OPINION :

Resurgence of placenta accreta in Indonesia

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Placenta accreta is a common term used for defining a clinical condition which part or all of the placenta attaches to the myometrium that difficult to remove. Placenta accreta is a placental disorder which has been around for a long time and became a resurgence in Indonesia since 2016 with its incidence reached 2% and is still increasing until now. Placenta accreta is one of the most terrifying conditions faced by gynecologists and resulted in the increase of mortality and morbidity of pregnant women in Indonesia. In the United States, the incidence increased from less than 1 per 2000 pregnancies in 1980 to around 1 per 500 pregnancies until recently. The increased cases of placenta accreta is always directly proportional to the cesarean delivery rates.

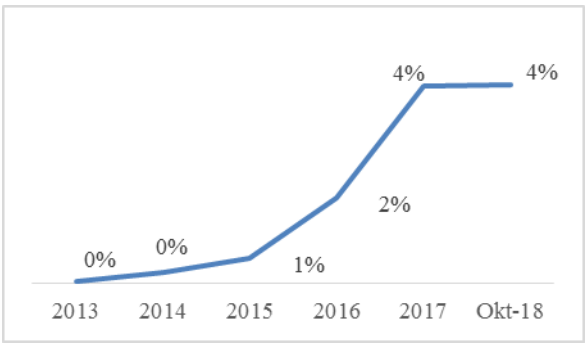

Figure 1. The incidence of placenta accreta from 2013 until October 2018 in RSUD Dr. Soetomo, Surabaya, Indonesia.

The main reason why this case is considered as terrifying is the massive bleeding because of the formation of blood vessels from the organs surrounding the uterus and the other organ invasion[3,4]. A different anatomical approach besides the usual one is needed to treat placenta accrete. Palacios classified the placenta accrete criteria into focal and diffuse based on the conservative uterus surgery success and also invasion types into 4 types based on the surgery difficulties and the conservative uterus surgery success[5,6].

Due to technical difficulties of placenta accreta management, so a special team is needed that consists of maternal-fetal medicine specialist, gynecologic oncologist, neonatologist, anesthesiologist, intensivist, pathologist, urologist, cardiothoracic surgeon, and intervenional radiologist[7]. And it is recommended to be performed in central hospital with adequate facilities[8].

A specific strategy is needed to eliminate morbidity and mortality due to placenta accreta. Early detection that could be done is by detecting gestational sac on the lower segment of the uterus on the first trimester of pregnancy[9]. The pregnancy termination after the early detection is highly recommended done with laparotomy – evacuation – repair or using intrathecal methotrexate in order to avoid the morbidity of placenta accreta. The evacuation with sharp curettage is not recommended because of the massive bleeding which is difficult to control[10].

The tiered referral system which is applied in Indonesia is not suitable for placenta accreta case, because in general, pregnant women got their antenatal care in the primary health care first and then get referred to the secondary health care near the third trimester. The early detection and treatment for placenta accreta is difficult to be done because it causes morbidity and mortality due to inadequate treatment in secondary health care. We recommend for pregnant women with previous cesarean delivery history to get transvaginal ultrasound examination for early detection and treatment in order to minimize the number of morbidity and mortality in pregnancy.

REFERENCES

1. Aryananda RA, Akbar A, Wardhana MP, et al. New three-dimensional/four-dimensional volume rendering imaging software for detecting the abnormally invasive placenta. Journal of Clinical Ultrasound. 2019;47(1):9-13.
2. Silver RM, Landon MB, Rouse DJ, et al. Maternal morbidity associated with multiple repeat cesarean

deliveries. Obstetrics and Gynecology. 2006;107(6): 1226-1232.
3. Cali G, D'Antonio F, Forlani F, Timor-Tritsch IE, Palacios-Jaraquemada JM. Ultrasound detection of bladder-uterovaginal anastomoses in morbidly adherent placenta. Fetal diagnosis and therapy. 2017;41(3):239-240.
4. Palacios-Jaraquemada JM, Karoshi M, Keith LG. Uterovaginal blood supply: the S1 and S2 segmental concepts and their clinical relevance. 2nd ed. London: Sapiens Publishing; 2012.
5. Palacios Jaraquemada JM, Pesaresi M, Nassif JC, Hermosid S. Anterior placenta percreta: surgical approach, hemostasis and uterine repair. Acta Obstetricia et Gynecologica Scandinavica. 2004; 83(8):738-744.
6. Palacios-Jaraquemada JM. One-step conservative surgery for abnormal invasive placenta (Placenta Accreta–Increta–Percreta). 2nd ed. London: Sapiens Publishing; 2012.
7. Silver RM, Fox KA, Barton JR, et al. Center of excellence for placenta accreta. American Journal of Obstetrics & Gynecology. 2015;212(5):561-568.
8. Hasegawa J, Tanaka H, Katsuragi S, et al. Maternal deaths in Japan due to abnormally invasive placenta. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics. 2018;140(3):375-376.
9. Cali G, Francesco F, Timor-Trisch I, et al. Natural history of Cesarean scar pregnancy on prenatal ultrasound: The Crossover Sign. Vol 502016.
10. Timor-Tritsch IE, Khatib N, Monteagudo A, et al. Cesarean scar pregnancies: experience of 60 cases. Journal of Ultrasound in Medicine: Official Journal of the American Institute of Ultrasound in Medicine. 2015;34(4):601-610.