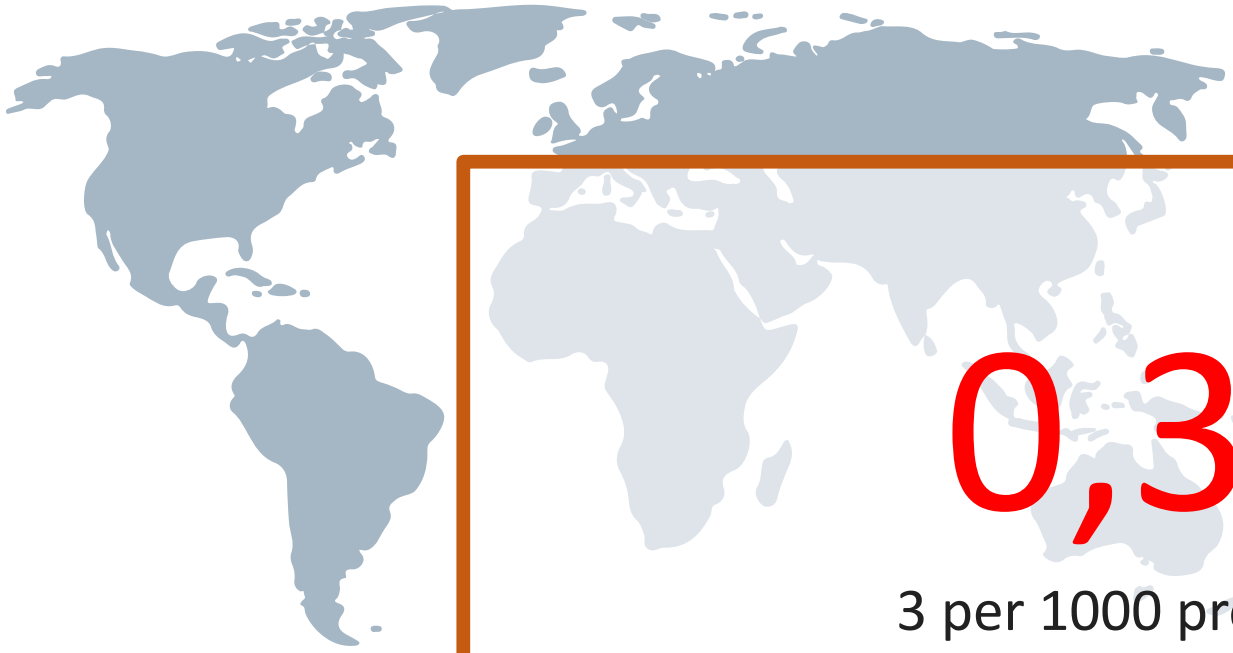
Traitement conservateur du placenta accreta

Pr Hassine Saber Abouda

Centre de maternité et de néonatologie de Tunis , Service C



0,3%

3 per 1000 pregnancies

Review > Obstet Gynecol Clin North Am. 2022 Sep;49(3):423-438. doi: 10.1016/j.ogc.2022.02.004.

Placenta Accreta Spectrum: Prenatal Diagnosis and Management

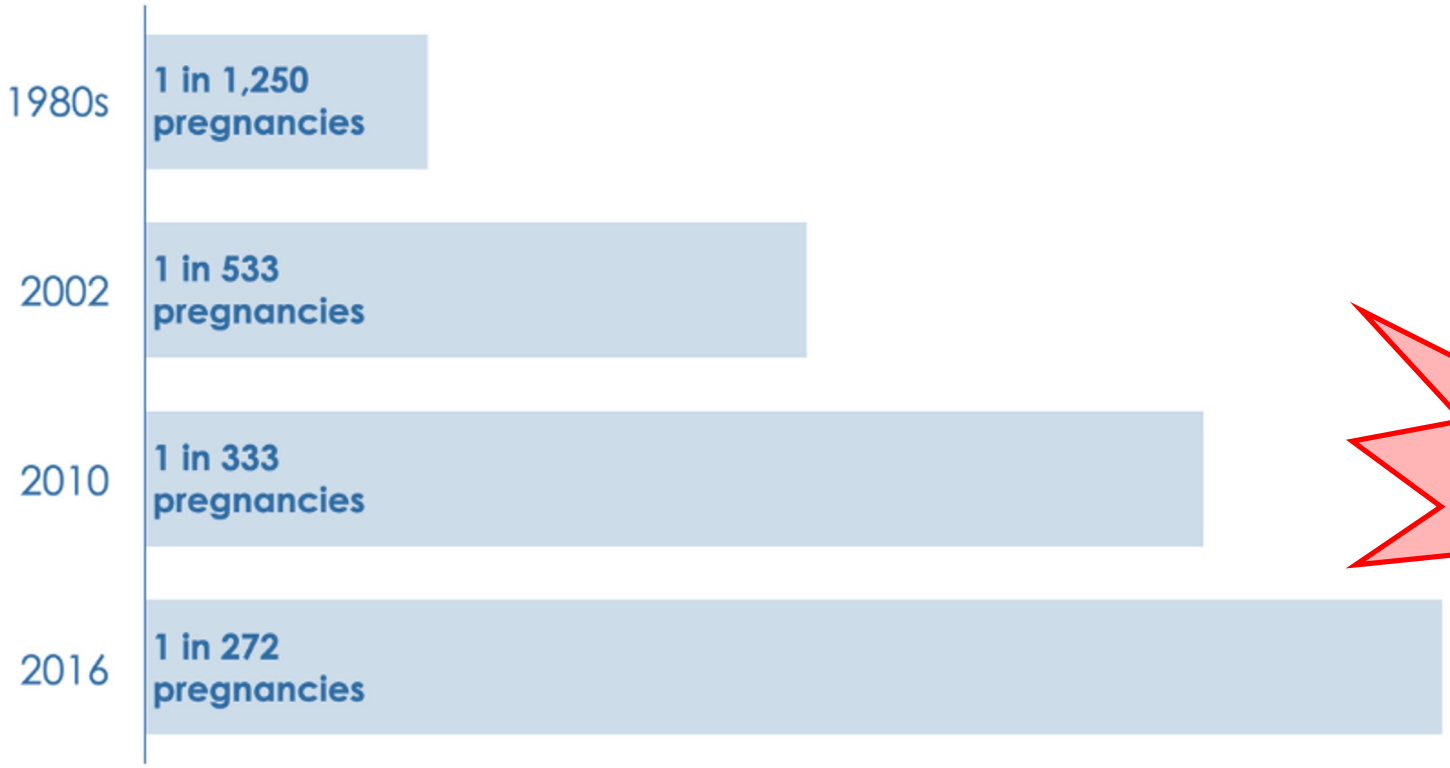
Rebecca Horgan [1], Alfred Abuhamad [2]

Affiliations + expand

PMID: 36122977 DOI: 10.1016/j.ogc.2022.02.004

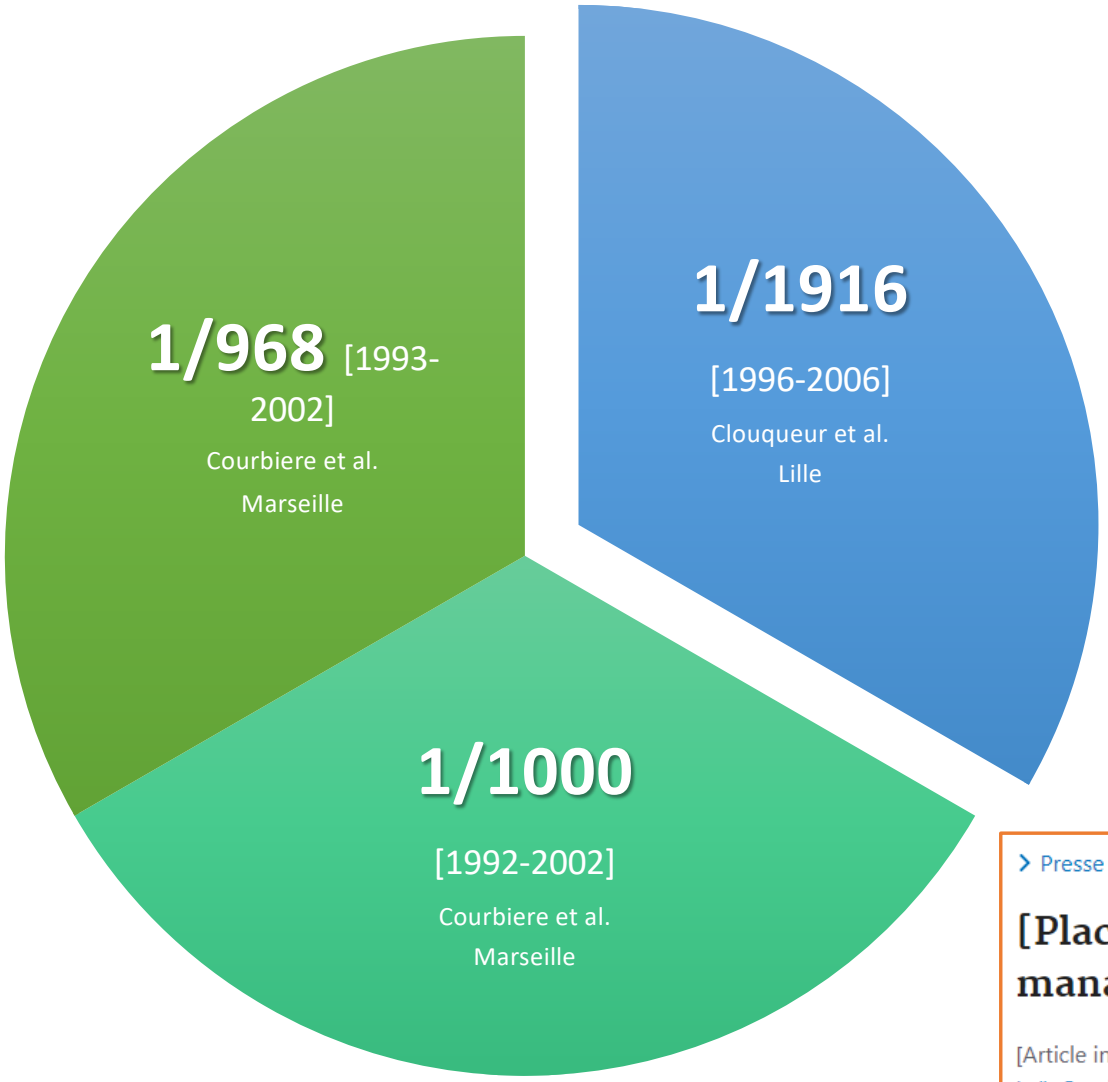
Horgan R, Abuhamad A. Placenta Accreta Spectrum: Prenatal Diagnosis and Management. Obstet Gynecol Clin North Am. 2022 Sep;49(3):423-438. doi: 10.1016/j.ogc.2022.02.004. PMID: 36122977.

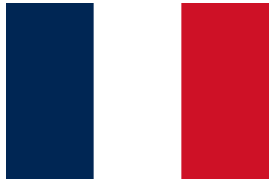
Incidence



national accreta foundation

1.Cahill, A. G., Beigi, R., Heine, R. P., Silver, R. M. & Wax, J. R. Placenta Accreta Spectrum. *American Journal of Obstetrics and Gynecology* **219**, B2–B16 (2018).





Presse Med. 2010 Jul-Aug;39(7-8):765-77. doi: 10.1016/j.lpm.2010.01.005. Epub 2010 Mar 19.

[Placenta accreta: Frequency, prenatal diagnosis and management]

[Article in French]

Loïc Sentilhes [1], Gilles Kayem, Clémence Ambroselli, Gilles Grangé, Benoit Resch, Françoise Boussion, Philippe Descamps

Entre **1 et 3/1000 naissances**

2021/2023 **15 Services**

144232 Accouchements

297 Placenta Accréta

2,06‰ des accouchements

Placenta du spectre accreta : prise en charge et morbidité dans une maternité française de niveau 3

Placenta accreta spectrum disorder: Management and morbidity in a French type-3 maternity

G. Chevalier [a,*], L. Devisme [b], C. Coulon [a]

Département de gynécologie obstétrique, centre hospitalier et universitair
Département d'anatomopathologie, centre hospitalier et universitaire de

Morbidité maternelle primaire pour les placentas accretas.

	Traitement conservateur ($n=3$)	Traitement non conservateur ($n=21$)
Hémorragie immédiate (mL)	1016 ± 1549	2956 ± 1182
Transfusion de CGR	1 (33 %)	15 (71,4 %)
Nombre moyen de CGR transfusés	4 ± 0	7 ± 1,6

Morbidité secondaire après traitement conservateur.

	Placenta accreta ($n=3$)	Placenta percreta ($n=9$)	Total = 12
Endométrite	1 (33,3 %)	4 (44,4 %)	5 (41,6 %)
Hémorragie retardée	2 (66,6 %)	0 (0 %)	2 (16,6 %)
CIVD	0 (0 %)	3 (33,3 %)	3 (25,0 %)
Hystérectomie secondaire	2 (66,6 %)	6 (66,6 %)	8 (66,6 %)
Délai moyen avant hystérectomie secondaire (jours)	12,5 ± 16	169 ± 97	130 ± 110
Hémorragie durant l'hystérectomie (mL)	2700 ± 424	633 ± 861	1077 ± 1058
Plaie de vessie	0 (0 %)	1 (11,1 %)	1 (8,3 %)
Hystéroscopie pour rétention placentaire	1 (33,3 %)	0 (0 %)	1 (8,3 %)

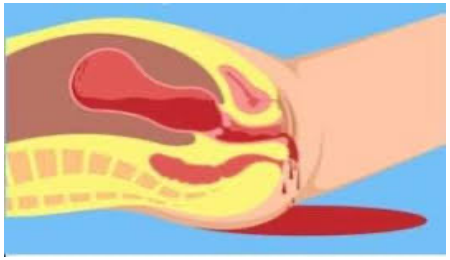
IVD : coagulation intravasculaire disséminée.

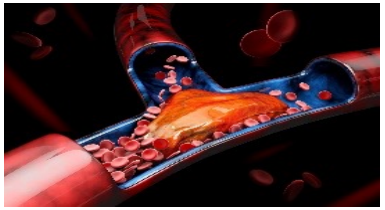
CGR : culot globulaire sanguin ; PFC : plasma frais congelé.

2 janvier 2020

Prise en charge

Cercle vicieux!



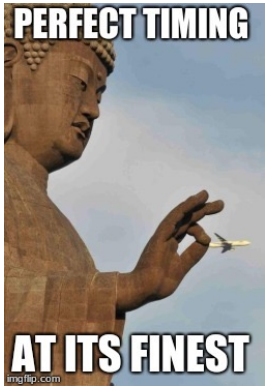


1- WHERE

- Maternité de niveau 3

2 Women with a diagnosis of placenta accreta spectrum disorder should be referred to a regional centre dedicated to the interdisciplinary management of this condition (II-3A).

JOGC



2- When

	Bizerte	H Monji Slim	CMNT A	CMNT B	CMNT C	CMNT D	H Aziza Othmena	HCN G25	HCN G26	H Ben Arous	H Farhat Hached	H Ibn Al-Jazzar	Monastir	Mahdia	Sfax	Total
Nombre de cas	13	7	9	19	62	20	4	13	11	20	18	27	8	23	43	297
Temre de découverte	30,9	27,8	28,5	31,1	31,7	34	34	29,7	32,2	27,2	32,2	31,8	33,1	32,9	32,7	31,32
Terme accouchement	34,3	32	34,1	33,7	35,4	36	35	34,4	34,7	33,6	36	33,2	36,3	37,2	35,5	**34,76**
C/S en urgence	8	7	7	12	23	8	4	9	5	11	7	1	2	12	23	139

Terme moyen d'accouchement 35 SA (32 SA- 37,2 SA)

46,8 % en urgence

FIGO GUIDELINES

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

Lisa Allen, Eric Jauniaux ✉, Sebastian Hobson, Jessica Papillon-Smith, Michael A. Belfort, for the FIGO Placenta Accreta Diagnosis and Management Expert Consensus Panel

First published: 06 February 2018 | https://doi.org/10.1002/ijgo.12409 | Citations: 161

À l'heure actuelle, les données ne suffisent pas à déterminer l'âge optimal exact de l'accouchement planifié. Différents centres ont publié des protocoles variés avec des recommandations allant de 34 à 36 semaines à 36-38 semaines d'âge gestationnel pour l'accouchement programmé.

=> Lorsque le risque d'hémorragie prépartum est faible, l'accouchement à **37 semaines** peut être optimal.

AJOG American Journal of Obstetrics & Gynecology

Accouchement à partir de **35 SA** pour diminuer le risque d'hémorragie sévère.
Si patiente est asymptomatique, ne pas dépasser le terme de **37SA**.

Recommandations 2015.

Royal College of Obstetricians & Gynaecologists

7.4 When should delivery be planned for women with placenta accreta spectrum?

In the absence of risk factors for preterm delivery in women with placenta accreta spectrum, planned delivery at 35^{+0} to 36^{+6} weeks of gestation provides the best balance between fetal maturity and the risk of unscheduled delivery. [*New 2018*] ☑

Guidelines 2018

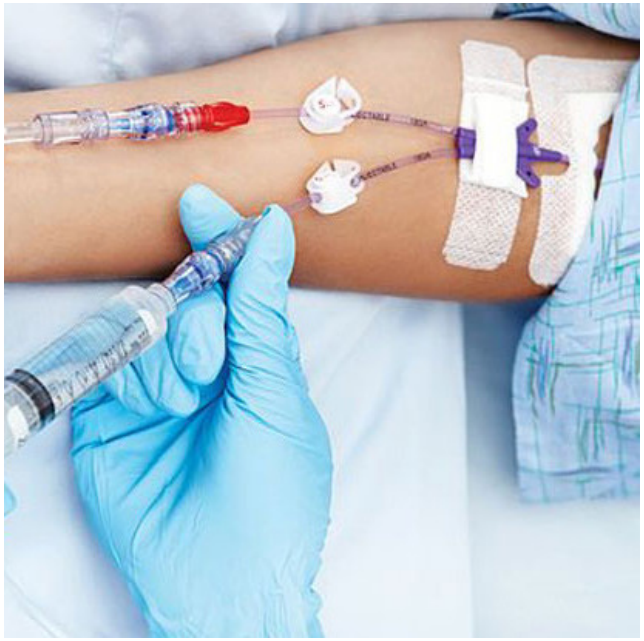
ACOG The American College of Obstetricians and Gynecologists

Delivery at 34 0/7–35 6/7 weeks of gestation is suggested as the preferred gestational age for scheduled cesarean delivery or hysterectomy absent extenuating circumstances in a stable patient. Earlier delivery may be required in cases of persistent bleeding, preeclampsia, labor, rupture of membranes, fetal compromise, or developing maternal comorbidities.

1A Strong recommendation, high-quality evidence

Décembre 2018

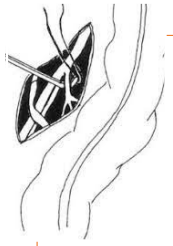
3-Préparation préopératoire



Morbidité

	Bizerte	H Monji Slim	CMNT A	CMNT B	CMNT C	CMNT D	H Aziza Othmena	HCN G25	HCN G26	H Ben Arous	H Farhat Hached	H Ibn Al-Jazzar	Monastir	Mahdia	Sfax	Total	
Plaie vésicale	1	0	0	1	3	2	0	0	2	1	4	5	2	3	7	31	10,4%
Plaie digastive	0	0	1	0	1	3	0	0	0	0	0	0	0	0	0	5	1,6%
Transfucion massive	7	4	5	13	38	10	2	6	6	9	6	12	2	10	25	155	52,2%
Séjour en Réanimation	0	0	2	1	16	12	0	0	0	0	0	0	0	0	4	35	11,8%
Complications hémorragiques	2	0	1	0	7	2	0	0	1	2	0	1	0	1	2	19	6,3%
Complications thrombo-emboliques	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	3	1%

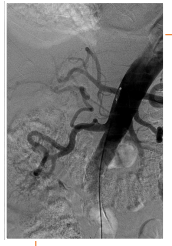
5-Traitements associés



Ligature des artères hypogastriques

Tourniquet

Ballonnet intra vasculaire



Embolisation

Packing

Sondes JJ

Mise en place d’un tourniquet

European Journal of Obstetrics & Gynecology and Reproductive Biology: X
Volume 21, March 2024, 100285

Tourniquet on the low segment of the uterus reduces blood loss in postpartum hemorrhage during hysterectomy for placenta accreta: Old but gold

Hassine S. Abouda [a], Sofiene B. Marzouk [b], Yecer Boussarsar [b], Haithem Aloui [a,*], Hatem Frikha [a], Rami Hammami [a], Badis Chennoufi [a], Hayen Maghrebi [b]

[a] *Department ‘C’ of Gynecology and Obstetrics, University of Tunis El Manar, Faculty of*
[b] *Department of Anesthesiology and Intensive Care, University of Tunis El Manar, Faculty*

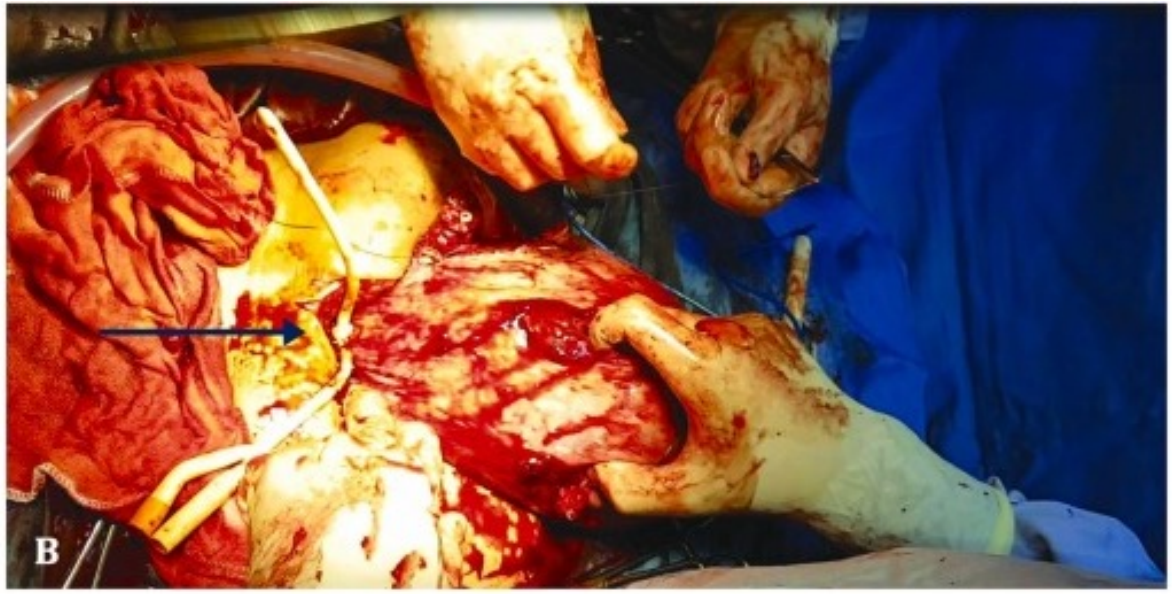


Table 2. Primary outcomes.

	TG* (n = 20)	CG† (n = 23)	*p*
Estimated blood loss, mean (SD), ml	530 ± 135	940 ± 120	0.0074
Lowest per operative Hb, median (IQR), g/dl	10.8[10.2-12.7]	8.7[8-10.3]	0.032
Δ Hb‡, median (IQR), g/dl	0.6[0.3-1.9]	2.5[2.5-3.6]	0.006
Transfused RBC§, mean (SD), units	2 ± 1.7	4.3 ± 2.1	0.046
Surgery duration, mean (SD), minutes	98 ± 21	137 ± 33	0.015
ICU‖ transfer, No. (%)	16(80%)	20(87%)	0.53

* Tourniquet group † Control group ‡ Hemoglobin variation § Red Blood cell ‖ Intensive care unit

Les ballonnets intravasculaires

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology: X

journal homepage: www.journals.elsevier.com/european-journal-of-obstetrics-and-gynecology-and-reproductive-biology

Prophylactic occlusion balloons of both internal iliac arteries in caesarean hysterectomy for placenta accreta spectrum disorder reduces blood loss: A retrospective comparative study

Saber Hassine Abouda [a], Haithem Aloui [a,*], Hadhami JAOUAD [a], Sofiene B. MARZOUK [b], Hatem Frikha [a], Rami Hammami [a], Mohamed Badis Channoufi [a], Hayen Maghrebi [b]

[a] Tunis Maternity and Neonatology Center/Department 'C' of Gynecology and Obstetrics, Tunisia
[b] Tunis Maternity and Neonatology Center/Department of Anaesthesiology and Intensive Care, Tunisia

2888 ± 863 ml in CG to 1828 ± 324 ml in OBIIAG ($p < 0.01$). It reduced the need for massive transfusion (10 ± 5 Red Blood Cell Unit in CG vs 4 ± 3 Red Blood Cell Unit in OBIIAG, $p < 0.01$). The average duration of surgery was 112 min. The operative time was estimated at 126 ± 36 min for CG and 92 ± 17 min for OBIIAG ($p = 0.04$). Placement of prophylactic intra-iliac occlusion balloons shortened the length

CMNT Centre de Maternité et de Néonatologie DE TUNIS

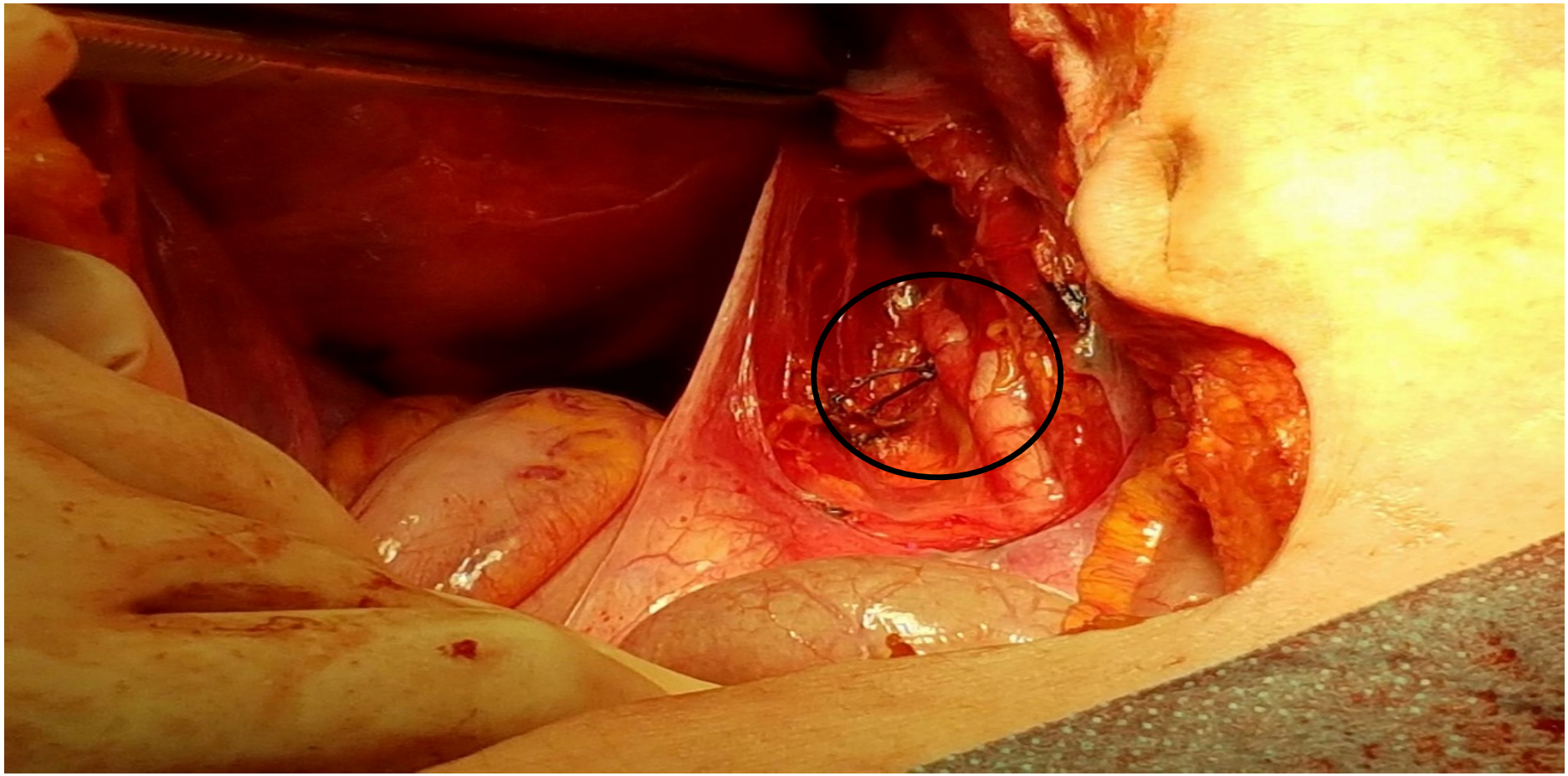
Notre expérience

Dr Hatem Rajhi

- 2 ans
- Service C du centre de maternité de Tunis
- 3000 accouchements / an

CG* (n = 22) **OBIIAG† (n = 16)**

Ligature bilatérale des artères hypogastriques



	Bizerte	H Monji Slim	CMNT A	CMNT B	CMNT C	CMNT D	H Aziza Othmena	HCN G25	HCN G26	H Ben Arous	H Farhat Hached	H Ibn Al-Jazzar	Monastir	Mahdia	Sfax	Total
Nombre de cas	13	7	9	19	62	20	4	13	11	20	18	27	8	23	43	297
Accreta Total	7	2	7	11	27	17	1	3	9	9	10	8	3	6	32	152
Accreta Partiel	6	5	2	8	35	3	3	10	2	11	8	19	5	17	11	145
Traitement radical	4	2	7	16	30	20	1	8	8	10	11	14	3	8	35	177
Traitement conservateur	9	5	2	3	32	0	3	5	3	10	7	13	5	15	8	120
Ligature hypogastrique	3	2	0	2	12	2	0	7	4	6	10	3	2	1	7	61

Recours à la ligature bilatérale des artères hypogastriques dans **20,5 %** des cas

Surgical Ligation of the IIAs

Review › Am J Obstet Gynecol. 2020 Sep;223(3):322-329. doi: 10.1016/j.ajog.2020.01.044. Epub 2020 Jan 30.

Minimizing surgical blood loss at cesarean hysterectomy for placenta previa with evidence of placenta increta or placenta percreta: the state of play in 2020

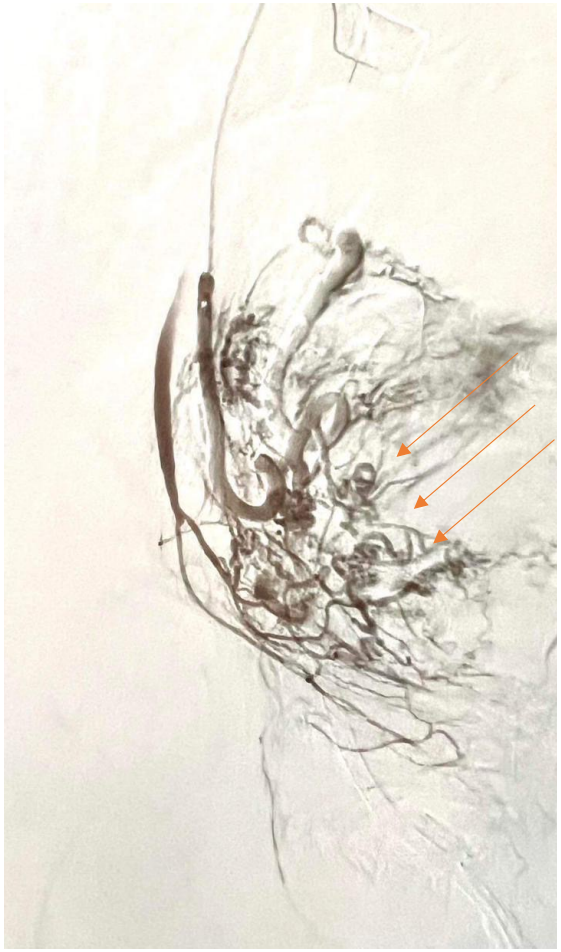
- Des expériences classiques ont observé que la ligature bilatérale des AII réduisait flux sanguin immédiatement dans segment distal de l'artère iliaque de **48 %**
- Faible efficacité immédiate de ce type de ligature par la présence d'anastomoses ilio-lombaires, sacrales et hémorroïdales vers la vasculature iliaque distale
- Par conséquent, tout bénéfice clinique significatif de cette intervention est probablement de courte durée et inférieur à **20 minutes**.

Randomized Controlled Trial › J Matern Fetal Neonatal Med. 2019 Oct;32(20):3386-3392. doi: 10.1080/14767058.2018.1463986. Epub 2018 Apr 25.

The role of prophylactic internal iliac artery ligation in abnormally invasive placenta undergoing caesarean hysterectomy: a randomized control trial

Un essai pilote randomisé égyptien n'a trouvé aucun bénéfice

Embolisation bilatérale des artères utérines



L'embolisation bilatérale des artères utérines :

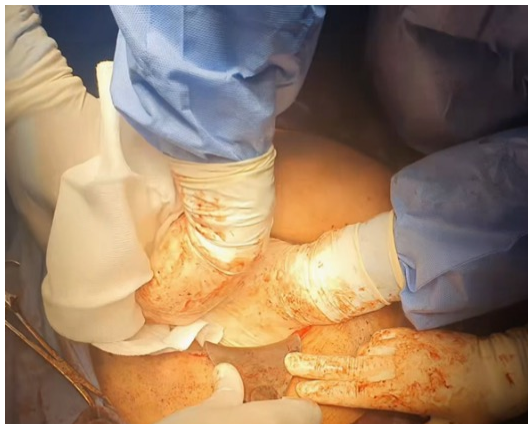
→en post partum : utile en cas de traitement conservateur

→en prophylactique : **non recommandée** en pratique
Pas assez d'études

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

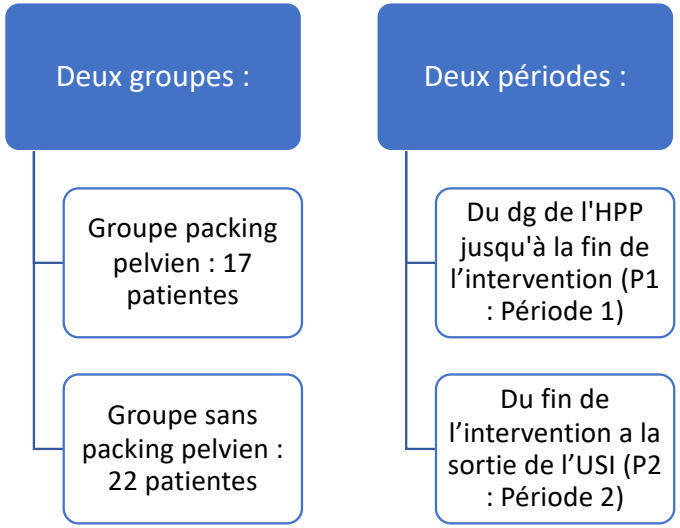


Efficacy and safety of pelvic packing after emergency peripartum hysterectomy (EPH) in postpartum hemorrhage (PPH) setting

Touhami Omar [a,*], Sofiene Ben Marzouk [b], Mahdi Kehila [a], Laidi Bennasr [b], Aymen Fezai [b], Mohamed Badis Channoufi [a], Hayen El Magherbi [b]

[a] "C" Department of Obstetrics and Gynecology, Tunis Maternity and Neonatology Center, Tunis El Manar University, Tu
[b] Anesthesiology and Reanimation Department, Tunis Maternity and Neonatology Center, Tunis El Manar University, Tu

- 39 patientes : HPP sévère



Blood products transfusion in P_1 and P_2.

	Packing group ($n=17$)	Non-packing group ($n=22$)	p-Value
Blood products transfusion in P_1, mean± standard deviation			
PRBC units	16.6 ± 5.3	14 ± 5	0.04
Fresh frozen plasma Transfusion units	24.5 ± 11.6	16.7 ± 8.7	0.01
Platelet transfusion units	12 ± 8.7	9.6 ± 8.9	0.4
Blood products transfusion in P_2, mean ± standard deviation			
PRBC units	3 ± 4	4.9 ± 7.9	0.3
Fresh frozen plasma Transfusion units	5.9 ± 7.7	4.3 ± 9.4	0.3

➔La réduction du nombre de CGR transfusés entre P1 et P2 était plus significative dans le groupe ayant bénéficié du packing(13,3) que dans celui packing (9,1). ($p < 0,01$).

Place de la montée de sondes urétérales

Placenta accreta spectrum: Risk factors, diagnosis and management with special reference to the Triple P procedure

Ana Piñas Carrillo[1] and Edwin Chandraharan[2]

maturity and the risk of emergency delivery. The RCOG does not recommend the routine use of ureteric stents as there are currently insufficient data; however, this may have a role when the urinary bladder is invaded by placental tissue or if it is anticipated that there is a parametrial invasion with a high risk of ureteric injury during the surgery.[35]

› Obstet Gynecol. 2022 Nov 1;140(5):806-811. doi: 10.1097/AOG.0000000000004957.
Epub 2022 O

Prophy … nary Injury … ta Spectr…

Decreased risk of genitourinary injury during hysterectomy for PAS.

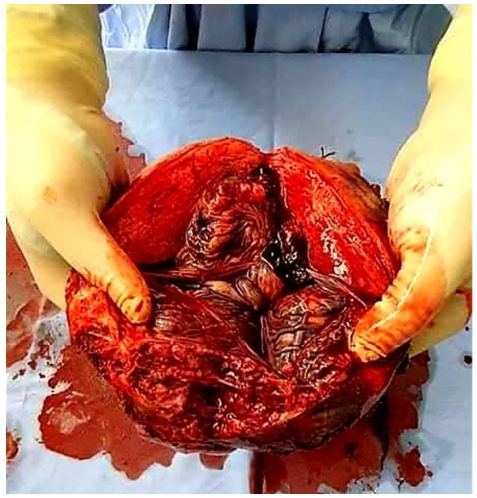
Morgan A Scaglione [1], Amanda A Allshouse, Dana R Canfield, Hannah D Mclaughlin, Ann M Bruno, Ibrahim A Hammad, D Ware Branch, Kathryn A Maurer, Robert L Dood, Michelle P Debbink, Robert M Silver, Brett D Einerson

Review › Am J Obstet Gynecol MFM. 2023 Oct;5(10):101120. doi: 10.1016/j.ajogmf.2023.101120.
Epub 2023 Aug 5.

Prophy … r the preven … during hyster… …rum: systematic review and meta-analysis

No difference in the rates of genitourinary tract injury

Césarienne - Hystérectomie



Surgical Approach

Generally, the recommended management of suspected placenta accreta is planned preterm cesarean hysterectomy with the placenta left in situ because removal of the

ACOG 2018

- La césarienne-hystérectomie, consistant à réaliser une hystérectomie après la naissance de l'enfant, est actuellement considérée dans le monde comme le « gold standard » pour la prise en charge des placentas accreta/percreta.

CNGOF 2009

Placenta Accreta*

N. R. DAVIDSON, M.D., *New Orleans, La.*

Incidence: Placenta accreta is rare. The first recorded case was described in 1889 by Ahlfeld. In 1897 Weisse first successfully performed a vaginal hysterectomy, and in 1900 Alexandroff performed an abdominal hysterectomy for placenta accreta.

	Bizerte	H Monji Slim	CMN T A	CMN T B	CMN T C	CMN T D	H Aziza Othmena	HCN G25	HCN G26	H Ben Arous	H Farhat Hached	H Ibn Al-Jazzar	Monastir	Mahdia	Sfax	Total
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Traitement radical	4	2	7	16	30	20	1	8	8	10	11	14	3	8	35	177
Traitement conservateur	9	5	2	3	32	0	3	5	3	10	7	13	5	15	8	120
Ligature hypogastrique	3	2	0	2	12	2	0	7	4	6	10	3	2	1	7	61

Statistiques élaborées par Dr Mehdi Bouassida_ TUNISIE 2024

OUI ! MaiS...

Associée à des taux élevés (40% à 50%) de **morbidité** maternelle sévère, et dans les cas de placenta percreta, les taux de mortalité peuvent atteindre jusqu'à 7%.

FIGO consensus guidelines on placenta accreta spectrum disorders: Conservative management 2018

Prevalence, Indications, Risk Indicators, and Outcomes of Emergency Peripartum Hysterectomy Worldwide

A Systematic Review and Meta-analysis

Indication	Prevalence (n=6,765)
Placental pathology	2,542 (38)
Abnormally invasive placenta	1,276 (19)
Placenta previa	650 (10)
Combined or unspecified placental pathology	517 (8)
Placental abruption or couvelaire uterus	99 (1)
Uterine atony	1,819 (27)
Uterine rupture*	1,740 (26)
Unspecified hemorrhage	352 (5)
Infection†	129 (2)
Cervical tear or laceration	85 (1)
Leiomyomas or myomas with major obstetric hemorrhage	56 (1)
Disseminated intravascular coagulation	30 (<1)
Hematoma‡	26 (<1)
Abnormal pregnancy§	12 (<1)
Other‖	33 (<1)
Unknown	126 (2)

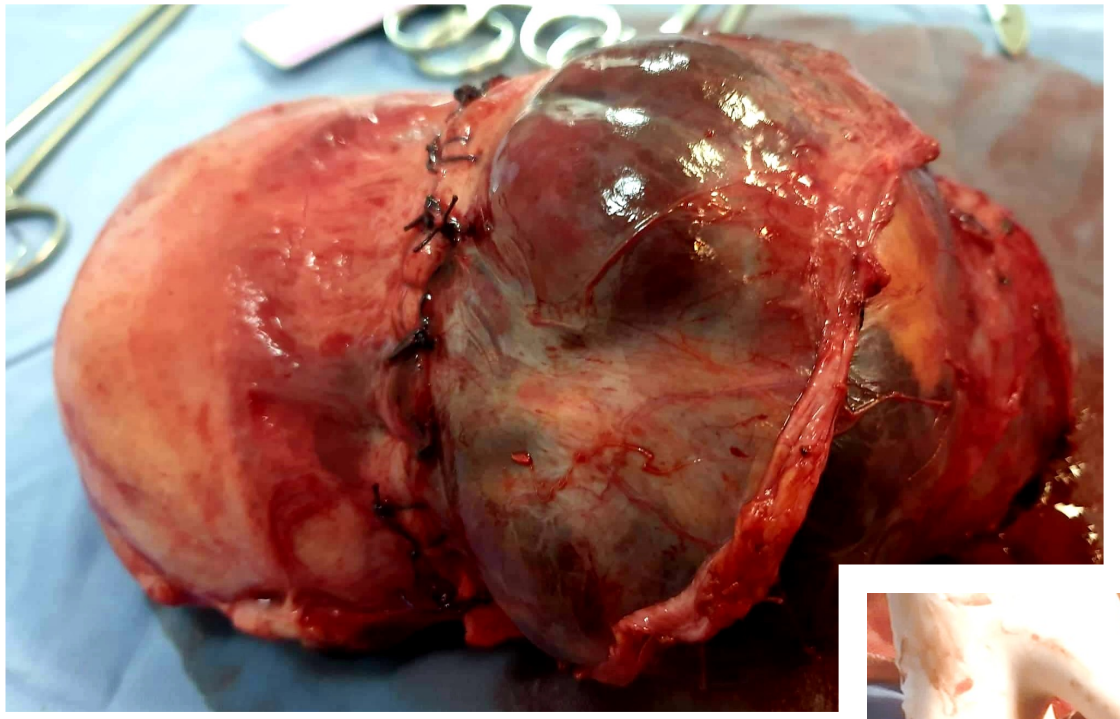
Complication	Prevalence (n=5,704 Women)
Hematologic*	1,477 (26)
Febrile morbidity	1,071 (19)
Genitourinary†	570 (10)
Wound‡	566 (10)
Infection§	564 (10)
Pulmonary‖	171 (3)
Renal¶	149 (3)
Gastrointestinal#	148 (3)
Thromboembolic**	57 (1)
Cardiovascular††	54 (1)
Psychologic disturbance	54 (1)
Neurologic‡‡	7 (<1)
Endocrinologic§§	7 (<1)
Other‖‖	71 (1)

van den Akker T, Brobbel C, Dekkers OM, Bloemenkamp KWM. Prevalence, Indications, Risk Indicators, and Outcomes of Emergency Peripartum Hysterectomy Worldwide: A Systematic Review and Meta-analysis. Obstet Gynecol. 2016 Dec;128(6):1281-1294. doi: 10.1097/AOG.0000000000001736. PMID: 27824773.

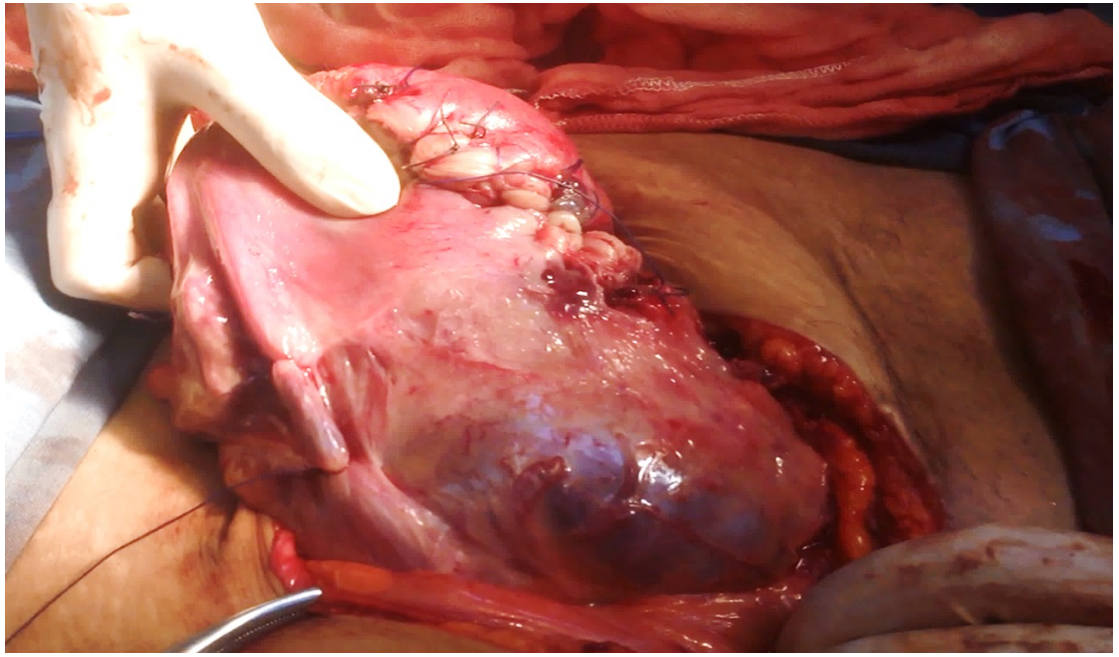
Qu'en est-il pour le long terme ?


"How are you?
Confused; Betrayed
Useless
Broken
Never good Enough
Fragile; Anxious
Falling apart and
you don't notice it
Pathetic; Annoying
Reject
Lonely
Defeated

Einerson BD, Watt MH, Sartori B, Silver R, Rothwell E. Lived experiences of patients with placenta accreta spectrum in Utah: a qualitative study of semi-structured interviews. BMJ Open. 2021;11(11):e052766. Published 2021 Nov 3. doi:10.1136/bmjopen-2021-052766



“LEAVING THE PLACENTA IN SITU” APPROACH



Traitement conservateur : technique

Incision cutanée: médiane sous ombilicale

→Pas de tentative de délivrance artificielle

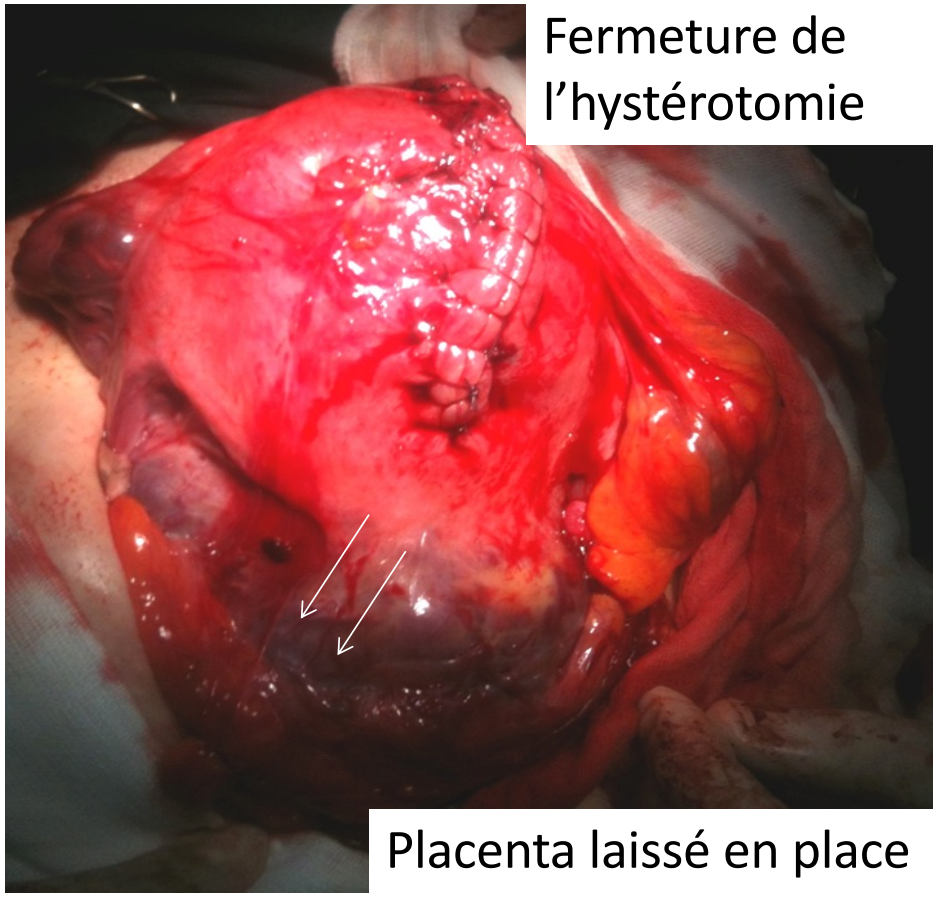
Hystérotomie verticale à distance de la zone d'insertion placentaire

→pas d'ocytociques

→Fermeture de l'hystérotomie

Après extraction fœtale:

→Ligature section du cordon à sa base



Fermeture de l'hystérotomie

Placenta laissé en place

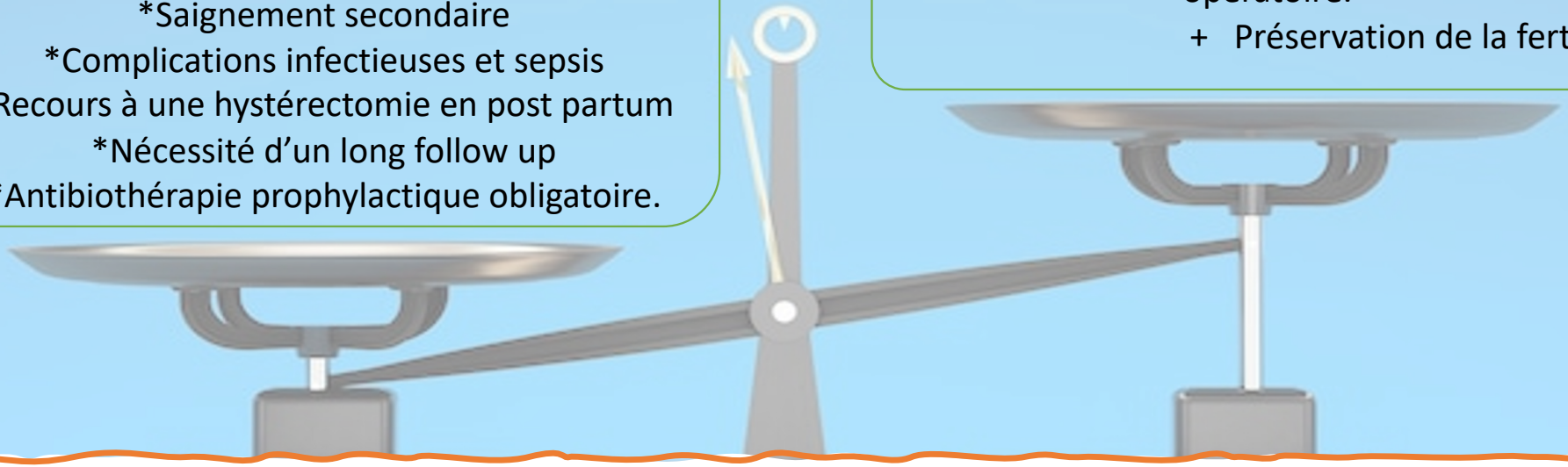
	Bizerte	H Monji Slim	CMNT A	CMNT B	CMNT C	CMNT D	H Aziza Othmena	HCN G25	HCN G26	H Ben Arous	H Farhat Hached	H Ibn Al-Jazzar	Monastir	Mahdia	Sfax	Total
Nombre de cas	13	7	9	19	62	20	4	13	11	20	18	27	8	23	43	297
Accreta Total	7	2	7	11	27	17	1	3	9	9	10	8	3	6	32	152
Accreta Partiel	6	5	2	8	35	3	3	10	2	11	8	19	5	17	11	145
Traitement radical	4	2	7	16	30	20	1	8	8	10	11	14	3	8	35	177
Traitement conservateur	9	5	2	3	32	0	3	5	3	10	7	13	5	15	8	120
Ligature hypogastrique	3	2	0	2	12	2	0	7	4	6	10	3	2	1	7	61

Statistiques élaborées par Dr Mehdi Bouassida_ TUNISIE 2024

40,4% Traitement conservateur

*Résorption lente : (20 semaines)
risque de :
*Saignement secondaire
*Complications infectieuses et sepsis
*Recours à une hystérectomie en post partum
*Nécessité d'un long follow up
*Antibiothérapie prophylactique obligatoire.

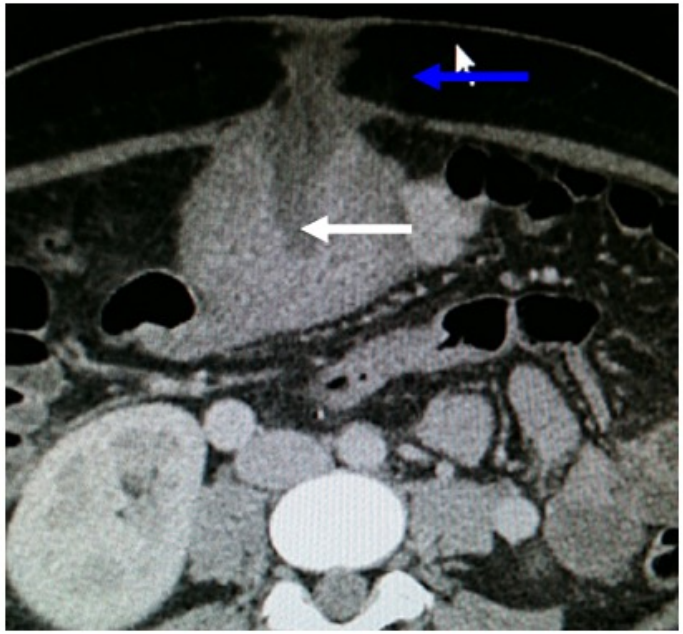
réduction du risque de saignement en per opératoire.
+ Préservation de la fertilité



En cas d'hémorragie massive incontrôlée ou d'échec des traitements adjuvants, une hystérectomie d'hémostase s'impose et ne doit pas être retardée.

Maternal Morbidity After Conservative Treatment for Placenta Accreta, Including Placenta Percreta

Characteristic	Placenta Accreta Including Percret (n=167)
Primary hysterectomy	18 (10.8)
Cause of primary hysterectomy	
Primary postpartum hemorrhage	18/18 (100)
Postpartum prophylactic antibiotic therapy more than 5 d	54 (32.3)
Transfusion patients	70 (41.9)
Units of packed RBCs transfused more than 5	25 (15.0)
Transfer to intensive care unit	43 (25.7)
Duration of stay in intensive care unit (d)	2.36±1.93
Acute pulmonary edema	1 (0.6)
Acute renal failure	1 (0.6)
Adjacent organ injury	1 (0.6)
Septic shock	1 (0.6)
Sepsis*	7 (4.2)
Infection	47 (28.1)
Endometritis	15 (9.0)
Wound infection	8 (4.7)
Peritonitis	2 (1.2)
Pyelonephritis	2 (1.2)
Vesicouterine fistula	1 (0.6)
Uterine necrosis	2 (1.2)
Isolated postpartum fever higher than 38.5°C for 24 h	17 (10.2)
Deep vein thrombophlebitis or pulmonary embolism	3 (1.8)
Secondary postpartum hemorrhage	18 (10.8)
Delayed hysterectomy	18 (10.8)
Median interval from delivery to delayed hysterectomy (d)	22 (9–45)
Cause of delayed hysterectomy	
Secondary postpartum hemorrhage	8/18 (44.4)
Sepsis	2/18 (11.1)
Secondary postpartum hemorrhage and sepsis	3/18 (16.7)
Vesicouterine fistula	1/18 (5.6)
Uterine necrosis and sepsis†	2/18 (11.1)
Arteriovenous malformation	1/18 (5.6)
Maternal request	1/18 (5.6)
Death	1 (0.6)
Success of conservative treatment	131 (78.4)
Severe maternal morbidity	10 (6.0)



Uterocutaneous fistulae following conservative management of placenta percreta. Blue arrow denotes anterior abdominal wall with uterocutaneous fistulous tract; white arrow denotes uterine cavity.

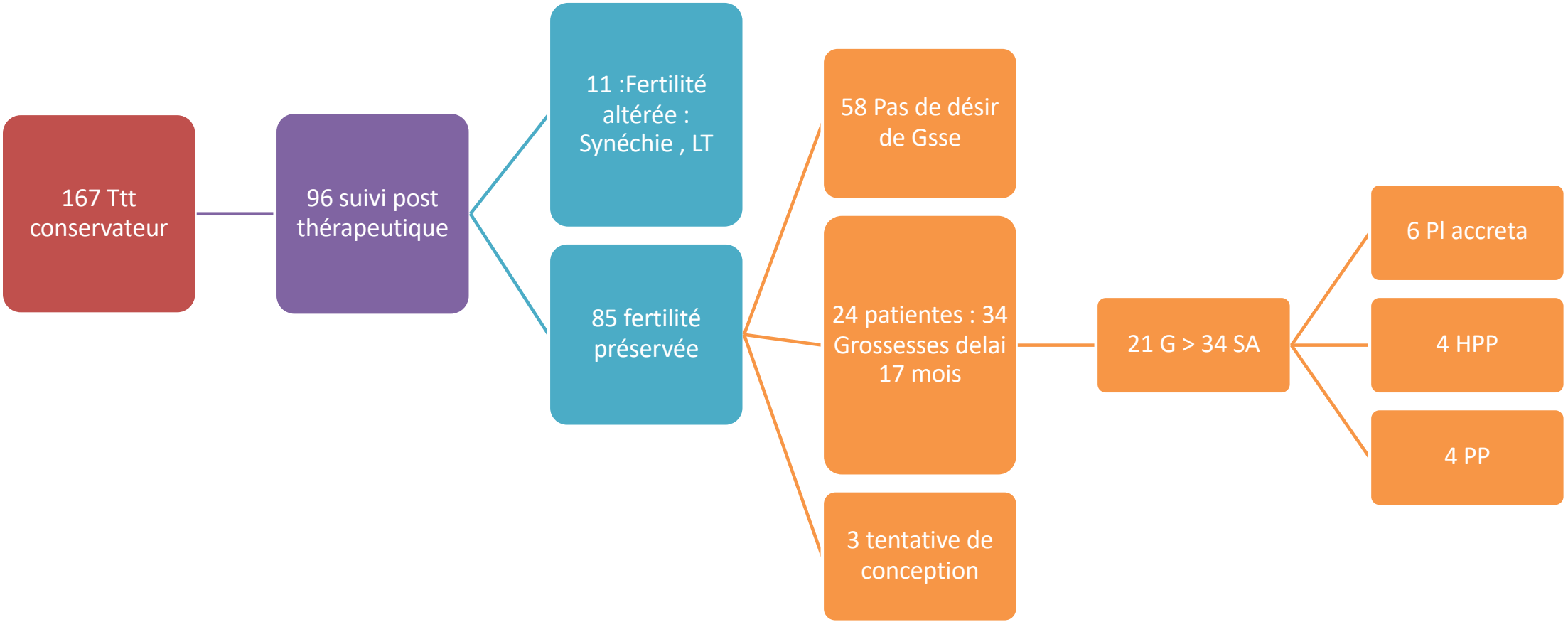
Sentilhes L, Ambroselli C, Kayem G, Provansal M, Fernandez H, Perrotin F, Winer N, Pierre F, Benachi A, Dreyfus M, Bauville E, Mahieu-Caputo D, Marpeau L, Descamps P, Goffinet F, Bretelle F. Maternal outcome after conservative treatment of placenta accreta. Obstet Gynecol. 2010 Mar;115(3):526-534. doi: 10.1097/AOG.0b013e3181d066d4. PMID: 20177283.

Perspectives a long terme et issues obstétricales:

- Troubles du spectre du PA
-HPP
-Rupture utérine

Fertility and pregnancy outcomes following conservative treatment for placenta accreta

Sentilhes et al , 2010



Sentilhes L, Kayem G, Ambroselli C, Provansal M, Fernandez H, Perrotin F, Winer N, Pierre F, Benachi A, Dreyfus M, Bauville E, Mahieu-Caputo D, Marpeau L, Descamps P, Bretelle F, Goffinet F. Fertility and pregnancy outcomes following conservative treatment for placenta accreta. Hum Reprod. 2010 Nov;25(11):2803-10. doi: 10.1093/humrep/deq239. Epub 2010 Sep 10. PMID: 20833739; PMCID: PMC3413618.

Conservative management or cesarean hysterectomy for placenta accreta spectrum: the PACCRETA prospective study

AJOG 2022

- 8 régions
- 176 Maternités
- 86 Traitement conservateur (placenta in situ) VS 62 césarienne hystérectomie

Conservative management was associated with lower rates of transfusion of >4 units of packed red blood cells, hysterectomy, total estimated blood loss exceeding 3000 mL, any blood product transfusion, and adjacent organ injury and higher rates of embolization, endometritis, and readmission within 6 months than cesarean hysterectomy.

Loïc Sentilhes, Aurélien Seco, Elie Azria, Gaël Beucher, Marie-Pierre Bonnet, Bernard Branger, Lionel Carbillon, Coralie Chiesa, Catherine Crenn-Hebert, Michel Dreyfus, Corinne Dupont, Jeanne Fresson, Cyril Huissoud, Bruno Langer, Olivier Morel, Sophie Patrier, Franck Perrotin, Pierre Raynal, Patrick Rozenberg, René-Charles Rudigoz, Francoise Vendittelli, Norbert Winer, Catherine Deneux-Tharaux, Gilles Kayem, Isabelle Avril, Sophie Bazire, Sophie Bedel, Fanny De Marcillac, Laurent Gaucher, Maëlle Guitton, Catherine Guerin, Laurence Lecomte, Marine Pranal, Laetitia Rault, Anne Viallon, Myriam Virlouvet, Justine Schwanka, Conservative management or cesarean hysterectomy for placenta accreta spectrum: the PACCRETA prospective study,
American Journal of Obstetrics and Gynecology,Volume 226, Issue 6,2022,
https://doi.org/10.1016/j.ajog.2021.12.013.

Placenta Accreta Spectrum

Obstetric Care Consensus | Number 7 | December 2018

Number 7 *(Replaces Committee Opinion No. 529, July 2012. Reaffirmed 2021)*

PLACENTA IN SITU

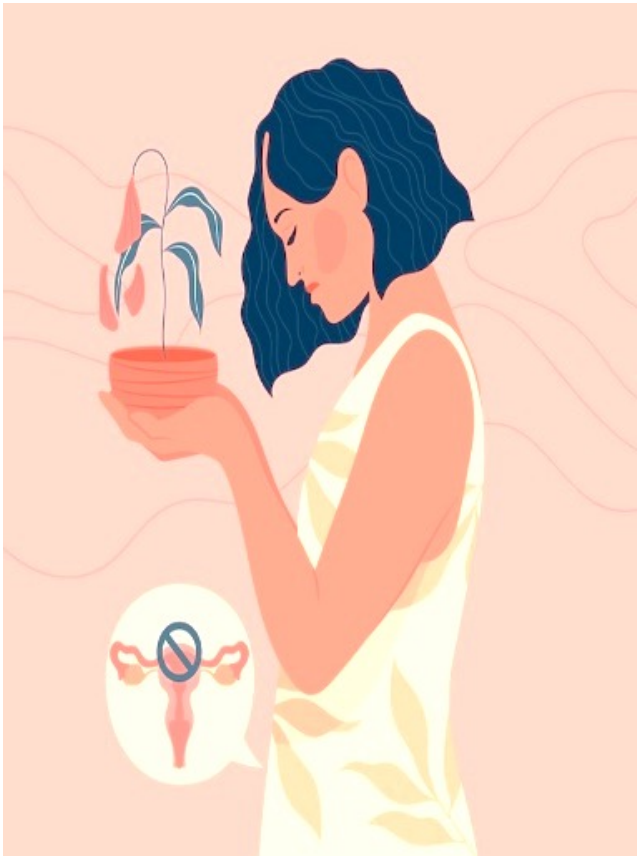
- cas soigneusement sélectionnés,
- **bénéfices incertains** et devrait être considérée comme **expérimentale**.

ACOG
The American College of Obstetricians and Gynecologists


SURGICAL
CONSERVATIVE
MANAGMENT
CONSERVATIVE
MANAGMENT PLACENTA
IN SITU

Techniques chirurgicales conservatrices

- The Triple-P procedure
- One-step conservative surgery



The Triple-P procedure as a conservative surgical alternative to peripartum hysterectomy for placenta percreta

Edwin Chandraharan [a,*], Sridevi Rao [a], Anna-Maria Belli [b], Sabaratnam Arulkumaran [a]

Triple P procedure

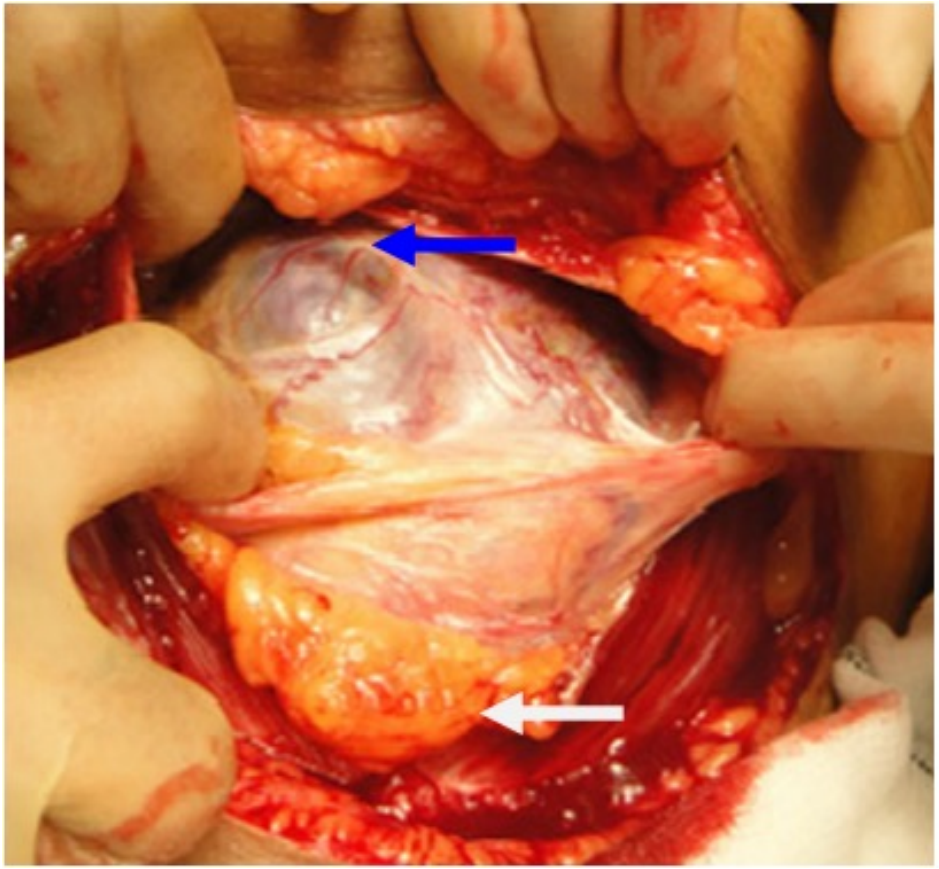
This procedure is a novel conservative surgical technique developed to avoid the complications of peripartum hysterectomy as well as IRP.[19] It consists of three steps:

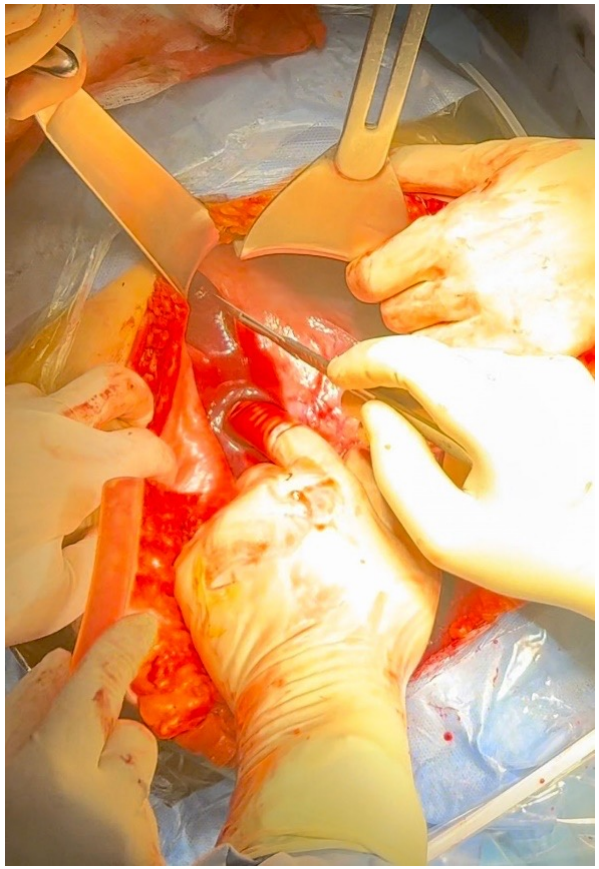
1 - **P**erioperative placental localization and delivery of the fetus via transverse uterine incision above the upper border of the placenta
2 - **P**elvic devascularization
3 - **P**lacental non-separation with myometrial excision and reconstruction of the uterine wall.

Chandraharan E, Rao S, Belli AM, Arulkumaran S. The Triple-P procedure as a conservative surgical alternative to peripartum hysterectomy for placenta percreta. Int J Gynaecol Obstet. 2012 May;117(2):191-4. doi: 10.1016/j.ijgo.2011.12.005. Epub 2012 Feb 11. PMID: 22326782.

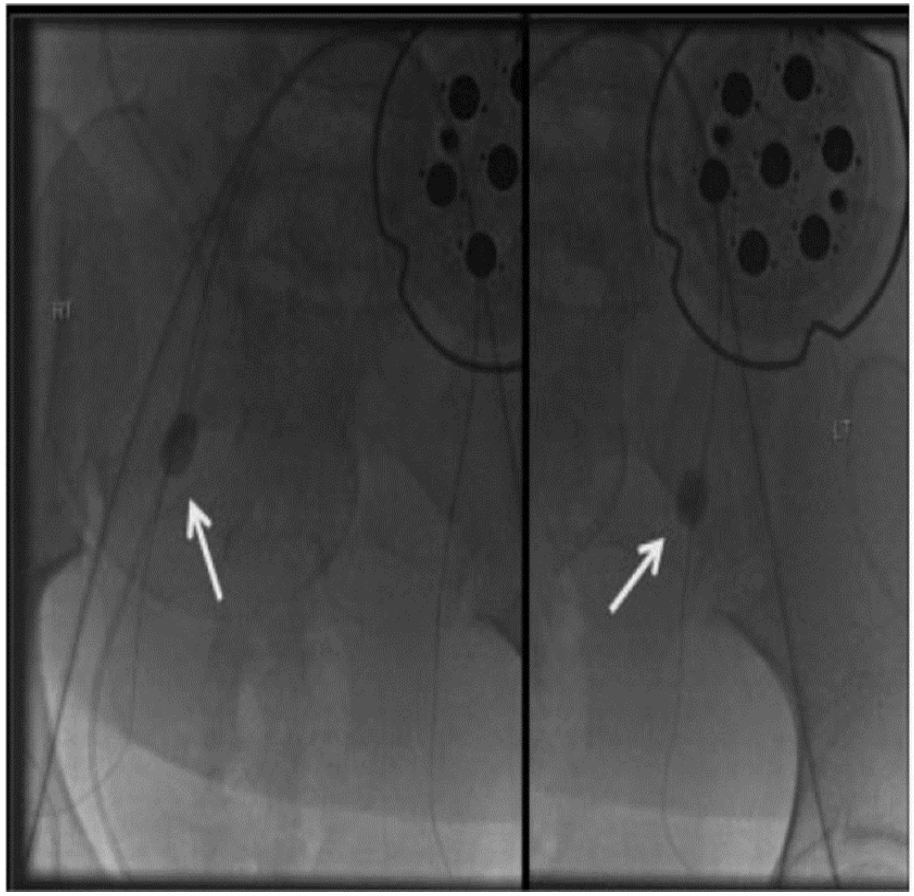
1 STEP

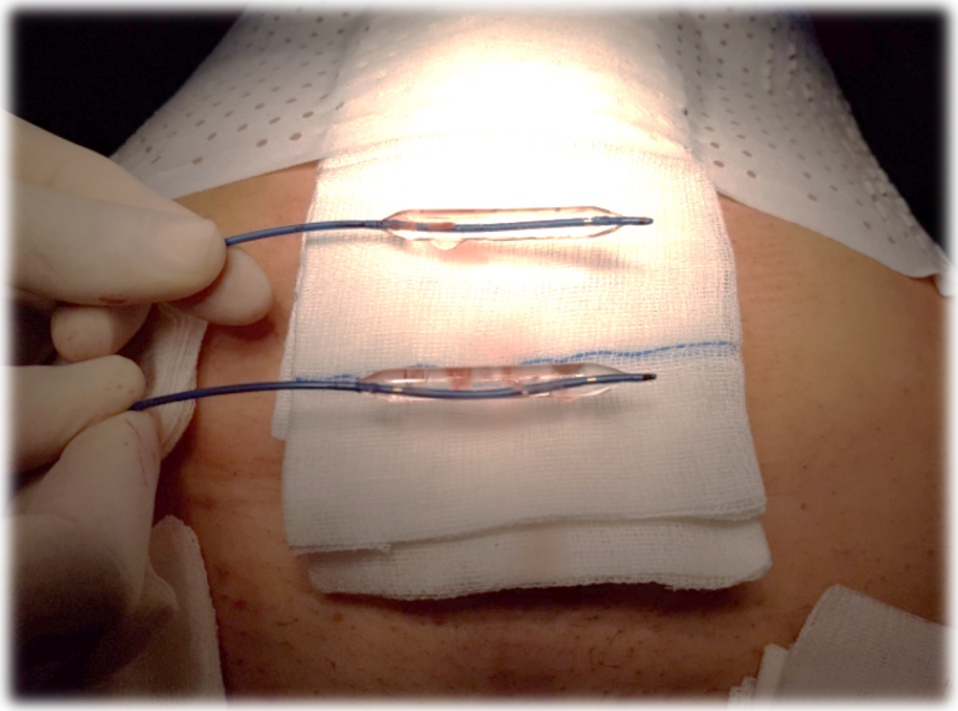
Perioperative placental localization and delivery of the fetus via transverse uterine incision above the upper border of the placenta





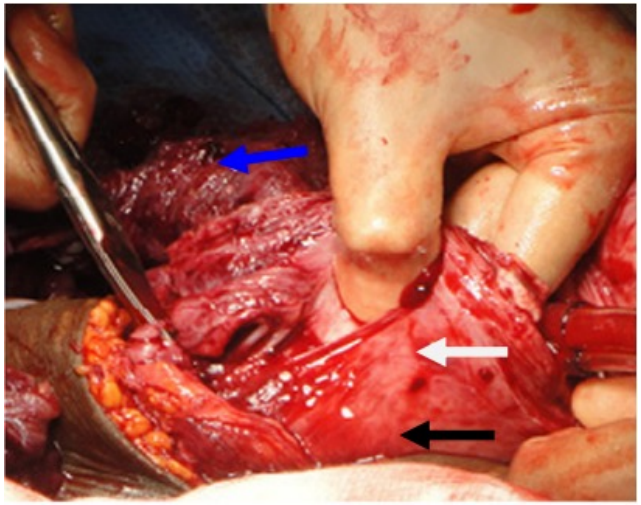
2 STEP Pelvic devascularization

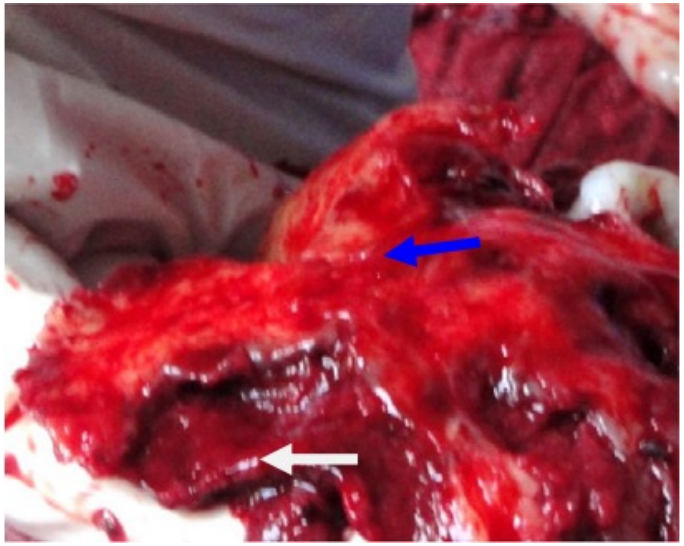


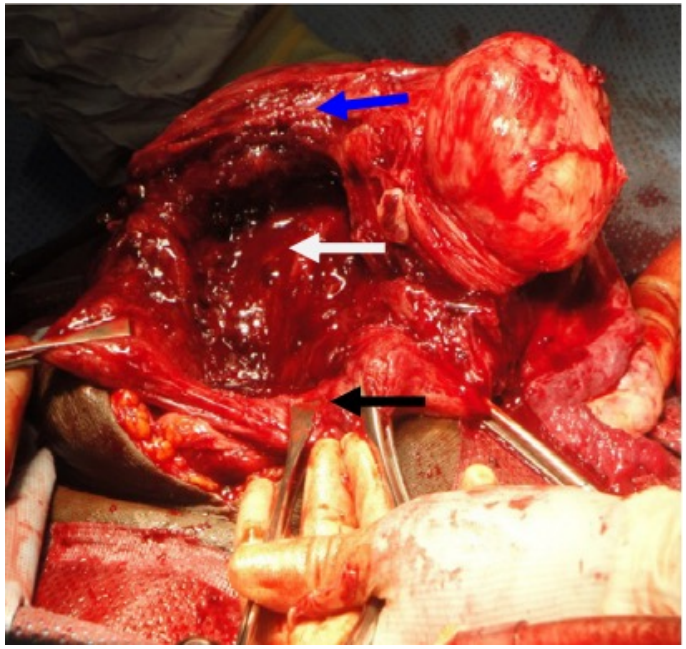


3 STEP

Placental non-separation with myometrial excision







Prevention of postpartum hemorrhage and hysterectomy in patients with morbidly adherent placenta: a cohort study comparing outcomes before and after introduction of the Triple-P procedure

M. Teixidor Viñas, A. M. Belli, S. Arulkumaran, E. Chandraharan 17 November 2014

- 19 patientes : Triple-P (groupe d'étude)
- 11 patientes Préservation de l'utérus (+placenta) (groupe témoin).
- Ballonnet intravasc pour toutes les patientes

➔L'introduction de la procédure Triple-P a entraîné une diminution significative du taux d'hystérectomie, de l'hémorragie post-partum et de la durée du séjour hospitalier.

Variable	Control group (*n* = 11)	Study group (*n* = 19)	*P*
Radiation dose (mGy)	168.91 ± 122.64	97.59 ± 65.29	0.042
Blood loss during procedure (L)	2.17 ± 2.46	1.70 ± 0.95	0.445
Total blood loss (L)*	3.82 ± 4.09	2.31 ± 1.38	0.454
Hemoglobin reduction immediately post-procedure (g/dL)	3.49 ± 3.93	2.16 ± 1.43	0.195
PPH observed	6 (54.5)	3 (15.8)	0.035
UAE required	5 (45.5)	3 (15.8)	0.091
Cesarean hysterectomy required	3 (27.3)	0 (0)	0.045
Transfusion required	5 (45.5)	9 (47.4)	0.610
Volume of transfused blood products (units)			
Total RBC	54	40	
Total FFP	23	8	
Total PL	7	6	
Total CRYO	4	0	
Maternal complications	0	1	

One-step conservative surgery

Anterior place
approach, hen

José M. Palacios Jaraquemada, Mar

From the Department of Obstetrics a
Buenos Aires, Buenos Aires, Argentina

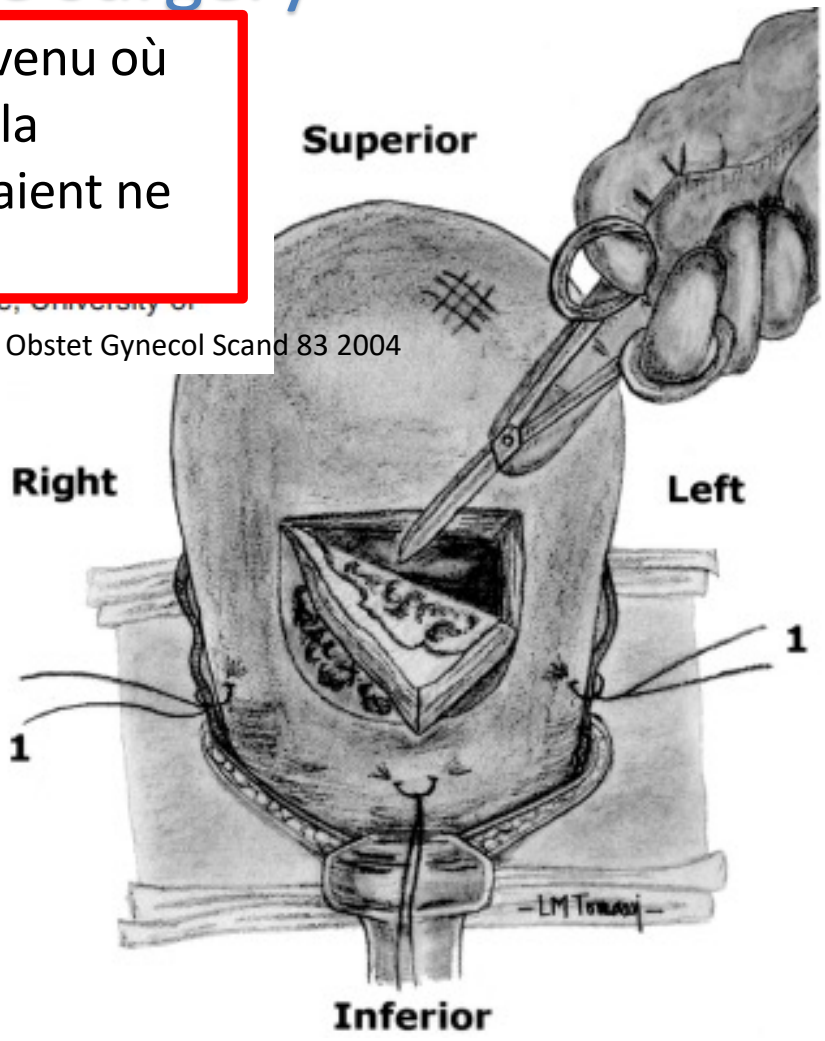
Dans les pays à faible et moyen revenu où des techniques coûteuses comme la radiologie interventionnelle pourraient ne pas être disponibles +++

Acta Obstet Gynecol Scand 2004; 83: 738–744. # Acta Obstet Gynecol Scand 83 2004

Box 1 One-step conservative surgery approach for placenta accreta spectrum (PAS) disorders.[a]

1. Vascular disconnection of newly-formed (feeder) vessels and the separation of invaded uterine tissues from invaded vesical tissues.
2. Upper-segmental hysterotomy and delivery of the fetus.
3. Resection of all invaded myometrial tissue and the entire placenta in one piece with previous local vascular control.
4. Surgical procedures for hemostasis.
5. Myometrial reconstruction in two planes.
6. Bladder repair if necessary.

[a] Modified from Palacios-Jaraquemada.[52]



Modified one-step conservative surgery for placenta accreta spectrum versus caesarean hysterectomy: The CMNT PAS prospective comparative Non-Randomized pilot study

Hassine S Abouda, Haithem Aloui, Sofiene B Marzouk, Hatem Frikha, Rami Hammami, Rachid Hentati, Badis Chennoufi, Hayen Maghrebi

doi: https://doi.org/10.1101/2024.04.14.24305051

Nos modifications par rapport à la technique princeps:

- Under spinal anaesthesia
- double JJ probe under spinal anaesthesia (grade 3b)
- Pfannestiel incision
- Single incision approach to facilitate both foetal extraction and uterine reconstruction
- Omitting the ligation of hypogastric arteries or uterine arteries
- Anterior defects encompassing up to 50% of the uterine circumference were deemed appropriate for uterine repair
- the modified B-Lynch suturing technique
- Indications: accreta, increta, percreta grade 3a, 3b

AOGS Acta Obstetricia et Gynecologica Scandinavica Open Access

Free Access

Anterior placenta percreta: surgical approach, hemostasis and uterine repair

José M. Palacios Jaraquemada, Mario Pesaresi, Juan C. Nassif, Susana Hermosid

First published: 15 July 2004 | https://doi.org/10.1111/j.0001-6349.2004.00517.x | Citations: 149

Grade 3a: Limited to the uterine serosa

Clinical criteria

- At laparotomy
  - Abnormal macroscopic findings on uterine serosal surface (as above) and placental tissue seen to be invading through the surface of the uterus
  - No invasion into any other organ, including the posterior wall of the bladder (a clear surgical plane can be identified between the bladder and uterus)
- Histologic criteria
  - Hysterectomy specimen showing villous tissue within or breaching the uterine serosa

Grade 3b: With urinary bladder invasion

Clinical criteria

- At laparotomy
  - Placental villi are seen to be invading into the bladder but no other organs
  - Clear surgical plane cannot be identified between the bladder and uterus

Histologic criteria

- Hysterectomy specimen showing villous tissue breaching the uterine serosa and invading the bladder wall tissue or urothelium

Grade 3c: With invasion of other pelvic tissue/organs

Clinical criteria

- At laparotomy
  - Placental villi are seen to be invading into the broad ligament, vaginal wall, pelvic sidewall or any other pelvic organ (with or without invasion of the bladder)

Histologic criteria

- Hysterectomy specimen showing villous tissue breaching the uterine serosa and invading pelvic tissues/organs (with or without invasion of the bladder)

REVIEW ARTICLE
Obstetrics

WILEY International Journal of Gynecology & Obstetrics FIGO

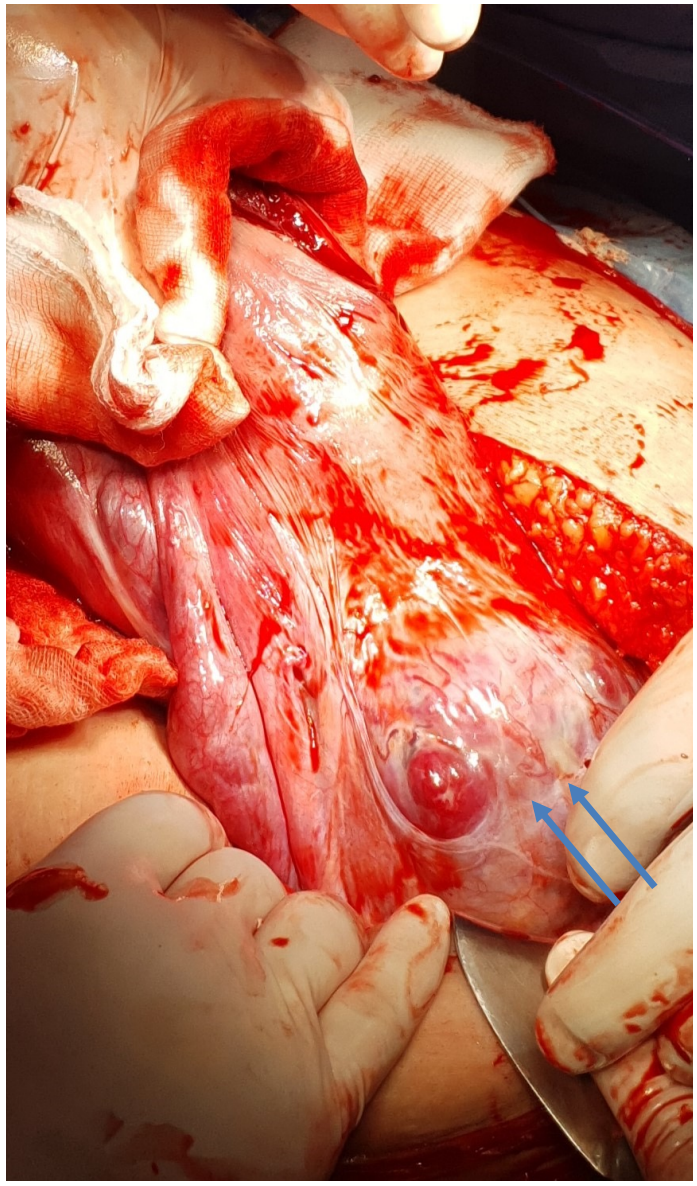
FIGO classification for the clinical diagnosis of placenta accreta spectrum disorders☆,★

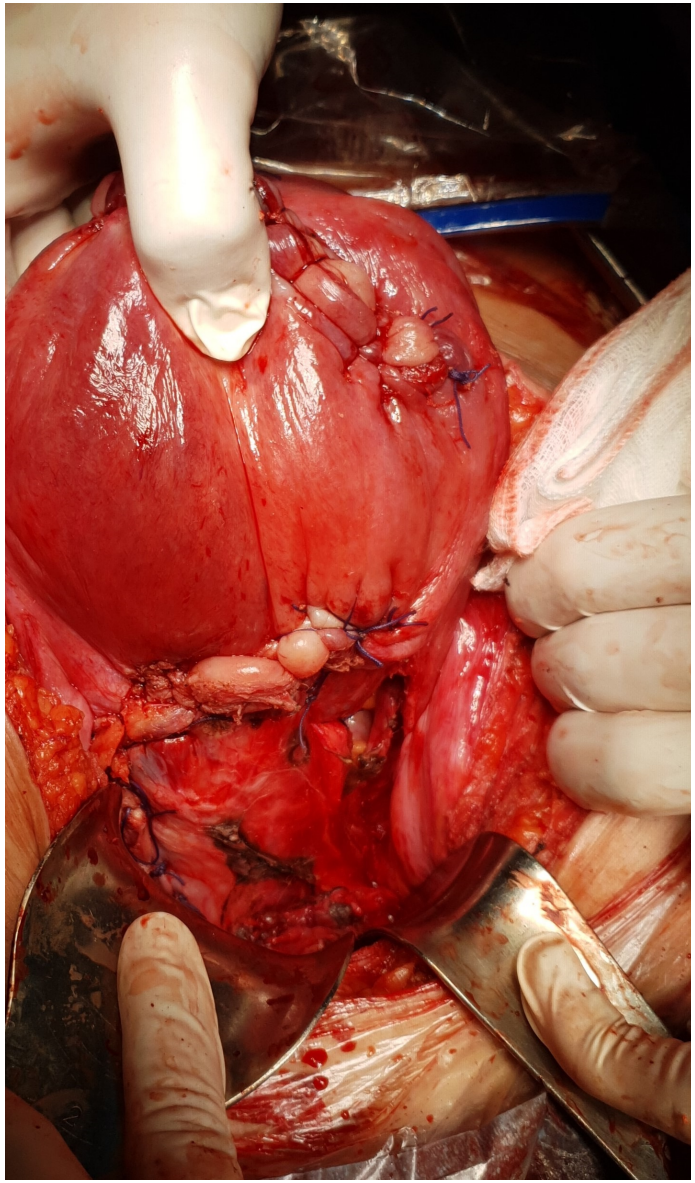
Eric Jauniaux[1,*] | Diogo Ayres-de-Campos[2] | Jens Langhoff-Roos[3] | Karin A. Fox[4] | Sally Collins[5,6] | FIGO Placenta Accreta Diagnosis and Management Expert Consensus Panel[a]

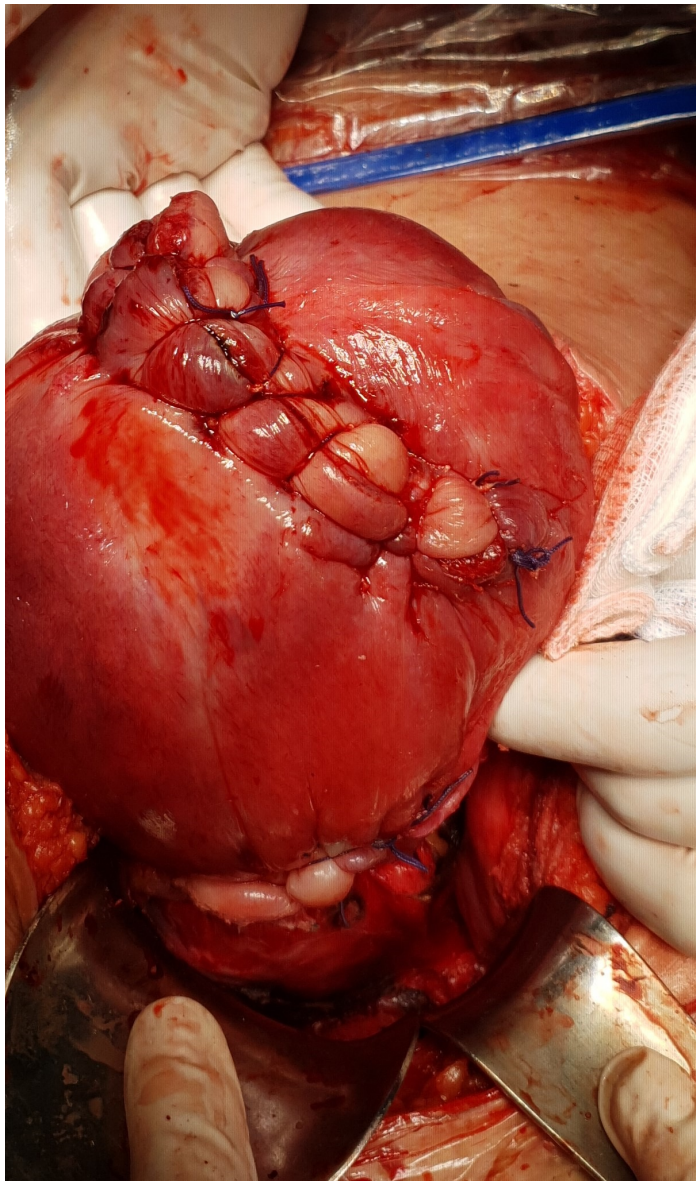
Placenta percreta : traitement conservateur

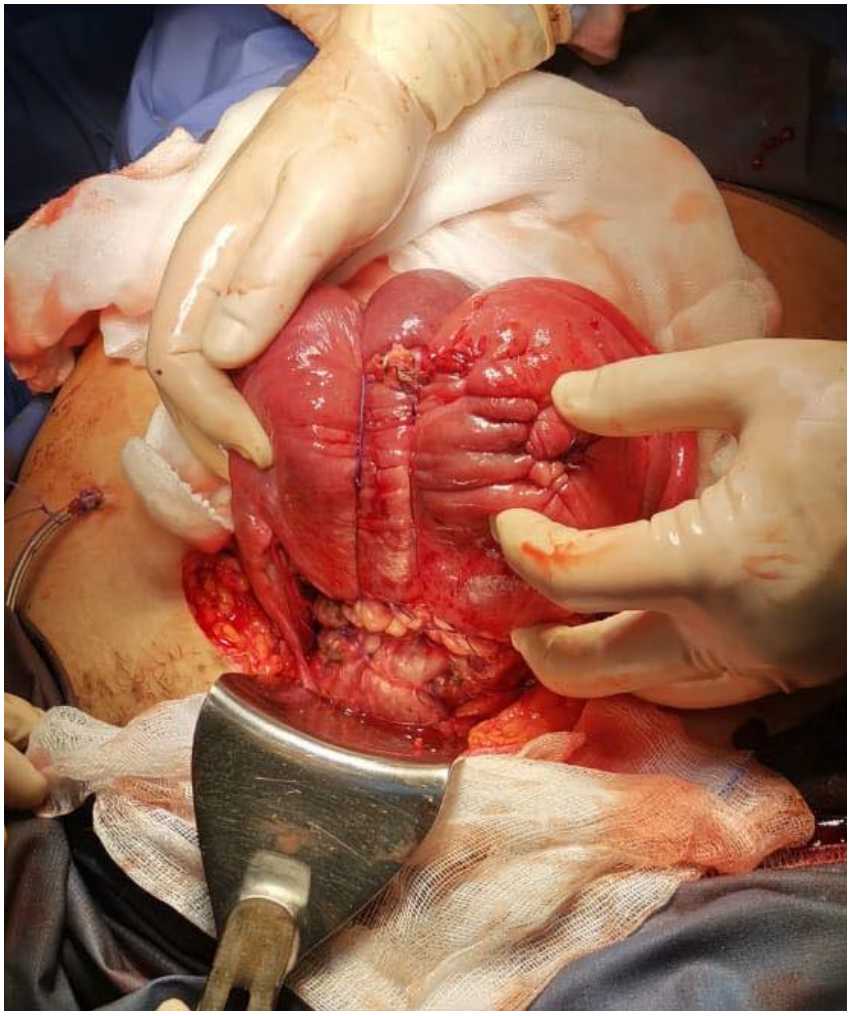
Dr Abouda S. H.

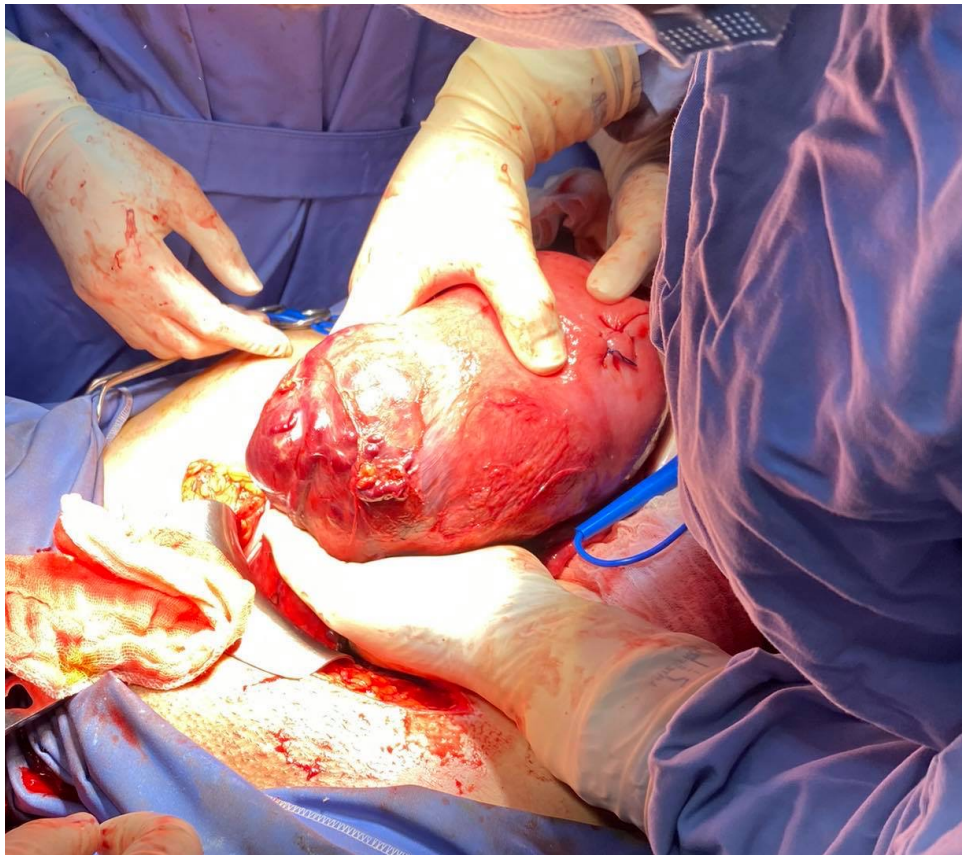
Service C CMNT



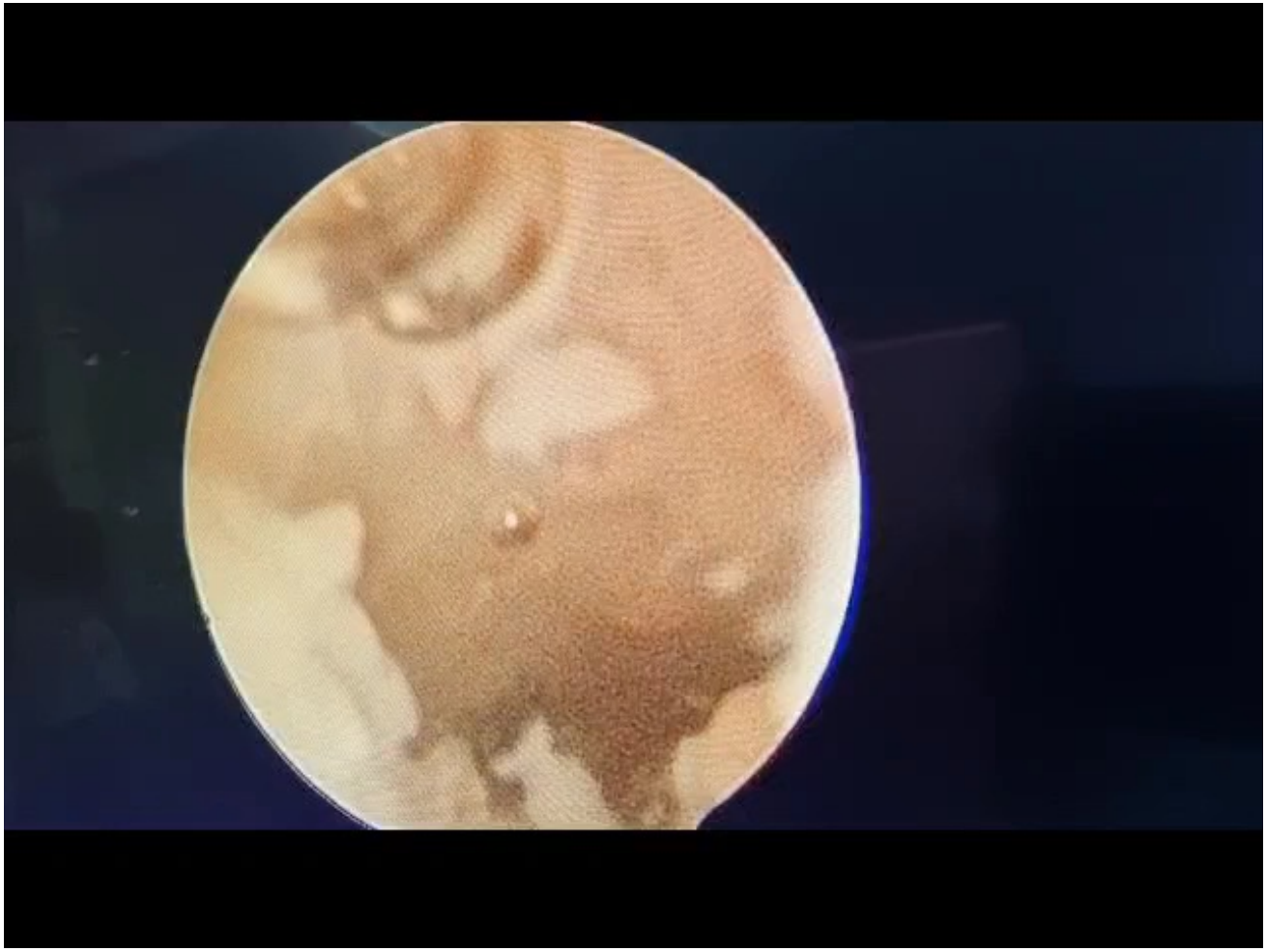








Contrôle hystéroscopique



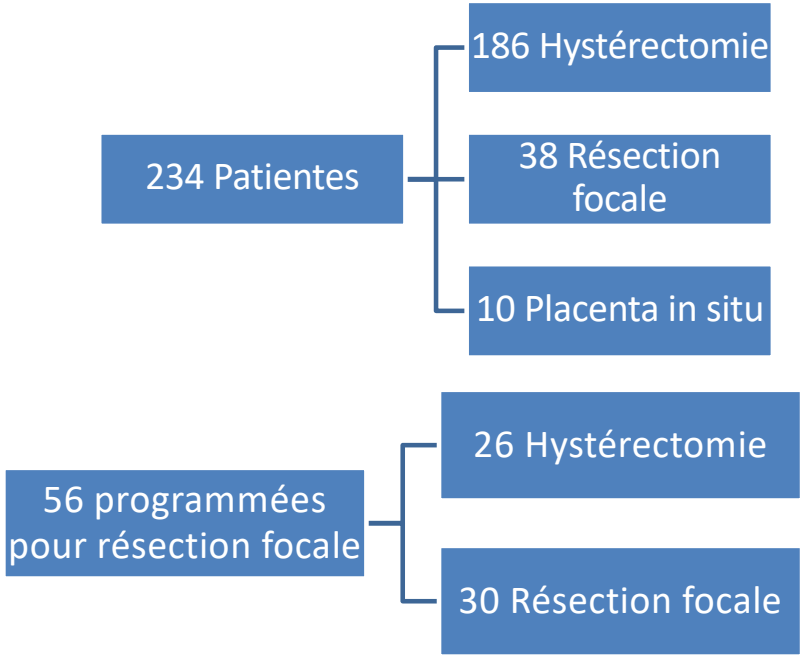
AOGS Acta Obstetricia et Gynecologica Scandinavica Open Access

02 May 2024

Opportunities for, and barriers to, uterus-preserving surgical techniques for placenta accreta spectrum

Alexander Paping ✉, Anja Bluth, Ammar Al Naimi, Mina Mhallem, Magdalena Kolak, Andrzej Jaworowski, Hubert Huras, Maddalena Morlando, George Daskalakis, Pedro Viana Pinto ... See all authors

- 22 Centres IS-PAS
- janvier 2020 et juin 2022
- Sondage en ligne rempli par les experts des centres IS-PAS



Paping A, Bluth A, Al Naimi A, et al. Opportunities for, and barriers to, uterus-preserving surgical techniques for placenta accreta spectrum. *Acta Obstet Gynecol Scand*. 2024; 00: 1-12. doi:10.1111/aogs.14855

Pratique des résections focales dans les centres IS-PAS

- Moins de la moitié des centres IS-PAS de renommée ont effectué des résections focales.
- Seuls deux centres ont traité plus de cinq cas sur une période de 30 mois (Berlin, Allemagne, et Cali, Colombie).

Techniques de préservation de l'utérus comme alternative à l'hystérectomie :

- Pertes sanguines et morbidité maternelle comparables, voire inférieures.
- N’est pas proposée systématiquement en raison de la crainte d’augmentation des pertes sanguines.

Recommandation selon le grade FIGO

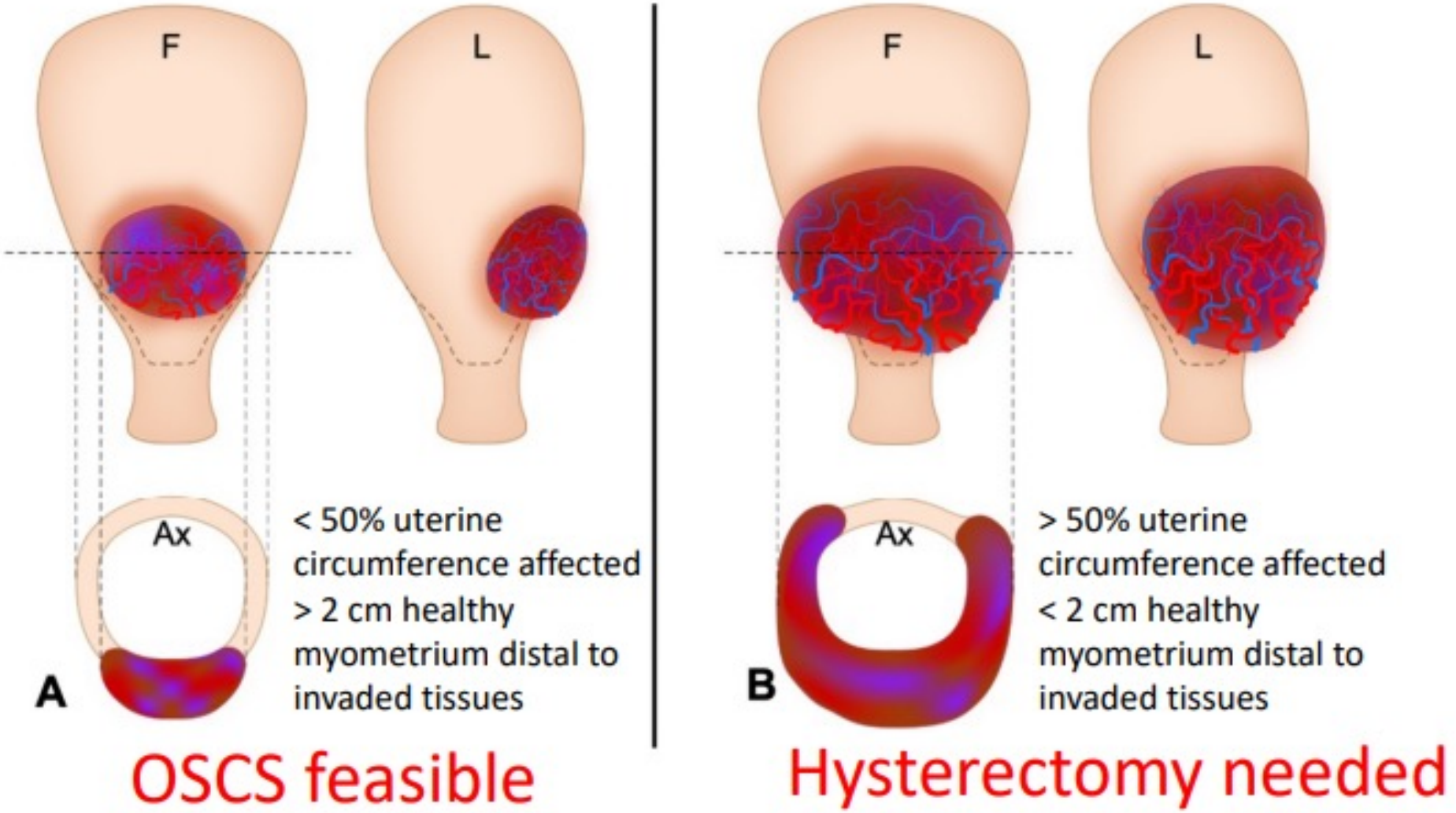
- Grade 2 : Résection focale
- Grade 3c : placenta in situ

Directives internationales

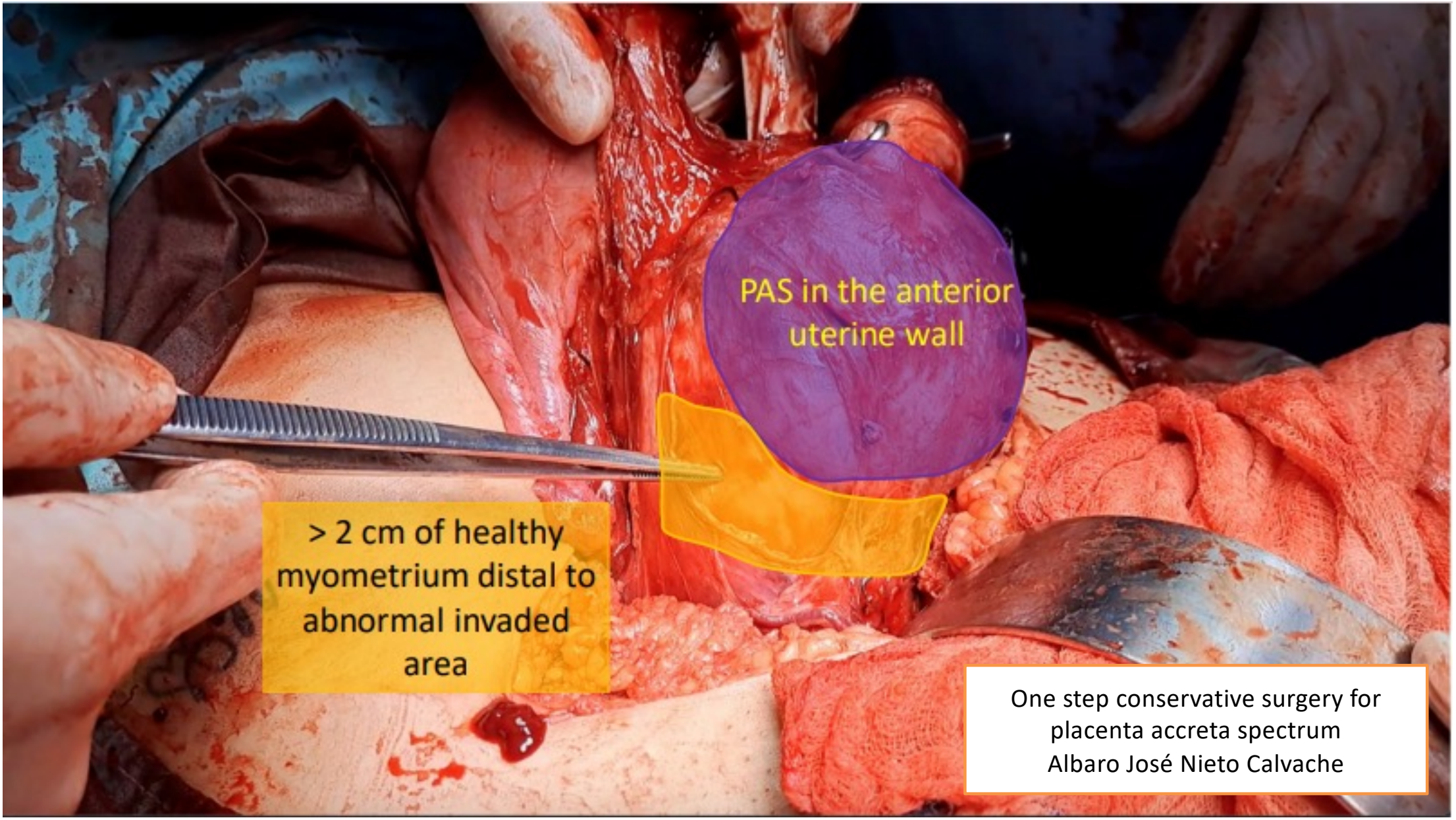
- Approches de conservation de l’utérus en fonction du grade de PAS, expertise équipe médicale et après consentement des patientes
- PAS de recommandation claire

Critères pour résection focale :

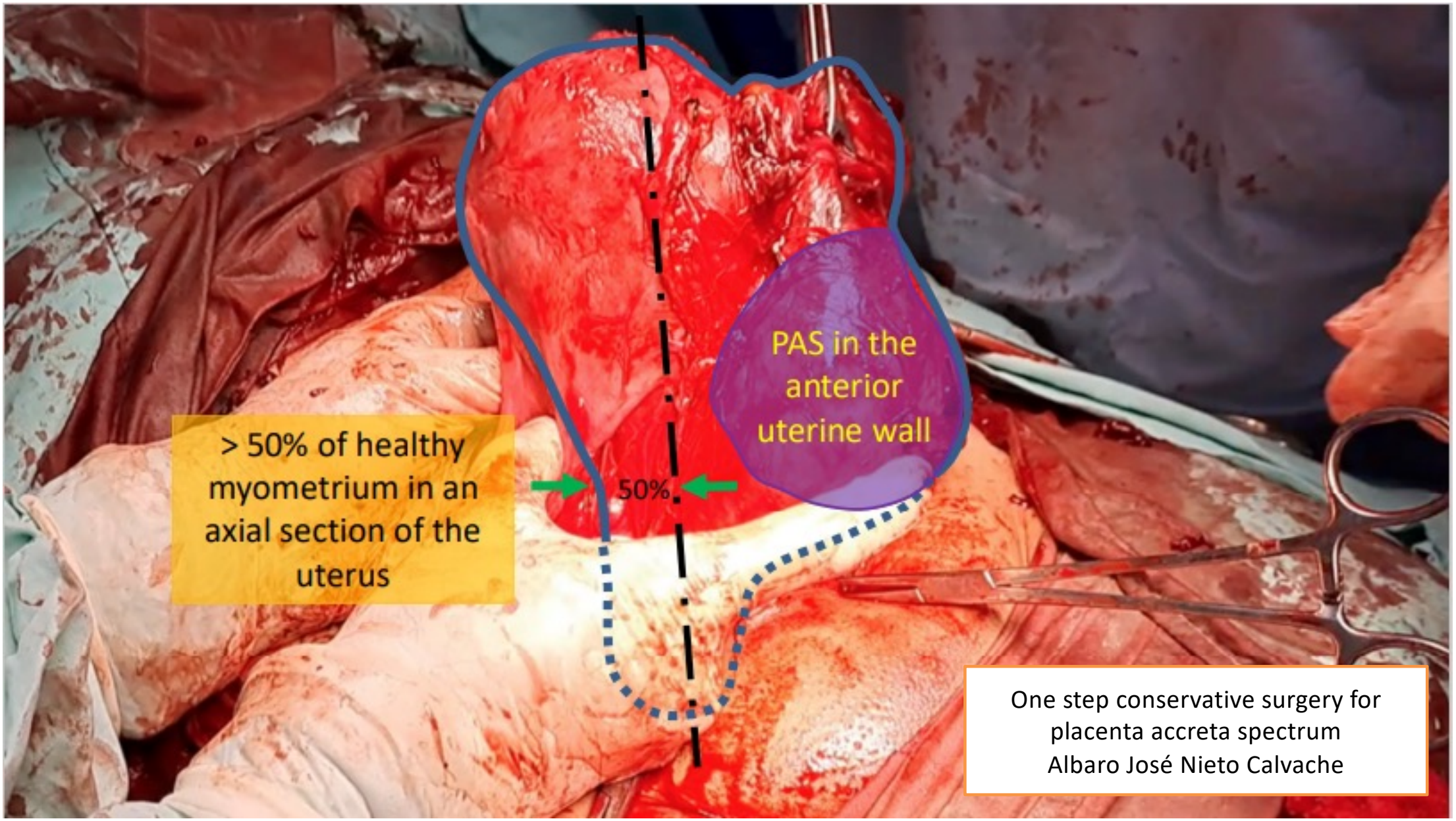
- Décollement possible de la vessie
- Présence d'au moins 2 cm de myomètre sain au-dessus du col de l'utérus
- Taille du myomètre affecté inférieure à 50% de la circonférence axiale de l'utérus



Nieto-Calvache. How to perform the one-step conservative surgery for placenta accreta spectrum move by move. AJOG MFM 2022



One step conservative surgery for placenta accreta spectrum
Albaro José Nieto Calvache



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Messages clés:

Intérêt du diagnostic anténatal

Standardiser les CR d'imagerie!

Diminuer les taux de césarienne!

HT: **Gold standard**, les autres sont considérées comme **expérimentales**.

WHERE ?

1.2.8 If placenta accreta is suspected following the greyscale ultrasound scan with colour doppler (see recommendation 1.2.7), refer the woman or pregnant person to a specialist placenta accreta spectrum centre for care and ongoing management. **[2024]**

NICE National Institute for Health and Care Excellence

Take home message

Si c’est une césarienne à froid, sous Rachi-anesthésie, découverte per-op: PAS

→ fermer et adresser la patiente, bb en place vers un **centre de référence!**

IS-PAS
International Society for Placenta Accreta Spectrum


TUNISIE, TOUS LES RÊVES POSSIBLES.
BIENVENUE À TUNIS.
Tunisie


Merci

34ème Congrès National de la STGO

SOCIETE TUNISIENNE DE GYNECOLOGIE OBSTETRIQUE

21,22& 23 Novembre 2024

Thèmes :

1- Foetopathies infectieuses

2- Insuffisance ovarienne prématurée

3- STGO-FEFOG

4- Pathlogie Cerviale

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6- Groupe de travail STGO

7- Greffe utérine

8- Thérapies foetales

9- AMP

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