It Takes a Village: A Multidisciplinary Approach to a Complex Case of Placenta Accreta Spectrum

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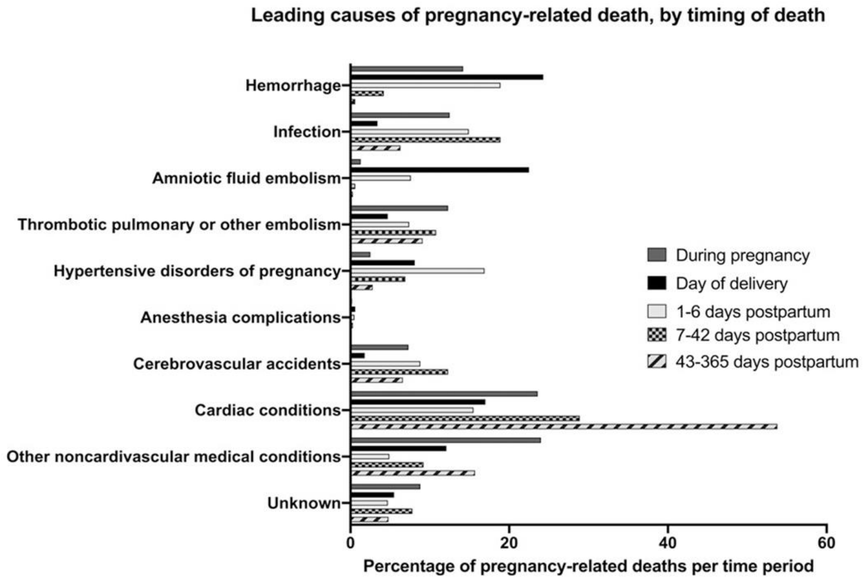
Placenta Accreta Spectrum

- Placenta Accreta Spectrum (PAS) is defined by ACOG as "pathologic adherence of the placenta."
- 3 types: placenta accreta, placenta increta, and placenta percreta
- Incidence has continued to increase as Cesarean section rates rise with the estimated incidence of PAS 1 in 272 deliveries.
- Risk factors: previous cesarean section, placenta previa, advanced maternal age, multiparity, prior uterine surgeries or curettage, and Asherman syndrome
- The most important ultrasonographic association of placenta accreta spectrum in the second and third trimesters is the presence of placenta previa which is present in more than 80% of accretas.
- Other ultrasound findings suggestive of PAS include multiple lacunae and turbulent flow



Deep Venous Thrombosis in Pregnancy

- Four-to-five-fold increased risk compared to nonpregnant state
- May account for up to 10% of maternal mortality in the US
- Multiple risk factors
  - Inherited: factor V Leiden, prothrombin G20210A
  - Acquired: lupus anticoagulants or anticardiolipin antibodies
  - Mechanical: compression of the left common iliac vein
- Often treated with anticoagulation, in pregnancy LMWH is the primary choice.

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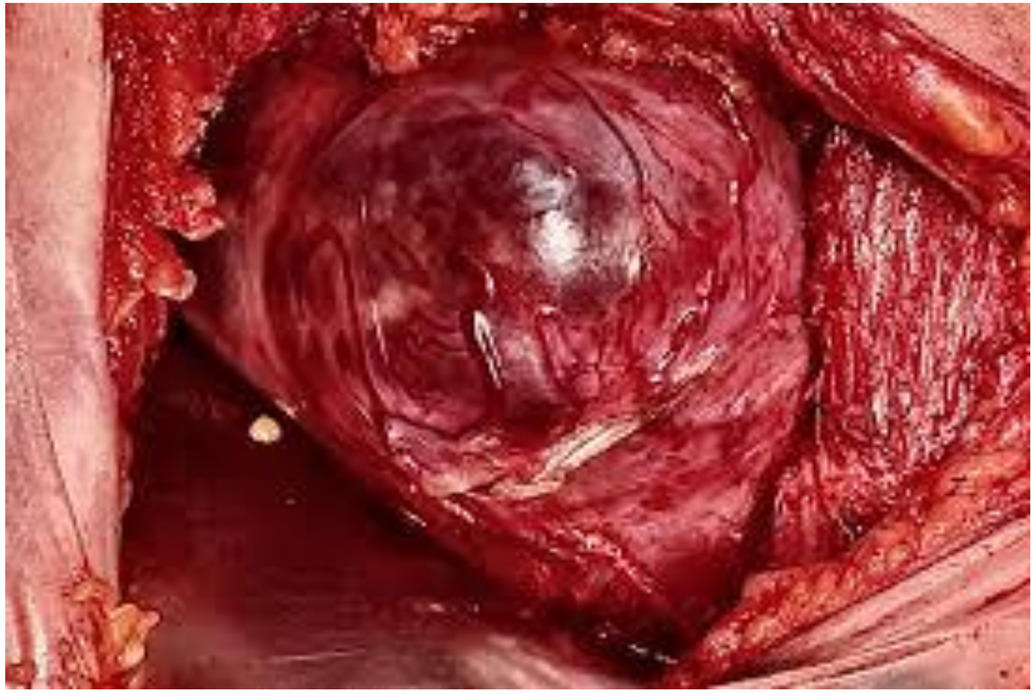
Case:

- 38 yo G5P2
- PMHx: cHTN, Factor V with previous DVT, Right MCA stroke, two previous c-sections
- Found to have possible PAS diagnosed on ultrasound, scheduled for cesarean with possible hysterectomy at 35 wks
- She presented at 31w4d with occlusive LLE DVT that extended from external iliac to popliteal vein. Vascular surgery was immediately consulted
- Thrombectomy was considered high-risk per MFM, and IR was consulted for IVC filter placement.
- A plan was made to place an infrarenal IVC filter two days prior to her scheduled cesarean
- Cardiothoracic surgery was consulted for possible ECMO cannulation during the surgery
- Our OB anesthesia team was involved with multidisciplinary meetings and helping plan day of surgery
- An anesthetic plan was made to place two large bore IVs and an arterial line followed by intraoperative placement of a combined spinal-epidural with conversion to GETA (at patient request) for the hysterectomy portion.
- QBL 2L requiring 2 units of pRBCs.
- The operative course was complicated by right ovarian vein thrombosis requiring salpingectomy.



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Takeaways

- This case required a multidisciplinary approach order to provide adequate and safe care for the patient
- In this case:
  - discussed with CT surgery plans for ECMO and cannulation
  - Aware of patient wishes during hysterectomy portion of the case
  - Extensive discussions with MFM and IR regarding anticoagulation and IVC filter removal
- It is vital in these cases to plan for worst case scenarios and have contingency plans if those scenarios do occur.
- Two opposing issues were at play: bleeding risk of PAS and the need for anticoagulation due to significant DVT burden
- IVC Filter complications can be higher in pregnancy
- Obstetric Anesthesiology will continue to be integral in leading multidisciplinary meetings and be available to consult and advise on these complex cases

References

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