Does a more exact definition mean being able to reduce maternal morbidity in placenta accreta spectrum?

TO THE EDITORS: We read the article by Dr Jauniaux et al1 with particular interest. As for placenta increta and percreta, specialists know that trophoblastic advancement in the uterine wall is not a case of real invasion; these forms usually occur owing to the dehiscence of a cesarean delivery scar, which leads to the presence of chorionic villi deep in the myometrium. Regarding extension into the myometrium, this apparent “invasion” of the chorionic villi into the uterine wall may depend on the depth of the original scar. Consequently, a placenta increta or percreta is more likely to arise owing to scar dehiscence, allowing the trophoblast better access to the large external myometrial vessels; this description is consistent with the term “placental intrusion”2 rather than invasion. The International Federation of Gynecology and Obstetrics classification correlates well with the degree of intrusion but not with maternal morbidity3. Therefore, histologic diagnosis is not essential for decision-making in the operating room. In contrast, the placenta accreta spectrum (PAS) topographic classification correlated with maternal morbidity, as different uterine areas originated from specific arterial pedicles. In addition, the location, access, and anastomotic connections of specific vessels presented specific morbidity, regardless of the degree of placental intrusion. It should be noted that if the PAS investigators considered the sample areas correctly, specialized interpretation and other issues could introduce multiple biases and be invalid. The case images in the publication are probably not PAS histologically but have evident scarification remodeling and variable degrees of placental intrusion, which clinically means a high possibility of bleeding. Furthermore, the external appearance of PAS indicates a low probability of significant PAS but does not exclude the possibility of a minor or synchronous case. Factors related to vascular control and precise dissection techniques have been shown to reduce maternal morbidity. However, even if there were a significant histologic database, this information would not be extrapolated to a clinical case, as the degree of placental intrusion is polymorphic in the same specimen and also because the histologic analysis is retrospective for a particular subject. The topographic classification of the PAS performed after surgical staging allows decisions and the surgical technique or strategy to be modified, thereby reducing maternal morbidity.4 Although the concept that placenta accreta is not an invasive disorder is not new to placentologists or PAS experts, the article reinforces the role of scar remodeling as a primary risk factor for the genesis of placenta accreta or variations.

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