Operative Management of Placenta Accreta Spectrum

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Disclosures

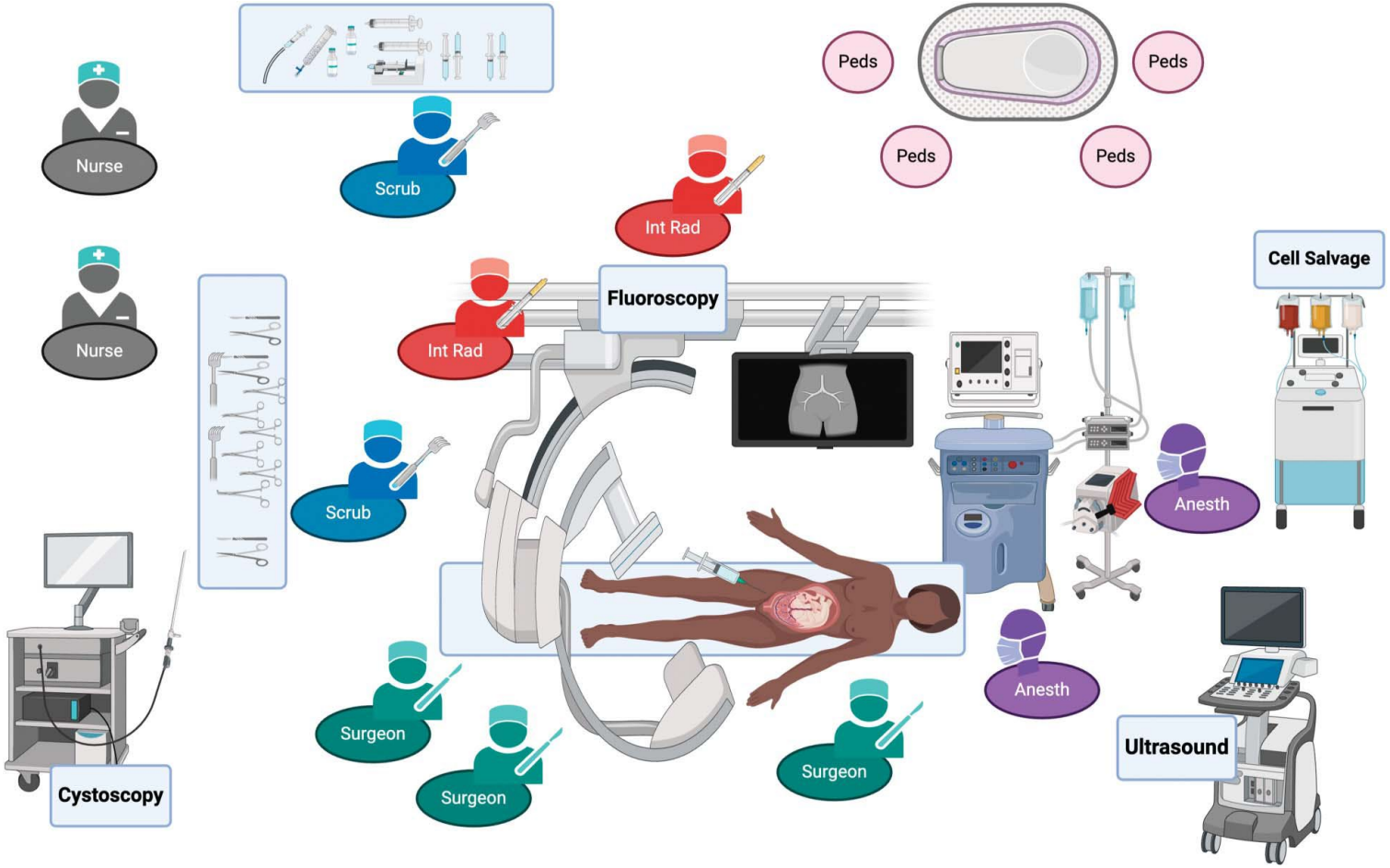
- none

Objectives

- After viewing this presentation the learner will be able to
  - Adress pre-operative optimization of the PAS patient
  - Discuss operative techniques involved in the delivery of the PAS patient

Delivery and Surgical Planning

- Coordination of care with MFM/OB for delivery timing and steroid administration, assess need for pre-admission
- Updated placental imaging, ideally 3rd trimester ultrasound and/or MRI
- Patient optimization
- Determine the location of delivery, i.e. main OR at a tertiary facility
- Verification of equipment and resources including the following:
  - Blood products with blood bank notification of possible MTP
  - Fetal monitoring prior to incision
  - Intra-op ultrasound with sterile sleeve
  - Anesthesiology equipment for intubation after infant delivery
  - NICU support
  - Surgical equipment (i.e. vessel-sealing devices, argon beam coagulation, cystoscopy with ureteral catheter placement, cell saver with considerations for amniotic fluid and Rh status)
  - Interventional radiology (pre-op balloon catheter placement vs. on standby for hemorrhage)



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Blood Products

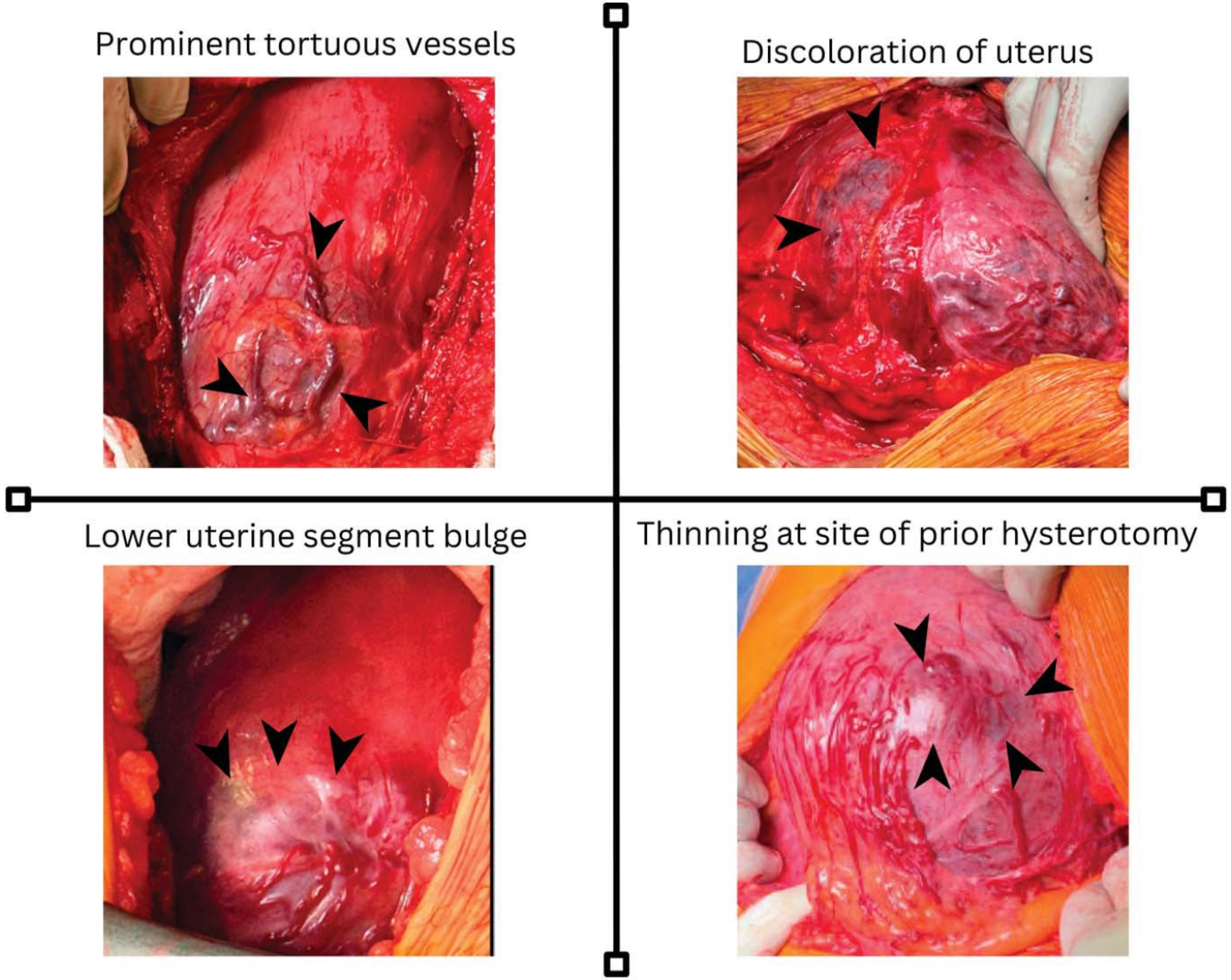
- Crossmatch for 6 units PRBC’s
- Consider FFP crossmatch
- Notify blood bank pre-operatively of possible need for MTP

Cystoscopy

- Highly useful for 2 reasons
  - Placement of ureteral catheters for intra-operative ureter identification
  - Assessment of the bladder mucosa for vascular involvement, evidence of percreta

Incisions

- Vertical midline for skin (even if prior Pfannenstiel)
- Assess placenta intra-operatively with ultrasound directly on uterine serosa with sterile sleeve to determine optimal incision, consider a high classical incision that even extends onto the posterior aspect of the uterus if necessary, or a transverse fundal incision from cornua to cornua



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Surgical Dissection

- After repair of the hysterotomy, assess your surgical planes, if you can get around the lower uterine segment without compromising sidewall structures – you are a “go” for hysterectomy
- When the going gets tough, the tough go somewhere else!
  - So…Deal the with the adnexa first
    - Ligate the utero-ovarian ligaments bilaterally first and make this separate from the Fallopian tube ligation off of the cornua
    - Do NOT waste time dissecting the Fallopian tubes off of the mesosalpinx at this point
  - Ligate the round ligaments
  - Skeletonize the uterine vessels (within reason)
  - Bladder will often be adherent in the midline, mobilize the bladder off of the lower uterine segment from a lateral approach
  - Consider a vessel-sealing device if the bladder is adherent in the midline
  - Clamp or seal on the uterine with one hand covering the ureter (palpate ureteral cather)
  - Mobilize the uterine pedicles a bit farther than you normally would for a routine hysterectomy

Questions?