



Case report of Placenta accreta spectrum (PAS) with intrapartum diagnosis and management

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INTRODUCTION:

1937- obstetrician Frederick C. Irving and pathologist Arthur T. Hertig-pivotal publication and definition of PAS

PAS incidence is continuously increasing in the last decades:

- **Major risk factors:** prior cesarean section (CS) and placenta praevia (PP)
- **Additional risk factors:** uterine pathology (adenomyosis, endometritis), multiparity, previous uterine surgeries or curettage, Asherman syndrome, assisted reproductive technologies (ART), smoking.

CLINICAL CASE:

32 yrs.female,P3, 38GW presents in the first stage of labour for delivery;

POH (past obstetric history): 2 previous vaginal births – ART (IVF) pregnancies (hydrosalpinges and bilateral salpingectomy);

Following the vaginal birth placenta did not deliver after 30 minutes despite active management (uterotonics,cord traction) and gentle manual removal failed to find the clivage plane;

Clinical diagnosis of PAS was set and sustained by transabdominal Us. (Fig.1);

Absence of PPH (postpartum hemorrhage) - conservative management was tempted for uterine arteries embolization, considering patient desire for future fertility;

PPH prophylaxis: continuous oxytocin infusion, rectally misoprostol, antibiotic prophylaxis; Intensive maternal monitoring: vaginal bleeding, vital signs, hemodynamic and biochemistry parameters;

1,5 hrs. postpartum - massive vaginal hemorrhage - hemostasis hysterectomy (Fig. 2).

IMAGING RESULTS:

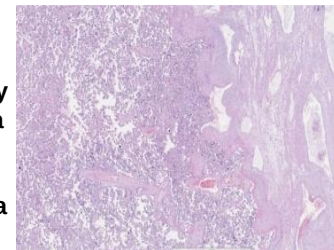
Fig .1 Postpartum Us.-
Posterior and fundal retained placenta with irregular maternal border, focally absent hypoechoic retroplacental space, thin underlying myometrium (<1 mm)



Fig.2 Uterine specimen with placenta in situ (PAS- Grade 2)



Fig. 3
Histopathology – Thin decidua and Nitabuch layer, focally absent decidua



CONCLUSIONS:

- Systematically consider early (1st trimester) Us. screening for PAS in subsets of women based on risk factors stratification.**
- Clinical factors remain equally important predictors.**
- Us. follow-up at 18-20, 28-30, 32-34 GW in asymptomatic patients (ACOG Recommendations).**
- Optional complementary MRI at 28 GW (Cristina. Bradeanu, radiologist-fetal MRI - good medical practice standards).**
- MRI improves sensibility and sensitivity of diagnosis (depth of invasion percreta signs of periuterine invasion,abnormal vascularity) in difficult (e.g.: posterior PP). or inconclusive cases.**
- Multidisciplinary care team optimizes management (complex cesarean, conservative or extirpative procedure), outcome and confidence of care.**
- Histopathologic confirmation is golden standard for PAS diagnosis (Fig. 3).**
- Clinical-imaging-pathologic correlation is essential for improving PAS incidence data, targeted screening, diagnosis skills and management protocols.**