

Advantages of intraoperative staging and topographic classification in placenta accreta spectrum

We read with interest the article by Jauniaux et al,¹ and we applaud the authors for such a judicious analysis of 101 patients who appear somewhat the same during surgical planning but show important differences after surgical exploration.

Although the study interestingly focuses on demonstrating the infrequency of placenta percreta, the results presented are extremely important when thinking about the surgical management of placenta accreta spectrum (PAS) as a whole.

We have the following comments:

1. The authors make it clear that prenatal diagnosis fails. Twenty percent of their cases with prenatal PAS suspicion end up not really having the disease. It is clear that the management protocol for PAS must include intraoperative confirmation of the diagnosis before implementing potentially morbid therapeutic interventions.
2. The authors expose 10 nonaccreta cases that were classified intraoperatively as percreta by 2 expert observers. Figures 1 and 2 of the Jauniaux et al study suggest that it is impossible to differentiate a placenta percreta from a uterine dehiscence (UD) before attempting to detach the placenta. In our experience, a safe and easy-to-apply strategy to approach the diagnosis and define the probability of complications before incising the uterus is intraoperative staging.²
3. The authors describe 15 cases of UD but only 7 cases of partial myometrial resection. This suggests that many patients with UD were treated with hysterectomy. We can conclude that UD also leads to surgical difficulty for expert groups. It would be interesting to know the volume of blood loss in patients with UD compared with those with PAS. In our experience, inadequate management of UD with placenta previa can cause massive bleeding.

Management protocols should include safe but practical treatment for abnormal intraoperative findings, even those that raise doubts. Hysterectomy is not the only alternative. One-step conservative surgery (OSCS) is a valid option for many PAS patients²⁻⁴; it is also applicable to UD.

4. The authors described how seldom placenta percreta is. It is essential to refocus the PAS classification to one applicable before surgery, at least before incising the uterus and causing bleeding.

Our group has successfully applied the topographic classification,³ finding a correlation with surgical difficulty, risk of complications, and success of conservative management (all of these in retrospective studies) but above all, facilitating the planning of surgical management. A prospective and multicentric evaluation of the PAS topographic classification is necessary. ■

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