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## Diagnosis and management of placenta accreta

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The diagnosis of placenta accreta begins with clinical suspicion in patients at risk. Ultrasound and Doppler are first-choice diagnostic methods because of their accessibility and high sensitivity. Placental MRI is an accurate method of topographic stratification that makes it possible to define anatomy, to plan the surgical approach and to consider other therapeutic possibilities. Management of placenta percreta involves great technical dexterity and significant clinical support. The main challenges include controlling the haemorrhage and dissection of the invaded tissues. Nowadays, there are two treatment options: caesarean hysterectomy or a conservative approach. With the latter, there is a choice between leaving the placenta *in situ* and waiting for its later resolution, and a one-step surgery that addresses the problems of invasion, vascular control and myometrial damage in a single surgical act.

**Key words:** conservative treatment; diagnosis; one-step surgery; placenta accreta; therapeutic approach.

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### INTRODUCTION

Placenta accreta is a disorder characterized by abnormal placental penetration into the uterine wall. It is currently one of the main causes of maternal morbidity and mortality. This entity has been historically classified according to the degree of pathological penetration and includes superficial invasions (placenta accreta), middle-layer invasions (placenta increta), and deep invasions (placenta percreta). This chapter refers to all these varieties as placenta accreta.

As a result of its close relation to caesarean section<sup>1,2</sup>, the incidence of placenta accreta has grown in the last few decades. Myometrial damage secondary to repeated

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caesarean sections, and other myometrial injuries associated with dilatation and curettage (D&C) and corrective surgeries, among others, are the main predisposing factors. Ultrasound (US) and Doppler<sup>3,4</sup> are two first-line methods for the diagnosis of placenta accreta; both have a high degree of diagnostic sensitivity and both methods have made it possible to establish diagnostic signs that allow the suspicion of an abnormally implanted placenta in a high percentage of cases.

In addition, placental nuclear magnetic resonance imaging (pMRI) has proved to be a noteworthy auxiliary when it comes to plan the surgery of placenta accreta.<sup>5</sup> Placental MRI (pMRI) makes it possible to have total acquisition of images; its multiplane characteristic allows a correct three-dimensional (3D) reconstruction, necessary for surgical planning.

Placenta accreta causes morbidity and mortality due to haemorrhage, coagulopathy and its inherent surgical difficulty; these facts make this disorder the first cause of obstetric hysterectomy.<sup>6</sup>

Traditionally, the treatment of placenta accreta has consisted of puerperal hysterectomy. This is a high-risk procedure, especially when haemorrhage and coagulation disorders coexist. To minimize damage and conserve the reproductive potential in women, a series of procedures that aim to preserve the uterus affected by placenta accreta have been incorporated.<sup>7,8</sup> These conservative tactics have proved to be effective and safe under controlled conditions.

Below, we provide a synthesis of the current knowledge about placenta accreta, including practical data for obstetricians and surgeons. We emphasize early detection of risk factors, diagnostic guidelines and treatment alternatives in accordance with the human and technical resources available.

## TERMINOLOGY

From a histopathological perspective, there are marked differences among placenta accreta, increta and percreta. However, from a clinical–surgical point of view, sectors that show a different degree of invasion can coexist in the same patient. This phenomenon leads to discrepancies between what is observed during surgery and the final pathological diagnosis. This difference is not only semantic; it makes comparisons of surgical techniques and clinical results from different authors virtually impossible.

Unlike other illnesses, the histopathological study of invasive placenta does not always constitute a diagnostic “gold standard”. This phenomenon occurs when biopsy is obtained in an area without invasion or with a degree of minor penetration. In these cases, there is a mismatch between histology and the surgical finding. We prefer to define placenta accreta according to its clinical–surgical characteristics.<sup>9,10</sup>

## RISK FACTORS

Patients with myometrial damage secondary to repeated caesarean sections in association with placenta praevia constitute the main risk factor for placenta accreta.<sup>11,12</sup> Multiple uterine D&C, particularly those performed in patients who have had previous caesarean section(s)<sup>13</sup>, are closely associated with adherent placentation.

Myometrial tissue damage, whether surgical, instrumental or physical<sup>14</sup>, followed by a secondary collagen repair, is closely related to the appearance of placenta accreta. The challenge of confirming or discarding the diagnosis of invasive placenta is greatest when the topography of the uterine lesion coincides with the placentation zone.

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