Placenta percreta: the ghost of the accreta opera

We thank Dr Palacios-Jaraquemada for his interest in our work.

Dr Palacios-Jaraquemada makes 2 assertions on placenta accreta spectrum (PAS). First, that “histological diagnosis is not essential for decision making in the operating room.” We agree that maternal morbidity from PAS is dependent on accurate preoperative diagnosis and on management by an experienced multidisciplinary team. Triage of patients to hysterectomy, conservative (uterine-sparing) surgery, or expectant management leaving the placenta in-situ depends on the gestational age at presentation, comorbidities, desire for future fertility, and a detailed anatomic assessment by imaging and intraoperative dissection. However, as with any other pathologic condition, outcomes can only be improved by high-quality diagnosis including postoperative histopathology, given that definitions may vary widely.

Our study showed that most reported cases were not confirmed by histology, and that some cases reported in the literature were clearly owing to causes other than PAS, including acute uterine rupture away from the area of implantation, cornual ectopic pregnancy, and misinterpretation of implantation site over the cervix as extension beyond the myometrium.1 In case reports with gross images, it is clear that the photographs were taken after substantial dissection of the uterus from the bladder in an area of scar dehiscence, suggesting that the finding of exposed placenta was because of surgical artifact rather than extrauterine extension. None of the histologic photographs showed evidence of transmural villous invasion, a classical description of placenta percreta.1 The importance of pathology reporting as part of quality assurance and training was even highlighted recently by Nieto-Calvache et al.2

On the second point, Dr Palacios-Jaraquemada suggests that the International Federation of Gynecology and Obstetrics (FIGO) grading system for PAS does not include sufficient anatomic detail to define surgical risk of bleeding and cannot predict the success of conservative management. Here we suggest that he is conflating resectability with extent of disease. As in the case of cancer, the ability of a surgeon to resect a tumor depends on anatomic considerations, preoperative conditioning or therapy, and surgical training. These factors are notoriously hard to capture in a scoring system or consensus guidelines. Although the FIGO grading system is only one of many indicators of morbidity, including extent of pelvic scarring from previous surgery and extent of scar dehiscence, it has value and does perform better than traditional 3-tiered classification (accreta, increta, percreta) in predicting postoperative complications, including the rate of readmission, bladder injury, and blood loss.3

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