

Original Article

# Conservative Management of Placenta Accreta: Hysteroscopic Resection of Retained Tissues

Guillaume Legendre, MD\*, Félicia Joinau Zoulovits, MD, Juliette Kinn, MD, Loïc Senthiles, MD, PhD, and Hervé Fernandez, MD, PhD

From the Service de Gynécologie-Obstétrique, Assistance Publique des Hôpitaux de Paris, Hôpital de Bicêtre (Drs. Legendre, Zoulovits, Kinn, and Fernandez), CESP, Inserm 1018 (Drs. Legendre and Fernandez), Le Kremlin Bicêtre, and Service de Gynécologie-Obstétrique, Centre Hospitalier Universitaire d'Angers, Angers (Drs. Legendre, Kinn, and Senthiles), France.

**ABSTRACT** **Study Objective:** To evaluate the feasibility and the results of hysteroscopic removal of tissue after conservative management of retained placenta accreta.

**Design:** Retrospective study (Canadian Task Force classification II-3).

**Setting:** Tertiary care university hospital.

**Patients:** Twelve consecutive patients with hysteroscopic resection of retained tissues after conservative management of placenta accreta.

**Intervention:** Hysteroscopic removal of retained placenta tissue using a 24F bipolar resectoscope.

**Measurements and Main Results:** Twelve patients with retained placenta tissue, complete in 2 and partial in 10, were included. Mean retained placenta size on magnetic resonance imaging was 54 mm (range, 13–110 mm). Complete removal was achieved in all but 1 patient who underwent a secondary hysterectomy after the first incomplete hysteroscopic resection. Complete evacuation of the uterus was completed after 1 procedure in 5 patients, after 2 procedures in 2 patients, and after 3 procedures in 4 patients. All but 2 patients had normal menstrual bleeding after hysteroscopy. Four pregnancies occurred in our series, resulting in 1 ectopic pregnancy, 1 miscarriage, and 2 deliveries.

**Conclusion:** Hysteroscopic resection of retained placenta seems to be a safe and effective procedure to prevent major complications and to preserve fertility in cases of conservative management of placenta accreta. Journal of Minimally Invasive Gynecology (2014) 21, 910–913 © 2014 AAGL. All rights reserved.

**Keywords:** Fertility; Hysteroscopy; Placenta accreta; Retained placenta

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During the past few decades, the incidence of placenta accreta has increased considerably as a consequence of the upsurge in cesarean section deliveries, which have now reached a rate of approximately 1 per 1000 deliveries [1]. Placenta accreta is an important cause of maternal morbidity and mortality because of the high risk of delayed hemorrhage and sepsis. Optimal management of placenta accreta remains a

topic of debate. On the basis of the current state of knowledge, in patients with no desire to pursue future pregnancy and when the tissue cannot be extirpated, it is reasonable to propose cesarean hysterectomy. However, in those patients who desire preservation of fertility, conservative treatment that leaves part of or the entire placenta adherent in utero could be proposed. The place and timing of additional systematic treatments such as arterial ligation, embolization, or methotrexate therapy have not been clearly defined.

The primary disadvantages of conservative treatment are the risk of persistent bleeding and sepsis, and hence the risk of secondary hysterectomy. Operative hysteroscopy of retained tissue can be an additional option for conservative treatment [2].

Disclosures: None declared.

Corresponding author: Guillaume Legendre, MD, Service de Gynécologie-Obstétrique, Hôpital de Bicêtre, Le Kremlin Bicêtre F-94270, France. E-mail: [g\\_legendre@hotmail.com](mailto:g_legendre@hotmail.com)

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The objective of the present study was to assess the feasibility and the results of conservative treatment of placenta accreta via operative hysteroscopy.

## Material and Methods

An observational retrospective study was performed in our department of gynecology from March 2001 to December 2011. The database of our institution was retrospectively searched to identify women with placenta accreta. A total of 45 women (from >31 987, or 1.4 per 1000 deliveries) were identified. Of these, 23 initially received conservative management of placenta accreta. Placenta accreta was diagnosed via either ultrasound in the prenatal period or magnetic resonance imaging (MRI) during delivery.

Of the 23 patients who received conservative treatment, 12 had major persistent bleeding or pelvic pain. As a result, they were selected to undergo hysteroscopic resection of retained tissues.

We included in our sample all patients who underwent delayed hysteroscopic resection of retained tissues after conservative treatment of placenta accreta. Data were collected from a computer database and were cross-checked with paper records. In 2012, all patients were recalled to assess their fertility.

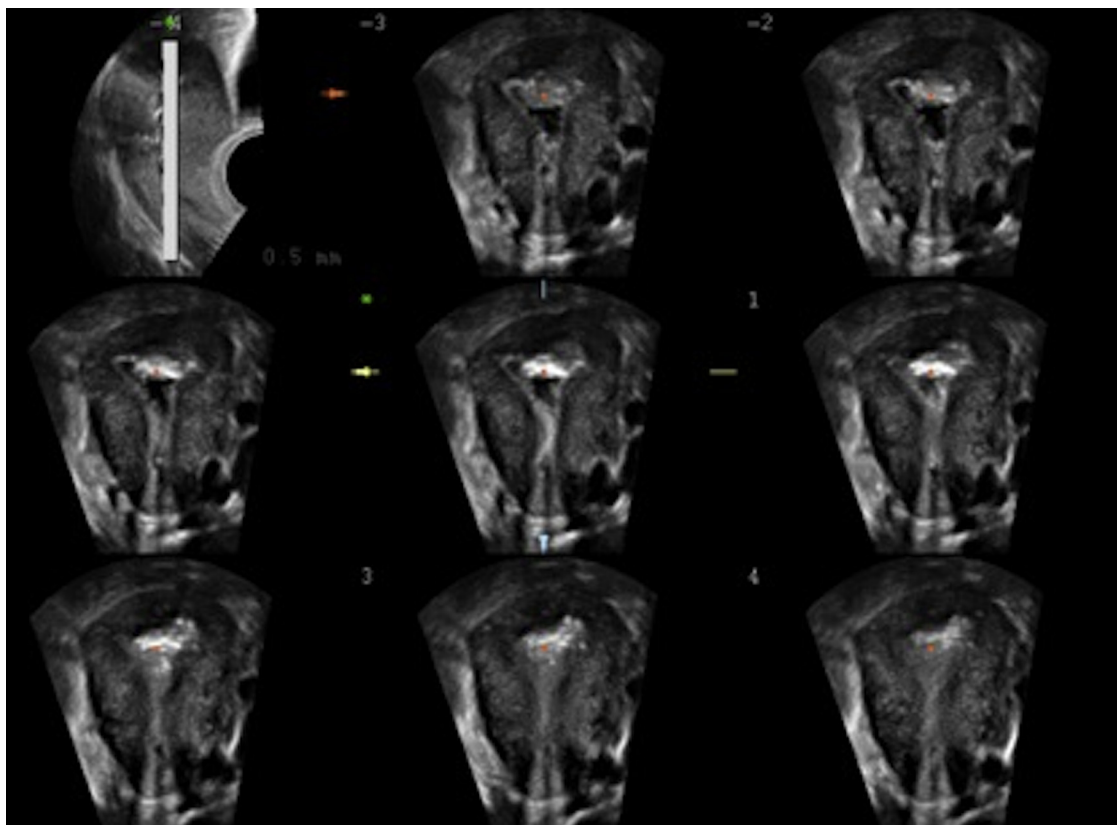
Imaging via both 2- or 3-dimensional ultrasound (Fig. 1) and MRI was performed during the postpartum period. All hysteroscopic resections were performed using a 24F bipolar loop resectoscope (Fig. 2). The use of bipolar energy was limited insofar as possible to the adherent zone of placenta. All procedures were performed systematically under ultrasound guidance. Second-look hysteroscopy was performed at 6 to 8 weeks after each procedure.

## Results

Overall, 12 patients who received conservative treatment of placenta accreta were included. Patient demographic data are given in Table 1. The mean age of the patients was 37.3 years. The immediate peripartum management and the methods of conservative treatment are given in Table 2 (several treatments could be associated). Placenta accreta was completely left in tissue in 2 patients and partially left in tissue in 10 patients. All 12 patients underwent further treatment via operative hysteroscopy to remove retained placenta accreta (Table 3). The median interval between delivery and the first hysteroscopic resection of retained tissue was 75 days (range, 51–179 days). The median size of the placenta, evaluated via ultrasound and MRI, was 54 mm. There were no surgical complications such as perforation,

**Fig. 1**

Ultrasonography of retained placenta accreta.



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