9/9/9, 2.6 kg
- Discharged on day 10

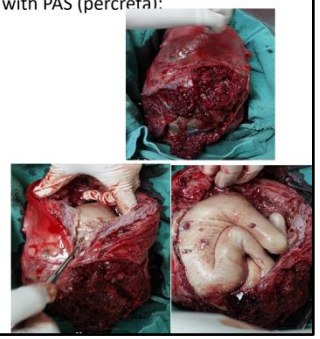


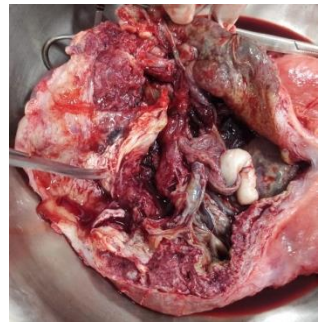


Atypical PAS Cases:

G3P2L2A0 with 29 weeks gestation with IUD with PAS (percreta):

- Patient came with BPV
- Taken for hysterectomy with foetus in situ
- Bladder injury, repaired
- Total blood loss – 2.5 litres
- Transfusions – 4 PRBC, FFP, Platelets each
- ICU stay 5 days
- Discharged after 3 weeks

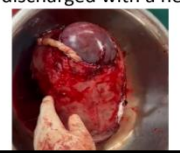


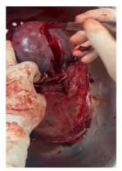


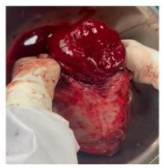
Atypical PAS Cases:

Elective PAS surgery taken at 36 weeks gestation: PARTIAL/FOCAL

- With the delivery of baby, patient started pouring vaginally and partially separated placenta started filling
- Prompt decision taken for hysterectomy without closing the uterine incision
- Vitals deranged to severe shock but with good backup of blood and blood products and senior anaesthetists team effort, patient recovered fully in OT itself.
- On day 12, discharged with a healthy baby.







Two undiagnosed PAS:

1. An unbooked G3P2L2 with 30 weeks gestation with previous 2 LSCS, came to casualty in shock, diagnosed as rupture uterus due to significant haemo-peritoneum and IUD.
- Turned out to be percreta with bleeding from the perforated placenta
- Hysterectomy done.
- Patient had prolonged ICU and hospital stay with hectic post-op period.

2. G4P2L2A1 with 37 weeks gestation with previous 2 LSCS was taken for a routine elective LSCS in a nursing home.
- Patient's abdomen was closed without delivering the baby due to adhesions, abnormal uterine vascularity and abnormal placental bulge.
- Patient was referred to our hospital and here, after placental mapping and with full PAS protocol, surgery was done.
- Baby delivered with APGAR 5/7/8 and had prolonged NICU stay.

TAKE HOME MESSAGE

- Suspicion of diagnosis of PAS is the first step towards preventing a maternal mortality.
- Diagnosing PAS in a high suspicion patient is step two.
- Delivering the baby in a multi speciality set up with PAS management protocol is the third step to save the mother.
- Experienced Obstetric surgeon, Anaesthetist, good blood bank, ICU, NICU and availability of adequate back up staff are the final step towards the best maternal and neonatal outcome.