FIGO consensus guidelines on placenta accreta spectrum disorders: Nonconservative surgical management

Lisa Allen [1] .
Eric Jauniaux [2] .
Sebastian Hobson [3] .
Jessica Papillon-Smith [4] .
Michael A. Belfort [5] .

[1]Department of Obstetrics and Gynecology, University of Toronto, Toronto, ON, Canada
[2]EGA Institute for Women's Health, Faculty of Population Health Sciences, University College London, London, UK
[3]Department of Obstetrics and Gynecology, University of Toronto, Toronto, ON, Canada
[4]Department of Obstetrics and Gynecology, University of Toronto, Toronto, ON, Canada
[5]Department of Obstetrics and Gynecology, Baylor College of Medicine, Texas Children's Pavilion for Women, Texas Medical Center, Houston, TX, USA

Correspondencia: Instituto de Medicina Tropical - Facultad de Medicina - Universidad Central de Venezuela.

Consignado el 08 de Marzo del 2018 a la Revista Vitae Academia Biomédica Digital.

FIGO CONSENSUS GUIDELINES ON PLACENTA ACCRETA SPECTRUM DISORDERS: NONCONSERVATIVE SURGICAL MANAGEMENT

For more than half a century after the first case series of placenta accreta was reported in 1937,[1] the main and often only approach to management was a cesarean hysterectomy. This approach had the advantage of reducing the immediate risks of major hemorrhage associated with accreta placentation at a time when there was no access to blood transfusion.

Over the last two decades, a variety of conservative options for the management of placenta accreta spectrum (PAS) disorders have evolved, each with varying rates of success, and peripartum and secondary complications.[2–4] In a recent systematic review and meta- analysis of the outcome of placenta previa accreta diagnosed prenatally, 208 out of 232 (89.7%) cases had an elective or emergent cesarean hysterectomy.[5] As a result of a lack of randomized clinical trials, the optimal management of PAS disorders remains undefined and is determined by the capacity to diagnose invasive placentation preoperatively, local expertise, depth of villous invasion, and presenting symptoms.[4]

In cases of high suspicion for PAS disorders during cesarean delivery, the majority of members of the Society for Maternal- Fetal Medicine (SMFM) proceed with hysterectomy and only 15%–32% report conservative management.[6,7]

However, there is considerable practice variation reported on aspects of care aroun delivery and hysterectomy by both obstetricians and maternal- fetal medicine specialists.[6,8]

There is also wide variation between high- incomecountries and low- and middle- income countries owing to limited or no access to specialist care and essentia additiona treatment, such as blood products for transfusion. Hysterectomy remains the definitive surgical treatment for PAS disorders, especially for its invasive forms, and a primary elective cesarean hysterectomy is the safest and most practical option for most low- and middle- income countries where diagnostic, follow- up, and additional treatments are not available. In this chapter, we review the evidence- based data onnonconservative surgery (i.e. cesarean hysterectomy) for the management of PAS disorders.