SUSPECTED PLACENTA ACCRETA, INCRETA AND PERCRETA CONDITIONS MANAGEMENT CHECKLIST

MANAGEMENT CHECKLIST

1.0 Risk Stratification for Placenta Accreta, Increta, Percreta (Screening Tool)
2.0 Planning and Preparation for Delivery or Procedure
3.0 Planning for Elective Cesarean Section or Termination
4.0 Post Operative and Postpartum Care
5.0 Discharge Planning

1.0 Risk Stratification for Placenta Accreta, Increta, Percreta

If a woman has a suspicious ultrasound or has risk factors for medium or high risk for placental invasive disease, use the following:

**Screening Tool to Determine Risk** - % - chance has placental invasive disease

<table>
<thead>
<tr>
<th><strong>Low Risk</strong> less than (&lt;) 5%</th>
<th><strong>Medium Risk</strong> 5 - 25%</th>
<th><strong>High Risk</strong> greater than (&gt;) 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Placenta previa, no prior Cesarean section</td>
<td>Placenta previa with: ☐ One prior Cesarean section ☐ Multiple curettage ☐ History of prior accreta</td>
<td>☐ Ultrasound or MRI diagnosed suspicion of accreta ☐ Placenta previa with at least two prior Cesarean sections</td>
</tr>
<tr>
<td>☐ Placenta previa, prior curettage x 1 or manual removal of placenta</td>
<td></td>
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</tr>
</tbody>
</table>

2.0 Planning and Preparation for Delivery or Procedure (✓ checkmark when complete)

**History - Complete the obstetrical, medical history and physical including:**

- Complete history as per antenatal form
- Include # of previous C-section, D&C, manual removal of placenta, or uterine surgeries
- Complex Care Planning Fax to Delivery Suite - CC0700 Appendix A
- Complete this checklist, fax to Obstetricians office, keep with her file, send in to BCW with antenatal record at 36 weeks
- APH (number of episodes and significance)
- Medical consultations as indicated
- Consider/arrange Autologous donation and/or Erythropoietin (as per Vancouver Blood Utilization Program guidelines for pre-operative hemoglobin improvement: EPO 20,000-40,000 units sc every 7 days X 3 doses - use lower dose if weight < 55 kg)
- Iron therapy
- Referral to Obstetrician for consultation
- Relevant imaging studies
- Woman’s desire for future fertility
- Other

**Diagnostic**

- See appended RCOG Guidelines for recommended frequency of assessment
- Abdominal or transvaginal ultrasound and colour flow doppler, assess for:
  - Placental location
  - Previa
  - Suspected accreta, increta or percreta with other organ involvement
- MRI (per physician’s request)
- Determine extent of involvement

**Laboratory**

- CBC within 72 hours of Operating Room (OR) date/time
- Chemistry profile within 72 hours of Operating Room date
- Coagulation profile within 72 hours of Operating Room date
- Cross match for 4 units packed red cells – 72 hours prior to OR date
- Group and screen
- Urinalysis (Routine & Micro)

**Consultations:**

- Anesthesia
- Gynecological Oncology
- Neonatology
- Urology
- Interventional Radiology

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Refer to online version – Print copy may not be current – Discard after use
3.0 Planning for Elective Cesarean Section or Termination (√ checkmark when complete)

<table>
<thead>
<tr>
<th>Clinical Teams</th>
<th>Consultations On - call for Operating Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologist</td>
<td>Gynecological oncology</td>
</tr>
<tr>
<td>Obstetricians x 2</td>
<td>Urologist</td>
</tr>
<tr>
<td>Operating Room Nursing Team</td>
<td>Notify Transfusion Medicine Laboratory</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Respiratory Therapist if requested by anesthesia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Process:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell saver - per request by anesthesia</td>
<td>Cesarean Section or D&amp;E</td>
</tr>
<tr>
<td>Cystoscopy Equipment</td>
<td>Anesthesia time – invasive lines and induction</td>
</tr>
<tr>
<td>Hysterectomy Instrument Set</td>
<td>Radiology for iliac artery balloon catheter placement pre-procedure, as indicated</td>
</tr>
<tr>
<td>Invasive Monitoring Equipment</td>
<td>Urology - Ureteral Stent insertion by urologist, as indicated</td>
</tr>
<tr>
<td>Sponges - extra large</td>
<td>Gynecological Oncology - notify for back-up if complications during hysterectomy</td>
</tr>
<tr>
<td>Urology Cart</td>
<td>Hysterectomy, if required</td>
</tr>
<tr>
<td>Other</td>
<td>Radiology - page if embolization is required (per on-call book in LDR)</td>
</tr>
</tbody>
</table>

4.0 Post Operative Care (√ checkmark when complete)

<table>
<thead>
<tr>
<th>Immediate Care</th>
<th>Postpartum Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Anesthetic Recovery Room (PAR) for initial recovery and stabilization</td>
<td>Admit to a single room, if possible</td>
</tr>
<tr>
<td>High Risk Delivery Suite until stable</td>
<td>Assess the need for longer than usual use of foley catheter</td>
</tr>
<tr>
<td>When mother is unstable/ ventilated, the newborn may be transferred to Central Nursery or go with a support person to the postpartum room.</td>
<td>Check physician’s orders for staple removal</td>
</tr>
<tr>
<td>Newborn stays with mother when stable</td>
<td></td>
</tr>
</tbody>
</table>

5.0 Discharge Planning (√ checkmark when complete)

**Conservative Management Follow-up**

Maternal Fetal Medicine/ Obstetrician clinic appointment in 2-3 weeks and follow-up as needed.

Ultrasound every 2-3 weeks post-operatively for 2 months; then every month for 6 months.

Advanced care plan - Liaison Nurse forwards plan to woman’s Community Health Unit.

Discharge teaching for the woman:
- If signs of hemorrhage return to BCWH (for up to 6 weeks)
- Monitor temperature daily for 1 week
- No intercourse for 1 month

**Hysterectomy:** Follow-up 6-8 weeks post-operatively with the surgeon involved. If woman lives far away, woman should see her primary care physician

**REFERENCE**