Fact Sheet
Placenta Accreta

What is the placenta?
The placenta is a blood-filled organ that develops alongside the baby in the uterus (womb). It looks like a small, round, brown cushion. By the end of pregnancy it measures 20cm across and weighs about half a kilogram.

The placenta:
- provides your growing baby with food & oxygen and carries away waste products like carbon dioxide
- prevents many, but not all, harmful substances from reaching your baby
- makes hormones needed to keep the pregnancy healthy and prepare your body for birth and breastfeeding

The placenta is also called the ‘after birth’. Once your baby is born the placenta is no longer needed and usually comes away from the uterus within 10 to 20 minutes. Before this:
- the placenta sits snugly against the inner walls of the uterus
- the placenta is completely separated from the muscle of the uterus by a layer called the decidua
- the placenta and uterus muscle are kept apart by this decidual layer which also allows the placenta to easily slide out of the uterus after your baby’s birth

What is placenta accreta?
Placenta accreta is a rare condition where the decidua layer is absent or patchy. This causes the placenta to become abnormally stuck onto the muscle layer of the uterus or even invade (grow into) the muscle. How deep the placenta grows into the muscle may vary:
- if it is stuck onto the muscle layer this is called placenta accreta
- if it grows into the uterine muscle this is called placenta increta
- if it grows all the way through the uterus and into other organs such as bladder and bowel, this is called placenta percreta (placenta precreta is rare)

Health professionals usually group placenta accreta, increta and percreta together and call it ‘placenta accreta spectrum’ or simply ‘placenta accreta’ for short.

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Because a placenta accreta is abnormally stuck, it does not come away easily after the birth of the baby. This can cause extremely (very) heavy bleeding.

How common is placenta accreta?
Placenta accreta is quite rare - it only happens in around 3 per 1,000 births (around 1 in 300). In the 1970s it was only 1 per 1,000 births. The reason placenta accreta is more common now is because having a caesarean section (including repeat caesareans) increases the risk.

- in the 1970s, 5 – 10% of births in Australian women were by caesarean
- in 2019, about 33% of births in Australian women are by caesarean

The placenta is more likely to be dangerously stuck if it is attached down low in the uterus (known as placenta previa) rather than attached up high where it should be. Low lying placentas are also more common if you have had a caesarean in the past.

Note: if you are reading this fact sheet to help you decide whether to have a repeat caesarean or a trial of vaginal birth please read it together with our fact sheet Next Birth after Caesarean to understand all your options.

Placenta accreta also occasionally happens with:
- fibroids (harmless muscle tumours of the uterus)
- an abnormally-shaped uterus
- past surgery
  - to remove fibroids (myomectomy)
  - endometrial ablation
- multiple minor surgical procedures inside the uterus such as D&Cs (dilatation and curettages) – especially if done during pregnancy such as to treat miscarriage or for pregnancy termination
- older mothers
- a twin pregnancy
- being a smoker

Why is placenta accreta important?
Placenta accreta is a serious condition which can often, but not always, result in
- the need to deliver the baby early
- the need for caesarean section birth
- the need for blood transfusion due to heavy bleeding after birth
- the need to remove the uterus (hysterectomy) to stop heavy bleeding

How is placenta accreta diagnosed?
Placenta accreta is usually identified (seen) on ultrasound. The features can often be seen on your 20 week ultrasound scan.

During every pregnancy scan the sonographer, or doctor, looks carefully at the placenta. They look especially closely if you:
- have a low-lying placenta
- had a previous caesarean
- have vaginal bleeding after the early months of pregnancy

While most placenta accretas are seen on ultrasound, a few may not be. This is because some cases are subtle and difficult to see (we call this a ‘false negative’ result).
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The opposite difficulty can also occur - sometimes the sonographer or doctor thinks the placenta is probably an accreta but it turns out not to be (we call this a ‘false positive’ result).

Your obstetrician may decide an MRI (magnetic resonance imaging) is needed to help sort out the diagnosis. However, MRI is also not 100% accurate. Sometimes it simply isn’t possible to be sure if the placenta is stuck or not until the time of birth.

What happens if my obstetrician thinks I have a placenta accreta?

If diagnosis of placenta accreta is likely, your obstetrician will discuss it with you in detail, including:

- what to expect during the rest of your pregnancy
- what type of birth you will have and when your baby will be born
- where you should birth your baby
- what the options are for managing the placenta at the time of birth

Will my placenta cause bleeding during pregnancy?

- With placenta accreta you may experience episodes of bleeding during pregnancy.
- If this happens, particularly if you live far from a hospital, you may need to be admitted for a while before the birth of your baby.
- You may be able to go home if the bleeding stops or you may have to stay in for many weeks. Unfortunately, what will happen can be unpredictable, so it’s a good idea to plan ahead for this possibility with your family and friends.

Where should I have my baby?

Because of the higher risks associated with placenta accreta, you will need to be cared for in a large hospital where the following are readily available:

- a team of obstetricians and specialist bladder and bowel surgeons experienced in managing placenta accreta
- expert anaesthetists
- blood transfusion services
- an intensive care unit (ICU)
- interventional radiologists – sometimes these experts are needed to help reduce your bleeding by inserting a small device into blood vessels to temporarily block blood supply to the placenta and uterus
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Will I need a caesarean birth?

- for placenta accreta involving a low lying placenta, the birth will **almost always** need to be a caesarean birth; even if the placenta is not low lying, **usually** a caesarean will be required
- if the placenta is high up in the uterus and only stuck over a very small area, then **occasionally** your obstetrician may allow a normal delivery
- Note: in CS for placenta accreta, the skin incision will often be up-and-down (vertical) in the midline of your abdomen, not low horizontal

When will I give birth?

Usually your caesarean will be planned and booked for when you are between 35 – 38 weeks pregnant. This is so:

- you don’t go into labour as we know that the contractions of labour may make you bleed
- the best surgical and nursing team can be put together to ensure the safety of you and your baby during surgery

However, if you do go into labour before the date of the booked caesarean, there is no need to worry - we can arrange your surgery quickly and at any time.

Will I need to have a blood transfusion?

- It is common for women with a placenta accreta to need a blood transfusion, often requiring many units (packets) of blood.
- To help build up your blood count (haemoglobin) before birth, so that you can better cope with heavy bleeding, you will usually be advised to take iron tablets during your pregnancy.

Will I need to have a hysterectomy?

It is when the obstetrician tries to remove the abnormally stuck and invasive placenta after the birth of the baby, that heavy bleeding usually occurs. There are **two main options** to avoid this:

- remove the uterus (hysterectomy) with the placenta still attached
- leave both the placenta and uterus inside the mother

Both of these options have advantages and disadvantages.

For many women with a placenta accreta, **immediate hysterectomy** is the safest option as it generally reduces the amount of bleeding that occurs. However:

- hysterectomy does not guarantee you will not require a blood transfusion
- although hysterectomy is a safe operation it does carry a low risk of complications such as injury to the bladder, ureters (tubes that connect the kidneys to the bladder) or bowel

Unfortunately, in the situation of placenta accreta and more specifically placenta percreta, these complications may be more common.

For women who wish to have future children, a caesarean birth without removing the placenta can be considered. The placenta is left attached to the wall of the uterus, and the uterus and tummy are then closed. This option has benefits and risks.
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If the placenta is left behind inside the uterus, 66% (about 2/3) of women will not need a hysterectomy

However:
• The 33% (1/3) who go on to need hysterectomy may experience very heavy bleeding. This can happen days or weeks after the baby’s birth and may require emergency surgery to control.
• There is a chance of serious infection because the placenta has been left inside the uterus.
• Because of bleeding and infection, any surgery may be more difficult than if it had been done at the time of birth.
• In the months after birth when the placenta has been left inside, there are usually regular follow up ultrasounds, blood tests and appointments. These can be quite time-consuming so it’s good to enlist the assistance of family & friends. In addition, since complications may happen at any time, it’s important to have someone you can call at short notice over these months. The uncertainty can be stressful - chat to your doctor about how you are coping. You can also see one of our social workers if you would like to.
• In the longer term, if a hysterectomy has been avoided, the chance that you will have another placenta accreta with your next pregnancy is 20 - 30%.

It is clear that every woman’s situation and preferences will be different. Your obstetrician will help you work through the best solution for you.

How will I feel during my pregnancy and after my baby is born?

Most women planning pregnancy do not expect any complications and so it can come as a surprise to find there are problems.
• It can be pretty scary to learn that the condition you have is serious.
• It’s even harder if you have to spend some weeks in hospital apart from your family.
• Going through a stressful pregnancy places a lot of strain on women and their families. Our staff understand that you and your family will be worried and finding the situation difficult.
• We also understand that if you do need to have a hysterectomy you are likely to have feelings of loss and even depression. Depending on your personal situation & the plans you had for future children, these feelings may be mild or severe.
• If you are finding it difficult to cope, please speak with your obstetrician, midwife, GP, or one of our social workers about issues that are bothering you. These health professionals can provide counselling and helpful information. Don’t keep your worries inside - talking about your feelings is important and will help you heal physically and mentally.
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Placenta accreta is a rare, but serious, condition of pregnancy which may mean you need to spend some weeks in hospital before your baby's birth.

Placenta accreta can cause heavy bleeding and need complicated surgery, blood transfusion, and specialised treatment. This may even include a short stay in the intensive care unit (ICU).

Our expert team of obstetricians, surgeons, anaesthetists, interventional radiologists, blood bank specialists and midwives are experienced in looking after pregnant women with this problem and will take good care of you.

Our staff understand that, even knowing you will be well looked after, you may still feel frightened or overwhelmed. Be assured that our doctors and midwives will provide the support you need during and after your pregnancy.

Please discuss any concerns you have with our staff.

We welcome further feedback on this brochure as a way of continually improving our service.

Please send your feedback to:
WSLHD-Get_involved@health.nsw.gov.au

<table>
<thead>
<tr>
<th>Chance of Placenta Previa and Placenta Accreta related to number of previous caesareans</th>
<th>Chance per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chance of <strong>placenta previa</strong> (placenta sitting down low in uterus) related to number of previous caesareans</td>
<td></td>
</tr>
<tr>
<td>At 1st caesarean section (CS) i.e. no previous CS</td>
<td>5 – 10 per 1000</td>
</tr>
<tr>
<td>At 2nd CS (1 previous CS)</td>
<td>15 per 1000</td>
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<tr>
<td>At 3rd CS (2 previous CS)</td>
<td>20 per 1000</td>
</tr>
<tr>
<td>At 4th CS (3 previous CS)</td>
<td>30 per 1000</td>
</tr>
</tbody>
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| Chance of **placenta accreta** related to number of previous caesareans (and chance of accreta if there is a placenta previa and previous CS) | |
| No previous CS | 1 per 1000 will have placenta accreta (if has placenta previa, 50 per 1000 (5%) will have accreta) |
| At 2nd CS (1 previous CS) | 2 per 1000 will have placenta accreta (if has placenta previa, 150 per 1000 (15%) will have accreta) |
| At 3rd CS (2 previous CS) | 6 per 1000 will have placenta accreta (if has placenta previa, 300 per 1000 (30%) will have accreta) |
| At 4th CS (3 previous CS) | 20 per 1000 will have placenta accreta (if has placenta previa, 600 per 1000 (60%) will have accreta) |