NHS
Isle of Wight
NHS Trust

# Standard Operational Procedure for the Management of Placenta Praevia and Suspected Placenta Accreta Spectrum

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## 1. Purpose/Background:

Maternal and fetal morbidity and mortality from placenta praevia are considerable and are associated with high demands on health resources.

**DEFINITIONS**

**Placenta praevia**: The term placenta praevia should be used when the placenta lies directly over the internal os at or more than 16 weeks of gestation

**Low-lying placenta:** should be used when the placental edge is less than 20 mm from the internal os at or more than 16 weeks of gestation

## 2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

## 3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this guidance
- Attend any mandatory training pertaining to the guidance

It is the responsibility of the department to:

- Ensure the guideline is reviewed as required in line with trust and national recommendations

Ensure the guideline is accessible to all relevant staff

## 4. Procedure:

### 4.1 Screening for placenta praevia

- All women should have placental location checked at the 20 week fetal anomaly scan.
- If the placenta is thought to be low it should be confirmed by performing a trans-vaginal scan (TVS). TVS for the diagnosis of placenta praevia or a low-lying placenta is superior to transabdominal and transperineal approaches, and is safe.

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- Once low lying placenta or placenta praevia is diagnosed at 20 weeks, she must be referred for a consultant appointment and check list to be triggered and the form added to her handheld notes.

**4.2 Timing of further scans following diagnosis of placenta praevia at 20 weeks**

- Women who bleed should be managed individually according to their needs
- If the placenta is thought to be low lying or at the routine foetal anomaly scan, a follow-up ultrasound examination including a TVS is recommended at 32 weeks of gestation to diagnose persistent low-lying placenta and/or placenta praevia
- In women with a persistent low-lying placenta or placenta praevia at 32 weeks of gestation who remain asymptomatic, an additional TVS is recommended at around 36 weeks of gestation to inform discussion about mode of delivery.
- Previous caesarean delivery and the presence of an anterior low-lying placenta or placenta praevia should alert the antenatal care team of the higher risk of morbidly adherent placenta.
- Ultrasound imaging is highly accurate when performed by a skilled operator with experience in diagnosing morbidly adherent placenta.
- The women with any ultrasound features suggestive of morbidly adherent placenta should be referred to feto medicine unit in Southampton for their imaging expertise.
- MRI may be used to complement ultrasound imaging to assess the depth of invasion and lateral extension of myometrial invasion, especially with posterior placentation and/or in women with ultrasound signs suggesting parametrial invasion.

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**4.3 Antenatal care for placenta praevia**

- All women with placenta praevia who have low-lying placenta or placenta praevia should be under consultant led care.
- Women with low-lying placenta or placenta praevia who experience any antenatal bleeding should be referred to consultant led antenatal clinic.

- Women with low-lying placenta or placenta praevia who do not experience any antenatal bleeding should be referred to consultant led antenatal clinic after the follow up scan at 32 weeks.
- A clear legible plan should be documented in the notes by the consultant obstetrician for elective and emergency delivery.
- All women with a placenta praevia should be seen by a consultant anaesthetist. A clear anaesthetic care plan should be documented in the notes for both an elective and emergency delivery.
- Asymptomatic patient being managed on an outpatient basis do not require blood to be cross matched. When a date for planned surgery has been organised the patient should have a blood cross matched for surgery .
- Symptomatic patients should have blood cross matched on admission to hospital. The crossmatch should be updated for as long as they are in hospital. When this patient is discharged to outpatient management no further cross match needs to organised until she is once again asymptomatic and requires readmission.
- Patients with abnormal antibodies require a direct consultation to be had with Haematology consultant and transfusion team to determine if crossmatch is required – as some abnormal antibodies can be dealt with on the island
- For all emergency APH O negative blood will be available
- If the woman is admitted as an emergency, the obstetric registrar, on call anaesthetist, consultant anaesthetist and consultant obstetrician should be informed as soon as possible. The haematologist on call should also be involved in the care plan.
- Prior to delivery, women with a placenta praevia should be made aware of the risk of hysterectomy and consent for caesarean section should include this.

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### 4.4 Antenatal care for placenta praevia for women with a previous caesarean

- Women with an anterior placenta praevia who have had a previous caesarean section are at risk of a morbidly adherent placenta.

- These women should have a scan at 32 weeks and be referred to the consultant antenatal clinic following this scan.
- At this stage she should be referred to the feto medicine unit in Southampton for an ultrasound scan to rule out placenta accreta spectrum
- A single course of antenatal corticosteroid therapy is recommended between 34+0 and 35+6 weeks of gestation for pregnant women with a low-lying placenta or placenta praevia and is appropriate prior to 34+0 weeks of gestation in women at higher risk of preterm birth.
- Tocolysis for women presenting with symptomatic placenta praevia or a low-lying placenta maybe considered for 48 hours to facilitate administration of antenatal corticosteroids.
- If delivery is indicated based on maternal or foetal concerns, tocolysis should not be used in an attempt to prolong gestation
- Prevention and treatment of anaemia during the antenatal period is recommended for women with placenta praevia or a low-lying placenta.

### 4.5 Delivery

- Late preterm (34+0 to 36+6 weeks of gestation) delivery should be considered for women presenting with placenta praevia or a low-lying placenta and a history of vaginal bleeding or other associated risk factors for preterm delivery. Delivery timing should be tailored according to antenatal symptoms
- Women presenting with uncomplicated placenta praevia, delivery should be considered between 36+0 and 37+0 weeks of gestation.
- All women with a placenta praevia must be delivered by caesarean section with a consultant obstetrician present.
- For women with a low lying placenta, vaginal delivery is possible if the leading edge of the placenta is > 2cm from the cervical os.
- In cases of placenta praevia or morbidly adherent placenta, the appropriate location for post-operative recovery and the availability of an ITU bed should be discussed with the consultant anaesthetist.
- Consultant anaesthetists should be present in the case of elective caesarean section; second anaesthetist should also be present when possible.

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- The choice of anaesthetic technique for caesarean section for placenta praevia should be made by the anaesthetist in consultation with the obstetrician and mother, but there is increasing evidence to support the safety of regional blockade.
- The consultant on call for the day should inform another obstetric consultant colleague about this case so they can be on standby should the need for caesarean hysterectomy arise - for joint decision and assistance if required.
- Close liaison with the hospital transfusion laboratory is essential for women presenting with placenta praevia or a low-lying placenta. 6 units cross-matched blood and any required blood products should be available on labour ward before commencing the caesarean section.
- Rapid infusion and fluid warming devices should be immediately available.
- Cell salvage is recommended for women where the anticipated blood loss is great enough to induce anaemia, in particular, in women who would decline blood products.
- In case of Major PPH follow the Major PPH guideline
- Consider vertical skin and/or uterine incisions when the foetus is in a transverse lie to avoid the placenta, particularly below 28 weeks of gestation.
- If the placenta is transected during the uterine incision, immediately clamp the umbilical cord after foetal delivery to avoid excessive foetal blood loss.
- If pharmacological measures fail to control haemorrhage, initiate intrauterine tamponade and/or surgical haemostatic techniques sooner rather than later. Interventional radiological techniques should also be urgently employed where possible.
- Early recourse to hysterectomy is recommended if conservative medical and surgical interventions prove ineffective.

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### 4.6 Planning delivery in Southampton

If decision to deliver in Southampton has been made the woman should be transferred to Southampton at 37 wks (if no history of APH). If APH has occurred and the woman is stable she should be transferred 1 week prior to planned delivery.

Delivery of women with placenta accreta should be on the Isle of Wight unless there is another documented care plan
Delivery of placenta increta and percretta should be planned in Southampton

## 5. Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

## 6. Auditable Standards

| What aspects of compliance with the document will be monitored | What will be reviewed to evidence this | How and how often will this be done | Detail sample size (if applicable) | Who will coordinate findings | Which group or report will receive findings |
|---|---|---|---|---|---|
| Consultant presence at caesarean section for major placenta praevia | Maternal Notes | within a month of discharge | All Cases | Audit Midwife | LW Forum/Audit Lead |
| X match availability at caesarean section for major placenta praevia | Maternal Notes | within a month of discharge | All cases | Audit Midwife | LW Forum/Audit Lead |
| Confirmation of diagnosis of placenta praevia with transvaginal ultrasound | Maternal Notes | within a month of discharge | All cases | Audit Midwife | LW Forum/Audit Lead |

## 7. Related Documents:

**Guidelines/SOP's:**

- SOP- management of Post-partum haemorrhage

## 8. References:


- RCOG guidelines 27a


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## 9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced

| DOCUMENT HISTORY | | | | | |
|---|---|---|---|---|---|
| **Date of Issue** | **Version No.** | **Next Review Date** | **Date Approved** | **Director Responsible for Change** | **Nature of Change** |
| Feb 2011 | 1 | Feb 2014 | Feb 2011 | | Maternity CSG |
| April 2014 | 2 | 29th April 2017 | 29th April 2014 | Executive Director of Nursing and Workforce | Reviewed, no changes |
| April 2017 | 3 | Nov 2019 | April 2017 | | Reviewed, no changes |
| Nov 2019 | SOP v1 | Nov 2022 | 21st Nov 2019 | MCSG | Reviewed. Converted to SOP Ratified |
| March 2021 | SOP v2 | Nov 2022 | March 9th 2021 | MCSG | Minor wording Change and addition of checklist |

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# Placenta previa check list

| | Date | Finding | Notes |
|---|---|---|---|
| 20 weeks scan | | | |
| Rx of anaemia @28 weeks | | | |
| 32-34 wkeeks scan | | | |
| Betamethasone injection | | | |
| Consultant involvement | | | |
| Haematologist involvement | | | |
| Blood Bank involvement | | | |
| Plan of management | | | |
| Mode ofdelivery | | | |
| Place of delivery | | | |