Placenta Percreta involving the bladder requiring massive transfusion protocol

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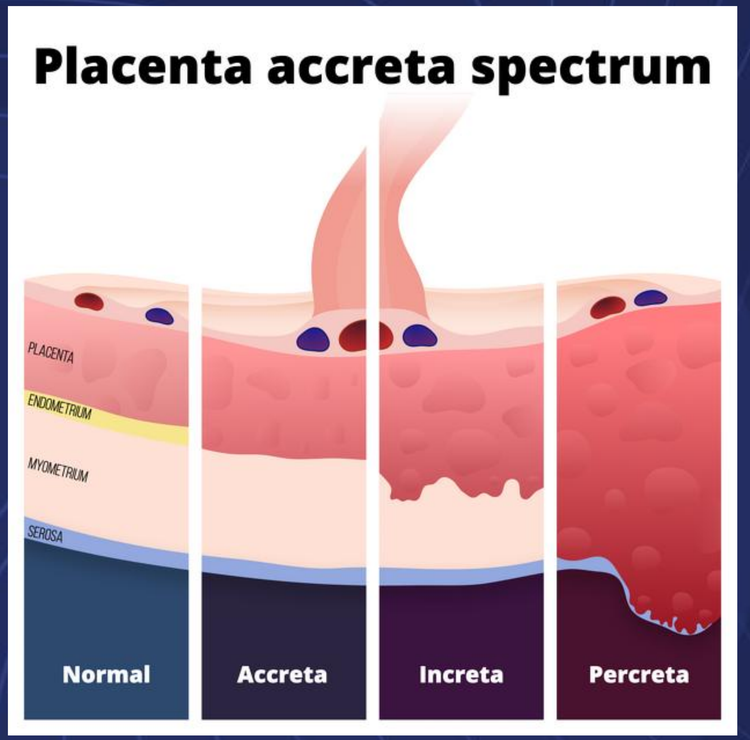
Background

- Placenta accreta spectrum (PAS) is becoming more common
  - From 1 in 30,000 in 1960s to 1 in 272 (1,2)
- Increased risk of morbidity and mortality especially if not known at time of delivery
- Risk factors: C-sections, uterine surgeries, advanced maternal age, multiparity
- Multidisciplinary care and coordination is necessary



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Case

- 37 year-old G6P4013, two prior C-sections and a D&C diagnosed with placenta percreta by ultrasound and MRI at 15 weeks gestation after an episode of vaginal bleeding
- Hematuria and vaginal bleeding at 33w3d with expedited delivery at 33w6d
  - Known bladder involvement
  - Planned for multidisciplinary C-hysterectomy with OB, MFM, gyn-onc, urology
  - Accommodated staffing and personnel changes at a high surgical volume tertiary hospital
- C-hysterectomy under CSE with planned conversion to GA
  - EBL ~17L; 24 pRBC, 17 FFP, 5 pooled platelets, 3 pooled cryoprecipitate, 3g TXA, 4g fibrinogen concentrate, 14L crystalloid
  - ACS and Interventional Radiology involvement for packing and gelfoam embolization
  - Abdominal closure POD1, extubated POD1, epidural removed POD3, discharged POD5
  - Complicated post-partum course with 3 additional urologic surgeries and hospitalizations

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Teaching points

- Delivery at III or IV care center for known PAS
- Careful coordination and team selection with back ups and flexibility
  - Obstetric complex care coordination committee
  - Obstetricians, MFM, anesthesiology, nursing, neonatal ICU, cardiology, blood bank and more
- Average blood loss is 3-5L
- Balanced lab guided resuscitation
- Epidural management post-operatively

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