Placenta Accreta Spectrum: *A Review at a Tertiary Maternity Centre Following a Three-Fold Increase in Caesarean Hysterectomies*

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Introduction

The rising incidence of Placenta Accreta Spectrum (PAS) and its associated risks have prompted an in-depth analysis at a tertiary maternity centre. PAS is strongly linked to prior uterine surgeries, particularly caesarean deliveries, which disrupt the uterine lining. As national caesarean section rates climb, Gold Coast University Hospital has witnessed a three-fold rise in Caesarean Hysterectomies in the last year.

Objective

This project aimed to review PAS cases over the past 12 months, focusing on patient demographics, PAS identification, management, surgical techniques, complications, and post-operative care.

Methodology

A single-centre audit was conducted at Gold Coast University Hospital. We retrospectively examined demographics, antenatal care, PAS diagnosis, surgical approaches, and outcomes through electronic medical records.

Results

Background

From 2023 to 2024, the rate of Caesarean Hysterectomy due to PAS **increased by three fold.**

Patients ranged from ages **26-41yo**

100% of patients had at least **1x previous uterine surgery** in the form of previous C/S or Suction D&C.

30% of cases were IHT's from other surrounding areas

Average length of stay as inpatients at GCUH was **18 days** which included pre and post operative periods.

100% of cases were managed by a **multidisciplinary team**.

Diagnosis of PAS

100% of cases had a **low lying placenta + anterior/posterior praevia** diagnosed on morphology scan.

PAS was correctly identified antenatally in over 90% of cases using ultrasound and MRI early in 3rd trimester.

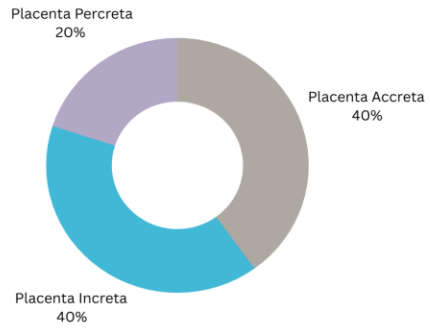
Delivery Indication

Elective delivery: 66% of cases

Emergent delivery: 33% of cases

100% of emergent deliveries were secondary to an **antepartum haemorrhage** in the context of PAS.

Histopathology



Surgical Outcomes

Minimum EBL: 450 mL

Maximum EBL: 6,000 mL

Blood products used: Varies from cell saver and PRBC to cryoprecipitate, with some cases requiring up to 8 units of PRBC.

Urology input utilised in 40% of cases in the form of placement of prophylactic ureteric stents.

Interventional Radiology input utilised in 60% of cases in the form of placement of Iliac balloons preoperatively.

100% of cases involved a **vertical midline incision + classical caeserean section + hysterectomy + bilateral salpingectomy**

30% of cases involved a bladder or ureteric injury which was fixed intraoperatively requiring **cystoscopy + ureteric reimplantation.**

Conclusion

Three-fold increase in Placenta Accreta Spectrum cases at Gold Coast University Hospital highlights the urgent need for enhanced early detection, multidisciplinary management, and optimised surgical techniques to mitigate maternal and fetal risks.