Caesarean birth – placenta accreta spectrum

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28/11/2023 – 11/12/2023

Stakeholder	Document	Line No	Comments	Developer's response
Association for Improvements in the Maternity Services			Thank you for the opportunity but we do not have any comments to make this time.	Thank you for your comment.
British Maternal & Fetal Medicine Society	Table	1	'refer for greyscale ultrasound scan with colour Doppler be performed by a consultant obstetrician specialising in fetal medicine' be expanded to a consultant obstetrician specialising in fetal medicine and/or specialising in the diagnosis of AIP'.	Thank you for your comment. The wording of this recommendation has been amended to advise that the scan should be carried out by a senior clinician with expertise in the diagnosis of placenta accreta. The committee agreed this may or may not be someone specialising in fetal medicine and so simplified the recommendation.
British Maternal & Fetal Medicine Society	Table	1	1.2.9 What about regions outside of NHS England where specialist invasive placenta services are not commissioned?	Thank you for your comment. NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive.
British Maternal & Fetal Medicine Society	Table	1	1.2.7 What evidence is there that seeing women at 28 weeks as opposed to after 32 weeks, (where the patient is seen by a general obstetrician in the first instance), will not increase the workload for the fetal medicine service?	Thank you for your comment. The committee agreed that leaving the scan until 32 weeks was too late and did not allow enough time to refer to a specialist placenta accreta spectrum centre if necessary, and to carry out the necessary multidisciplinary planning for birth. Moving the timing of the scan from 32 weeks to about 28

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				weeks does not increase the number of scans performed and so will not impact on workload.
British Maternal & Fetal Medicine Society	Table	3	Discussion should be carried out by a senior obstetrician (such as consultant or ST6). We would advise that the consultant should remain the standard. We do not agree that discussions such as potential morbidity of hysterectomy, blood products including potential refusal of blood products etc can be deferred to a ST6 to (a) discuss, (b) and by default lead ongoing planning. A small cost saving is irrelevant and not appropriate to suggest.	Thank you for your comment. This recommendation has been amended to advise that the discussion is carried out by a 'senior obstetrician' to allow some flexibility for individual obstetric units to make a local decision about who is the most appropriate person to carry out this discussion. The impact statement now advises that this recommendation reflects current practice and so is unlikely to have a resource impact.
British Maternal & Fetal Medicine Society	Table	4	Can you share the evidence/guidance with regards assessing for invasive placentation using 2D/ colour USS e.g Pro forma for ultrasound reporting in suspected abnormally invasive placenta (AIP): an international consensus (isuog.org)	Thank you for your comment. The committee discussed the ISUOG proforma but agreed that while this looked a useful guide they had not evaluated it because the details of ultrasound recording were not within the scope of this update, and so were not able to endorse it for use in all obstetric units.
British Maternal & Fetal Medicine Society	Table	4	1.2.13 When performing a caesarean birth for a woman or pregnant person suspected to have placenta accreta spectrum, ensure that: • a consultant	Thank you for your comment. The committee agreed that if the operation was being planned in a specialist placenta accreta spectrum centre than the consultant obstetrician performing the

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			obstetrician'. Should this be a consultant obstetrician with expertise in operating on PAS cases?	operation would have the necessary expertise. However, the committee did add that a consultant gynaecologist should be present as well, to ensure the necessary expertise to carry out a hysterectomy was available, if required.
British Maternal & Fetal Medicine Society	Table	5	Should the MRI be reported by a radiologist specialising in interpretation of invasive placentation as there are not many throughout the UK?	Thank you for your comment. The committee agreed that the MRI would be carried out in a specialist placenta accreta spectrum centre and therefore there would be expertise in the interpretation of placenta accreta scan. They therefore did not amend the recommendation.
Royal College of Anaesthetists	Table	3	Discussion on birth options may also include discussion of anaesthetic options and thus a senior anaesthetist may also be required.	Thank you for your comment. The committee agreed that a discussion with an anaesthetist would be held prior to any planned caesarean birth, and this was not specific to placenta accreta, and so did not add this to the recommendation.
Royal College of Anaesthetists	Table	4	The guideline doesn't consider emergency cases if a critical care bed is **not** available. Suggest that the fourth bullet point is changed to:	Thank you for your comment. The wording has been amended to clarify that this recommendation relates to a planned caesarean. In addition, the recommendation and rationale have been amended to clarify that while this is the ideal for planned surgery,

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			"a post-operative critical care bed will be available for the woman or pregnant person, and a critical care neonatal cot will be available for the baby" Rationale. The care of the woman or pregnant person should have been discussed with the critical care team in advance of surgery and a bed booked. A bed may not be immediately available prior to surgery but often the bed will become available later. If there is a delay waiting for an actual empty bed prior to the operation this may cause unnecessary delay with risk of surgery be done as an emergency or out-of-hours to the detriment of the patient.	emergency surgery should not be delayed if a bed is not immediately available.
Royal College of Nursing			Thank you for the opportunity to contribute to the above consultation, we received no member comments this time.	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	General		The diagnosis of placenta accreta is a clinical diagnosis made at birth. Imaging combined with patient history provides an antenatal evaluation of the probability of PAS at birth.	Thank you for your comment. The wording of the recommendation about diagnosing placenta accreta has been changed to 'suspected' instead of 'diagnosed'.
Royal College of Obstetricians and Gynaecologists	General		The terminology "invasive placenta" is confusing and does not apply to PAS. PAS is not a cancer (choriocarcinoma) and thus this should be deleted from the text as it is not evidence based but it is also stressing for the patients.	Thank you for your comment. The only times the term 'invasive placenta' is used in the recommendations or evidence report is when referring to the NHS commissioned specialist service, which uses this terminology. This is to

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				clarify that this specialist service applies to women with placenta accreta spectrum.
Royal College of Obstetricians and Gynaecologists	General		The concept of placenta "percreta" is also not evidence based and refers to the dehiscence of the lower uterine segment after multiple c-sections and the placental bulge or in rare cases to a uterine rupture with placental tissue protruding through the scar. This is independent of the abnormal adherence of part of the placenta at birth. Again, the placental tissue in PAS is normal and the issue is mechanical not cancer-like invasion of the uterine wall.	Thank you for your comment. The committee agreed that the terminology percreta was well-used and understood to mean placenta tissue that may impact on other organs or structures, did not signify a cancer-like invasion of the uterine wall and so did not amend this terminology.
Royal College of Obstetricians and Gynaecologists	General		The NICE committee should consider changing this section to "Complex cesarean section including PAS" as placenta praevia without accreta is associated with a similarly high maternal morbidity and should be managed by an MDT (I am referring to a meeting we had recently at NHS England involving the Medical director (M Jolly), National Senior Programme Care manager (A Prudhoe) and representatives from regional PAS centre).	Thank you for your comment. The caesarean birth guideline contains a separate section on the management of placenta praevia (as well as other conditions which may require a complex caesarean birth) and so management of placenta praevia has not been included in this section of the guideline which focuses on placenta accreta. In addition, the committee agreed that in some cases, placenta praevia could be managed by an obstetric unit without the need for specialist multidisciplinary care.

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Royal College of Obstetricians and Gynaecologists	Table	1	1.2.7 Please replace 'woman' with 'patient.'	Thank you for your comment. This change has not been made as NICE style is to use additive terms (such as 'woman or pregnant person') in the recommendations to include women, but to also recognise that the recommendations may apply to people who do not identify as women.
Royal College of Obstetricians and Gynaecologists	Table	1	1.2.7 Please replace 'a greyscale ultrasound scan with colour Doppler' with 'an ultrasound examination.'	Thank you for your comment. The evidence on which this recommendation was based (see evidence review H) identified that grey scale ultrasound with colour Doppler provided the best diagnostic accuracy and so this is the scan technique that has been recommended.
Royal College of Obstetricians and Gynaecologists	Table	1	1.2.7 Please replace 'specialising in fetal medicine by 28 weeks to assess for placenta accreta' with 'with obstetric ultrasound expertise at 24-28 weeks for signs associated with PAS at birth.'	Thank you for your comment. The wording of this recommendation has been amended to advise that the scan should be carried out by a senior clinician with expertise in the diagnosis of placenta accreta. This will allow more flexibility for units to determine locally who is best qualified to carry out these scans. In addition, the timing of the scan has been amended to advise that it6ncorpd be carried out around 28 weeks, but no later than 29 weeks, to clarify that only one scan is required and that the ideal time frame is limited to this period.

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Royal College of Obstetricians and Gynaecologists	Table	1	1.2.8 Please remove this recommendation.	Thank you for your comment. This recommendation has been removed, and the key information in it has been7ncorporateed into the preceding recommendation.
Royal College of Obstetricians and Gynaecologists	Table	1	1.2.9 Please replace 'women' with 'patients.'	Thank you for your comment. This change has not been made as NICE style is to use additive terms (such as 'woman or pregnant person') in the recommendations to include women, but to also recognise that the recommendations may apply to people who do not identify as women.
Royal College of Obstetricians and Gynaecologists	Table	1	1.2.9 Please replace 'a specialist regional placenta accreta centre' with 'a specialist regional PAS centre.'	Thank you for your comment. The word 'spectrum' has been included in this recommendation (and all other references to these centres). The abbreviation PAS has not been added as the term is used in full in the guideline.
Royal College of Obstetricians and Gynaecologists	Table	1	1.2.9 Please remove 'placenta or AIP centre.'	Thank you for your comment. This change has not been made as removing these words would leave an incomplete sentence.
Royal College of Obstetricians	Table	1	Rationale Please change 'and so recommended that the scan be conducted by 28 weeks' to 'and so	Thank you for your comment. The timing of the scan has been amended to advise that it should be carried out around 28 weeks, but no later

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and Gynaecologists			recommended that the scan be conducted **before** 28 weeks.'	than 29 weeks, to clarify that it should not be done much earlier than 28 weeks and the rationale has therefore been amended to reflect the revised recommendation.
Royal College of Obstetricians and Gynaecologists	Table	1	Rationale Please change 'The committee therefore recommended that, if placenta accreta is diagnosed or cannot be ruled out at the 28-week scan, women and pregnant people should be referred to a specialist regional placenta accreta centre' to 'The committee therefore recommended that, if placenta accreta is diagnosed or cannot be ruled out by a 24-28 week scan, women and pregnant people should be referred to a specialist regional placenta accreta centre.	Thank you for your comment. The timing of the scan has been amended to advise that it should be carried out around 28 weeks, but no later than 29 weeks, to clarify that it should not be done much earlier than 28 weeks and the rationale has therefore been amended to reflect the revised recommendation.
Royal College of Obstetricians and Gynaecologists	Table	2	1.2.10 Please change rec as shown: Consider an MRI scan to complement ultrasound findings when planning ongoing surgical management of PAS. Discuss the following with the woman or pregnant person: • what to expect during an MRI procedure • that MRI can help clarify the degree of	Thank you for your comment. The recommendation wording you have provided is identical to the current recommendation, except this version has an incomplete 2rd bullet. As it is unclear what changes if any you were suggesting, no changes have therefore been made to the recommendation.

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			• that current experience suggests that MRI is safe, but that there is a lack of evidence about any long-term risks to the baby. [2023]	
Royal College of Obstetricians and Gynaecologists	Table	2	Rationale Please amend final sentence as shown: However, the committee agreed that MRI was a useful imaging technique when planning surgical management of placenta accreta to identify if, for example, major remodelling of the lower uterine segment with placental bulge (previously called placenta percreta) had impacted on other organs, and so amended this recommendation for MRI.	Thank you for your comment. The committee agreed that the terminology percreta was well-used and understood to mean placenta tissue that may impact on other organs or structures, this was not the same as placental bulge, and so did not amend this terminology.
Royal College of Obstetricians and Gynaecologists	Table	3	1.2.11 Please remove example in brackets at end of rec.	Thank you for your comment. This recommendation has been amended to advise that the discussion is carried out by a 'senior obstetrician' to allow some flexibility for individual obstetric units to make a local decision about who is the most appropriate person to carry out this discussion.
Royal College of Obstetricians and Gynaecologists	Table	4	1.2.13 Please replace 'woman' with 'patient.'	Thank you for your comment. This change has not been made as NICE style is to use additive terms (such as 'woman or pregnant person') in the recommendations to include women, but to

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				also recognise that the recommendations may apply to people who do not identify as women.
University College London Hospitals NHS Foundation Trust	Table	1	"to be performed by a consultant obstetrician specialising in fetal medicine by 28 weeks". This can be interpreted as the scan to be performed by a subspecialist in fetal medicine. Most smaller hospitals do not have subspecialists and this recommendation may lead to many unnecessary referrals to tertiary centres. Better to phrase as a "consultant obstetrician with special interest in fetal medicine".	Thank you for your comment. The wording of this recommendation has been amended to advise that the scan should be carried out by a senior clinician with expertise in the diagnosis of placenta accreta. This will allow more flexibility for units to determine locally who is best qualified to carry out these scans.
University College London Hospitals NHS Foundation Trust	Table	General	In the table, ID number 4 comes after 5	Thank you for your comment and we apologise for this numbering error.
University College London Hospitals NHS Foundation Trust	Table	1	"to be performed by a consultant obstetrician specialising in fetal medicine by 28 weeks". The rationale for this recommendation talks about a 28-week scan rather than a 20-28-week scan. "Scan by 28 weeks" may be interpreted as a scan before 28 weeks and therefore lead to more than one scans (e.g. 24 and 28 weeks) and therefore more scans than currently. Most anterior low-lying placentas (not praevias) at 20 weeks are not low	Thank you for your comment. The timing of the scan has been amended to advise that it should be carried out around 28 weeks, but no later than 29 weeks, to clarify that it should not be done much earlier than 28 weeks and that only one scan is required.

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			by 28-32 weeks, therefore for the anterior low-lying placentas, the scan is best done at 28 weeks rather than up to 28 weeks. In this way, fewer women will have a rescan and fewer women will have to be referred to the regional centre.	
University College London Hospitals NHS Foundation Trust	Table	1	"to be performed by a consultant obstetrician". The phrasing may need to change slightly. I am the lead fetal medicine consultant for placenta accreta ultrasound in our Trust which is a regional centre. We have a team of excellent subspecialty fellows who perform the scans while I am in the room with them and rarely is there a need for me to take over and perform the scan. Although I do not "perform" the scan, I have the ultimate responsibility for the scan, the conclusion and the report. Similarly in a DGH, there may be a specialist sonographer working with a consultant. If "performed by a consultant" is interpreted verbatim, it will have resource and training implications. Consider a phrase such as consultant-led clinic.	Thank you for your comment. The wording of this recommendation has been amended to advise that the scan should be carried out by a senior clinician with expertise in the diagnosis of placenta accreta. This will allow more flexibility for units to determine locally who is best qualified to carry out these scans, but ensures that the diagnosis is always made by someone who is medically qualified with the necessary expertise.
University College London Hospitals NHS Foundation Trust	Table	2	Agree that MRI should be considered rather than be offered universally. This is our practice at UCLH.	Thank you for your comment.

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University College London Hospitals NHS Foundation Trust	Table	4	"a critical care bed is available for the woman or pregnant person, and a critical care neonatal cot is available for the baby". Consider a clarification that unavailability of e.g. neonatal cot should not lead to a delay of an emergency caesarean section for placenta accreta due to e.g. bleeding. Or change to "When performing a **planned** caesarean birth"	Thank you for your comment. The wording has been amended to clarify that this recommendation relates to a planned caesarean, as you suggest. In addition, the recommendation and rationale have been amended to clarify that while this is the ideal for planned surgery, emergency surgery should not be delayed if a bed is not immediately available.
University College London Hospitals NHS Foundation Trust	Table	6	Women with suspected accreta may present to their local unit with bleeding (or transferred by ambulance) so the network protocol should include initial emergency management at the local centre. The local ambulance service should also be part of the network stakeholders as for these women transfer to the regional centre may be more appropriate and included in LAS SOP.	Thank you for your comment. The committee agreed that the recommendation already advised that the protocol should include emergency care in local maternity units which would include the local ambulance trust, and so did not amend the recommendation.