RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN: WAIT AND SEE!

Marina Soto Sogorb MIR 4

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Servicio de Obstetricia y Ginecología.

CASO CLÍNICO

Mujer de 33 años gestante de 22+3 semanas que consulta por sensación de pérdida de líquido. No otra clínica.

ANTECEDENTES

No antecedentes médico-quirúrgicos de interés.

FO: 1.0.0

<u>Gestación actual:</u> Controlada y normoevolutiva

CASO CLÍNICO

EXPLORACIÓN
Afebril
Espéculo: paredes vaginales brillantes.
Test de detección temprana de RPM (AmniSure®) : positivo
TV: cérvix cerrado y formado
ECOTV: cervicometría de 30 mm
ECOAB: feto en podálica, LC+, MF+, ILA 2-3, placenta fúndica lateral izquierda. PFE: 470g

ANALÍTICA
Leucocitos 13470 mm^3 (N 75.3%) ; PCR 0.6 mg/dl ; resto normal.

CASO CLÍNICO

EVOLUCIÓN

- Ingreso: control clínico-analítico-ecográfico.
  Cultivos EC, CV, EGB y urocultivo.

- 3er día de ingreso: 22+6 SG, empeoramiento clínico-analítico ↑RFA/ Tª

  →**Sx corioamnionitis:** finalizar gestación

  Tto con prostaglandinas vaginales. Se produce expulsión fetal: 520g Apgar 0/0.

Retención de placenta

- Qx: alumbramiento manual
  Extracción de placenta muy dificultosa.
  Persistencia de restos → legrado ecoguiado
  TV: septo uterino.

  ↳ **Útero contraído**
  Sangrado fisiológico

CASO CLÍNICO

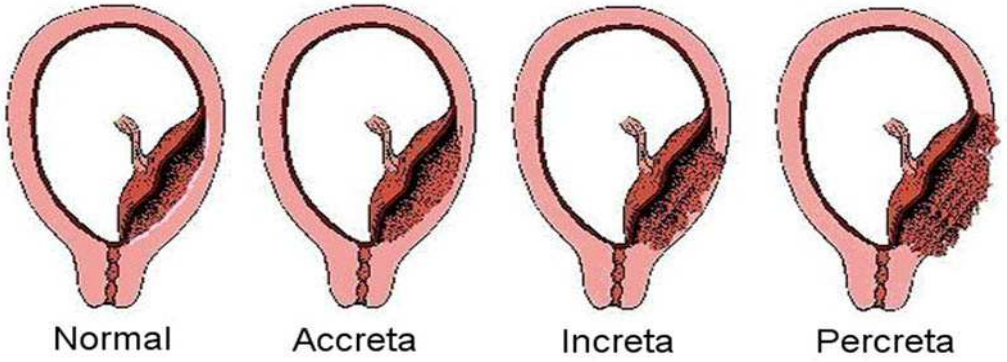
Sx: **espectro de placenta ácreta (PAS)**

- ✓ **Paciente hemodinámicamente estable**
- ✓ **Control estrecho y estudio del caso.**

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

Espectro de placenta ácreta o acretismo placentario (PAS):

Inserción anormal de las vellosidades coriales directamente en el miometrio



Ácreta (81.6%): vellosidades se insertan directamente en el miometrio.

Íncreta (11.8%): vellosidades penetran hasta el interior del miometrio.

Pércreta (6.6%): vellosidades alcanzan la serosa peritoneal o incluso penetran en la cavidad abdominal e invaden órganos vecinos.

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ETIOPATOGENIA

Defecto decidualización
Área de cicatrización por Cx uterina previa

80%
HP cesárea/legrado /miomectomía

Alteración interfase endometrio-miometrio

Adherencia de vellosidades directamente/ invasión miometrio

¿ % ?

Ciertas patologías uterinas: malformaciones, adenomiosis, miomas submucosos… pueden asociarse a defectos endometriales microscópicos que permiten la invasión placentaria anormal.

UpToDate®

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FACTORES DE RIESGO

- Placenta previa insertada sobre cicatriz de Cs previa

Cesáreas	Placenta previa (%)	No placenta previa (%)
Primera	3,3	0,03
Segunda	11	0,2
Tercera	40	0,1
Cuarta	61	0,8
Quinta	67	0,8
Sexta o más	67	4,7

Silver RM, et al. National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal morbidity associated with multiple repeat cesarean deliveries. Obstet Gynecol. 2006 Jun;107(6):1226-32.

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Antecedents of Abnormally Invasive Placenta in Primiparous Women

Risk Associated With Gynecologic Procedures

Heather J. Baldwin, PhD, Jillian A. Patterson, MBiostat, Tanya A. Nippita, FRANZCOG, Siranda Torvaldsen, MAppEpid, PhD, Ibinabo Ibiebele, MIPH, PhD, Judy M. Simpson, PhD, and Jane B. Ford, PhD

Table 2. Prior Gynecologic Procedures Undergone by Primiparous Women With Abnormally Invasive Placenta Compared With Those Without

Procedure (Before Pregnancy)	AIP (n=854)	No AIP (n=379,921)	Crude RR	99% CI	*P*
Gynecologic laparoscopy*	56 (6.6)	12,420 (3.3)	2.1	1.5–3.0	<.001
Hysteroscopy†	106 (12.4)	17,434 (4.6)	2.9	2.2–3.8	<.001
Curettage‡	105 (12.3)	23,746 (6.3)	2.1	1.6–2.7	<.001
Any of the above prior procedures	152 (17.8)	33,144 (8.7)	2.3	1.8–2.8	<.001
No. of prior procedures					<.001
0	702 (82.2)	346,304 (91.2)			
1	103 (12.1)	27,742 (7.3)	1.8	1.4–2.4	
2	32 (3.8)	4,274 (1.1)	3.7	2.3–5.9	
3 or more	17 (2.0)	1,119 (0.3)	7.4	4.0–13.9	

EPIDEMIOLOGÍA

Incidencia de **1/533** nacimientos.

Incidencia ← Tasa Cs

FIGO
INTERNATIONAL FEDERATION OF GYNECOLOGY & OBSTETRICS

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

- Clínica
- Ecografía
- RMN
- Biomarcadores

- Clínica

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

▪ Clínica

- Asintomáticas.
- Superponible a placenta previa: sangrado vaginal.
- Hematuria

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

- **Ecografía** Sx ECO semana 20, Dx placenta previa
  Seguimiento ECO c/3-4 sem

Table 1 Unified descriptors, as suggested by the European Working Group on Abnormally Invasive Placenta (EW-AIP), for ultrasound (U findings in AIP

US finding	*EW-AIP suggested standardized definition*
2D grayscale	
Loss of 'clear zone' (Figure 1)	Loss, or irregularity, of hypoechoic plane in myometrium underneath placental bed ('clear zone')
Abnormal placental lacunae (Figure 2)	Presence of numerous lacunae including some that are large and irregular (Finberg Grade 3), often containing turbulent flow visible on grayscale imaging
Bladder wall interruption (Figure 3)	Loss or interruption of bright bladder wall (hyperechoic band or 'line' between uteri serosa and bladder lumen)
Myometrial thinning (Figure 4)	Thinning of myometrium overlying placenta to < 1 mm or undetectable
Placental bulge (Figure 5)	Deviation of uterine serosa away from expected plane, caused by abnormal bulge of placental tissue into neighboring organ, typically bladder; uterine serosa appears intact but outline shape is distorted
Focal exophytic mass (Figure 6)	Placental tissue seen breaking through uterine serosa and extending beyond it; most often seen inside filled urinary bladder
2D color Doppler	
Uterovesical hypervascularity (Figure 7)	Striking amount of color Doppler signal seen between myometrium and posterior wall of bladder; this sign probably indicates numerous, closely packed, tortuous vessels in that region (demonstrating multidirectional flow and aliasing artifact)
Subplacental hypervascularity (Figure 8)	Striking amount of color Doppler signal seen in placental bed; this sign probably indicates numerous, closely packed, tortuous vessels in that region (demonstrating multidirectional flow and aliasing artifact)
Bridging vessels (Figure 9)	Vessels appearing to extend from placenta, across myometrium and beyond serosa into bladder or other organs; often running perpendicular to myometrium
Placental lacunae feeder vessels (Figure 10)	Vessels with high-velocity blood flow leading from myometrium into placental lacunae, causing turbulence upon entry
3D ultrasound ± power Doppler	
Intraplacental hypervascularity (Figure 11)	Complex, irregular arrangement of numerous placental vessels, exhibiting tortuous courses and varying calibers
Placental bulge	(as in 2D)
Focal exophytic mass	(as in 2D)
Uterovesical hypervascularity	(as in 2D)
Bridging vessels	(as in 2D)

Proposal for standardized ultrasound descriptors of abnormally invasive placenta (AIP)

S. L. COLLINS*†, A. ASHCROFT†, T. BRAUN‡, P. CALDA§, J. LANGHOFF-ROOS¶, O. MOREL**, V. STEFANOVIC††, B. TUTSCHEK‡‡ and F. CHANTRAINE§§¶¶, on behalf of the European Working Group on Abnormally Invasive Placenta (EW-AIP)

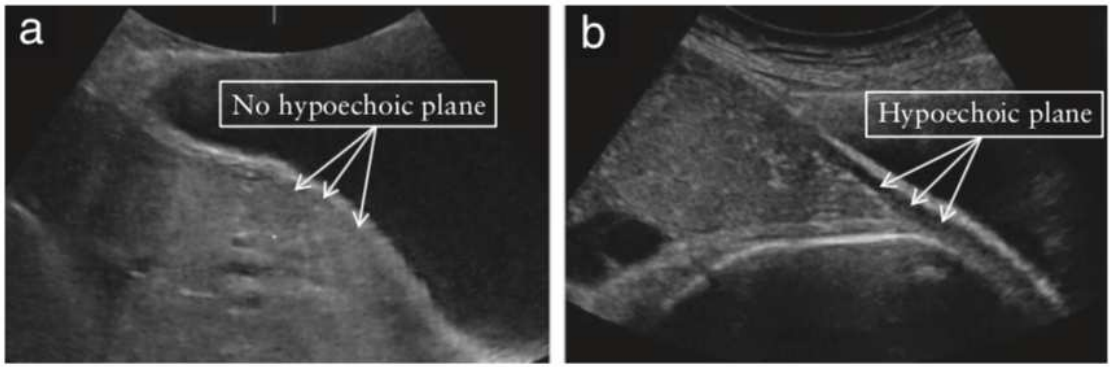
gold standard

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

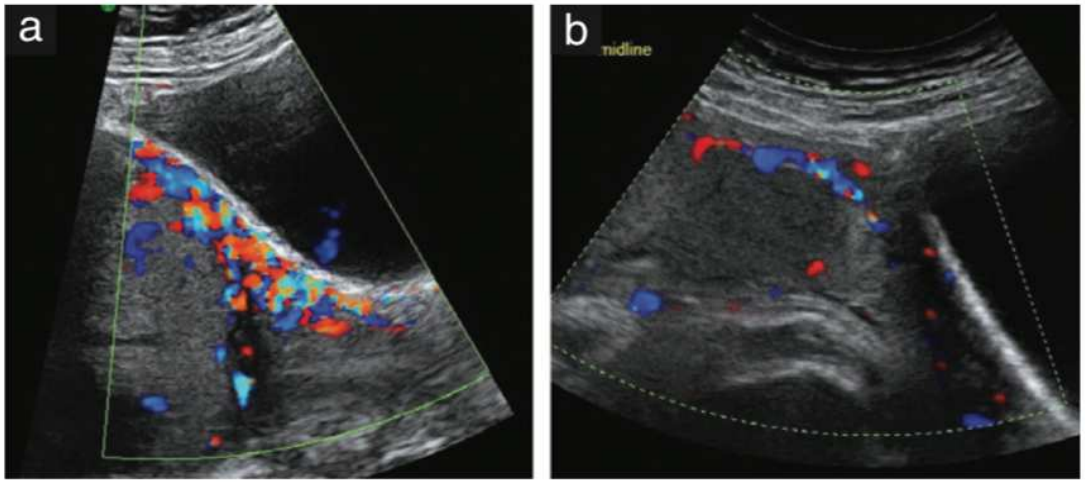
DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

- **Ecografía**



Interfase serosa uterina-vejiga



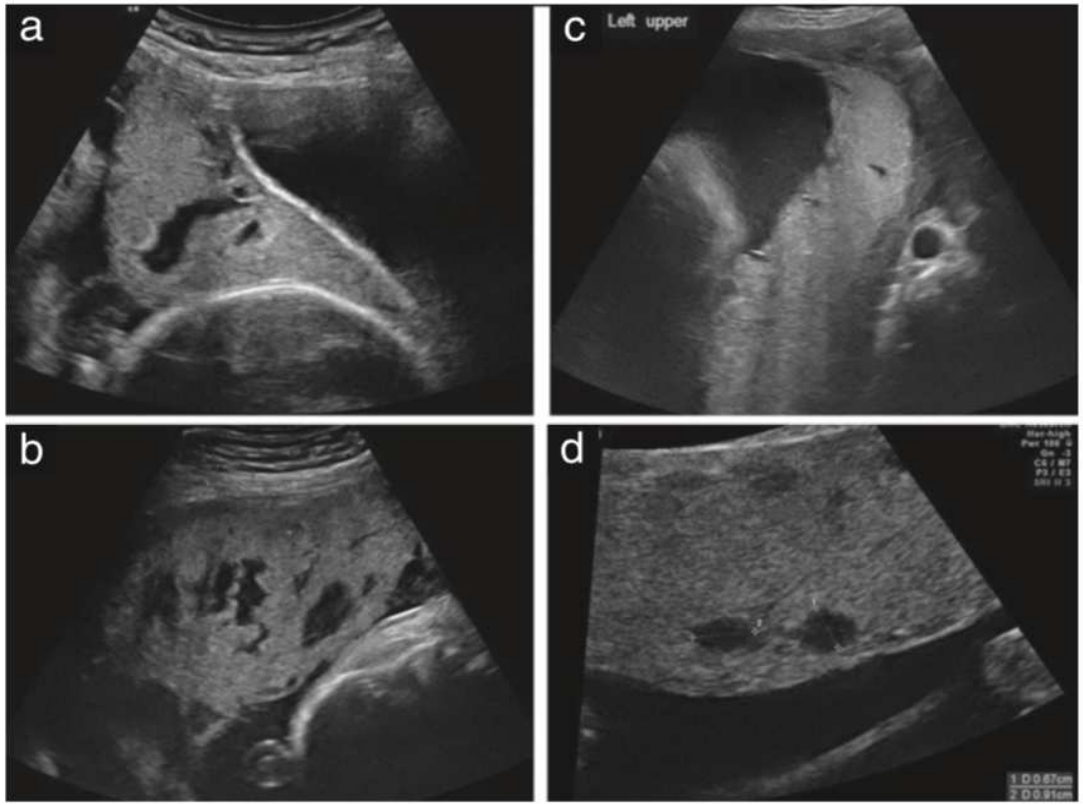
Hipervascularización útero-vesical

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

- **Ecografía**



Lagunas placentarias

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

- **RMN**

Establecer ***profundidad de invasión miometrial*** y valorar ***afectación parametrial***
Pero… NO aumenta la precisión del diagnóstico.

ACOG
The American College of Obstetricians and Gynecologists

TABLE 1
Recommendations Regarding Management of Placenta Accreta Spectrum

Recommendation	Grade of Recommendation
Diagnosis of Placenta Accreta Spectrum	
Although ultrasound evaluation is important, the absence of ultrasound findings does not preclude a diagnosis of PAS; thus, clinical risk factors remain equally important as predictors of PAS by ultrasound findings.	1A Strong recommendation, high-quality evidence
It is unclear whether MRI improves diagnosis of PAS beyond that achieved with ultrasonography alone. Accordingly, MRI is not the preferred recommended modality for the initial evaluation of possible PAS.	1B Strong recommendation, moderate-quality evidence
Women with suspected PAS diagnosed in the antenatal period based on imaging or by clinical acumen should be delivered at a level III or IV center with considerable experience whenever possible to improve outcomes.	1B Strong recommendation, moderate-quality evidence

Hallazgos:
- Protusión uterina en vejiga.
- Intensidad heterogénea dentro de placenta.
- Bandas intraplacentarias en imagen T2-W.
- Vascularización anormal.
- Interrupción focal de miometrio.

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

ANTEPARTO ← → INTRAPARTO

- Clínica
- Ecografía
- RMN

No Dx

- ~~**Biomarcadores**~~

- MSAFP (alfa feto-proteína en suero materno): aumento.
- Beta-hCG libre: aumento.

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

DIAGNÓSTICO

<u>Criterios clínicos:</u>

- Retención placentaria.
- Imposibilidad de extracción manual completa de placenta.
- Sangrado de cavidad uterina tras extracción forzada.

*** 50-70% permanecen sin diagnosticar hasta el momento del parto.**

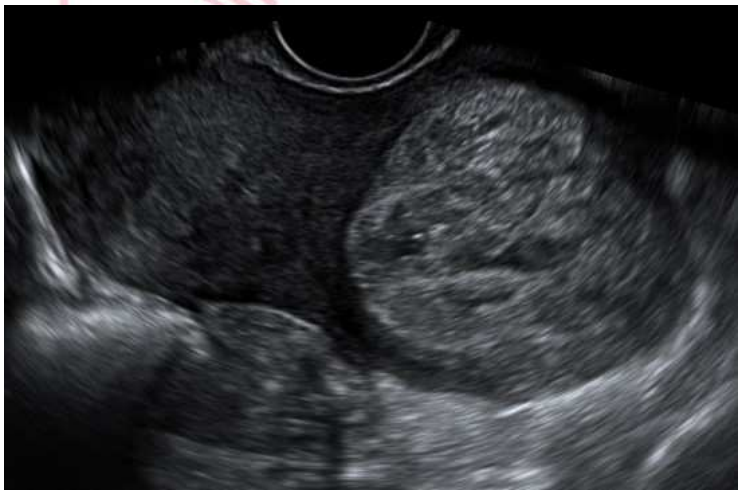
Shamshirsaz A, Fox KA, Erfani H, Clark SL, Salmanian B, Baker BW. Multidisciplinary team learning in the management of the morbidly adherent placenta: outcome improvements over time. Am J Obstet Gynecol 2017;216:612.

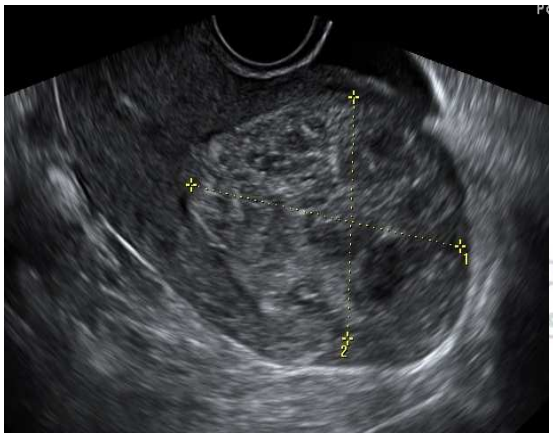
CASO CLÍNICO

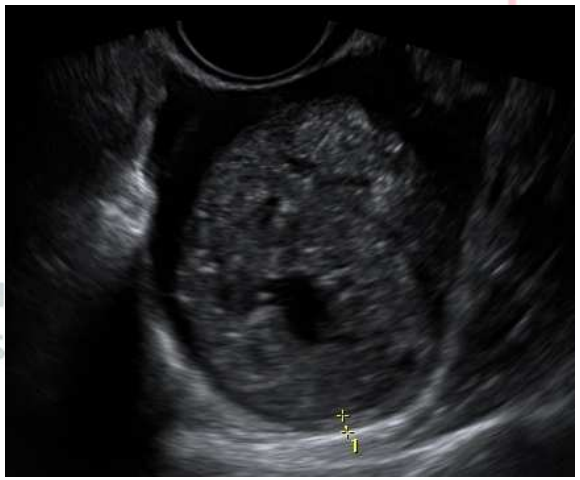
DIAGNÓSTICO: **intraparto → criterios clínicos.**

ECOGRAFÍA TV/ABD: **útero septo**. Hemiútero izquierdo: en fondo a 2mm de serosa, formación ecorrefringente homogénea de 4x7.92cm. Compatible con **cotiledón placentario íncreto.**

GENERALITAT VALENCIANA
Hospital General Universitari d'Alacant



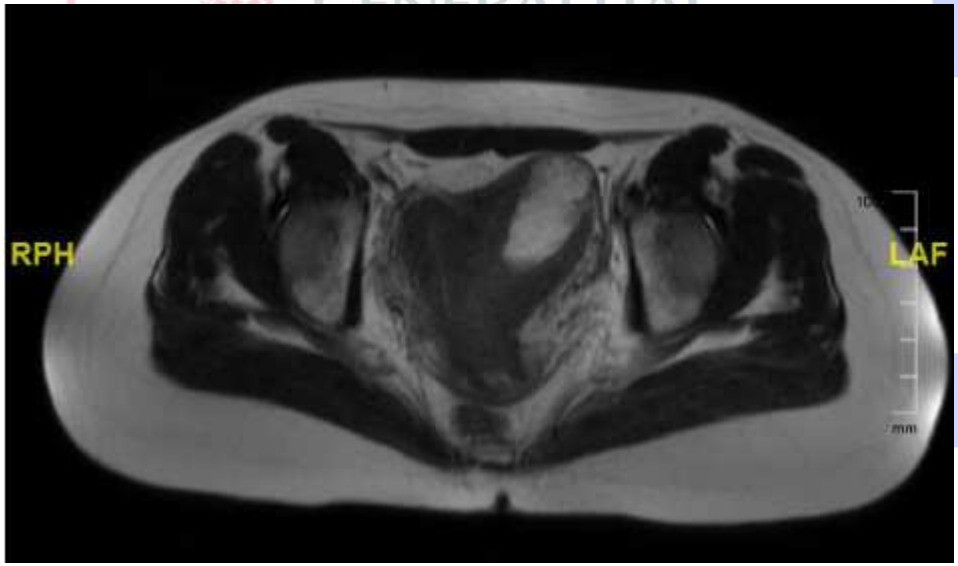


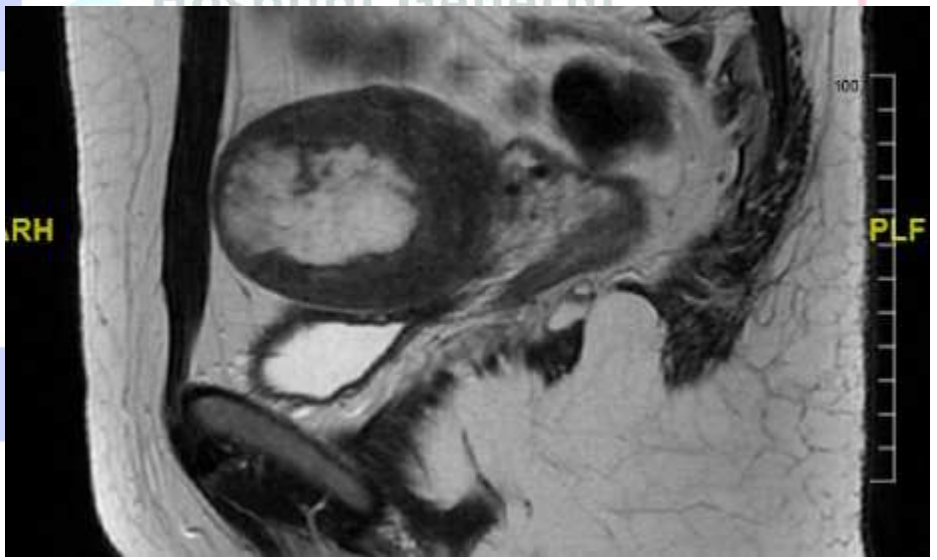


CASO CLÍNICO

DIAGNÓSTICO: **intraparto → criterios clínicos.**

RMN pelvis contraste: **útero bicorne unicollis. Placenta íncreta con infiltración miometrial** en el polo anteroexterno del cuerpo del hemiútero izquierdo. **Sin signos de invasión a estructuras adyacentes.**





RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

MANEJO

Hospital 3er Nivel

Equipo multidisciplinar

- *Obstetras*
- *Anestesiólogos*
- *Urólogos*
- *UCI*
- *UCI neonatal*
- *Banco de sangre*

Management	
Optimal management involves a standardized approach with a comprehensive multidisciplinary care team accustomed to management of PAS.	1B Strong recommendation, moderate-quality evidence
Delivery at 34 0/7–35 6/7 weeks of gestation is suggested as the preferred gestational age for scheduled cesarean delivery or hysterectomy absent extenuating circumstances in a stable patient. Earlier delivery may be required in cases of persistent bleeding, preeclampsia, labor, rupture of membranes, fetal compromise, or developing maternal comorbidities.	1A Strong recommendation, high-quality evidence
In the setting of hemorrhage, data from other surgical disciplines support the use of a range of 1:1:1 to 1:2:4 strategy of packed red blood cells: fresh frozen plasma: platelets.	1A Strong recommendation, high-quality evidence
Conservative management or expectant management should be considered only for carefully selected cases of PAS after detailed counseling about the risks, uncertain benefits, and efficacy and should be considered investigational.	2C Weak recommendation, low-quality evidence

Abbreviations: *MRI*, magnetic resonance imaging; *PAS*, placenta accreta spectrum.

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RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

MANEJO

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- *UCI neonatal*
- *Banco de sangre*

- CLÍNIC BARCELONA Hospital Universitari: • Cs electiva sem 36-37 /HT
- Sociedad Española de Ginecología y Obstetricia S.E.G.O.: • Cs electiva sem 36-37/HT
- Royal College of Obstetricians & Gynaecologists: • Cs electiva sem 35-36+6/HT
- ACOG The American College of Obstetricians and Gynecologists: • Cs electiva 34-35+6/HT
- FIGO International Federation of Gynecology & Obstetrics: • Cs electiva sem 34-37/HT
- UpToDate: • Cs electiva34-35+6/HT

CASO CLÍNICO

MANEJO

✓ ***Paciente hemodinámicamente estable***

✓ ***1 gestación: 1 aborto tardío***

¿ Histerectomía ?

WAIT AND SEE !

CASO CLÍNICO

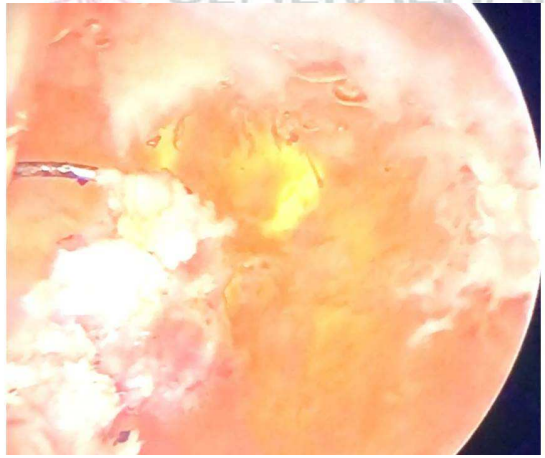
MANEJO CONSERVADOR

- Antibioterapia + Tromboprofilaxis
- <u>Control:</u>

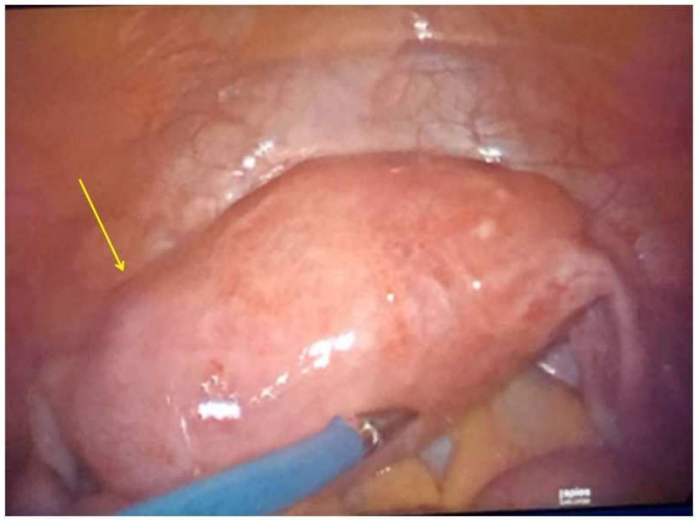
Clínica
Hemograma y PCR
bHCG
EcoTV
Cultivo

CASO CLÍNICO

HISTEROSCOPIA QX CONTROLADA POR LPS



HSC: septo desde 1/3 inferior . Cavidad izquierda ocupada por RPOC en pared postero-lateral izq.



LPS: equimosis en la superficie

RESECCIÓN DE RESTOS PLACENTARIOS RETENIDOS + SEPTOPLASTIA

CLASIFICACIÓN MALFORMACIONES

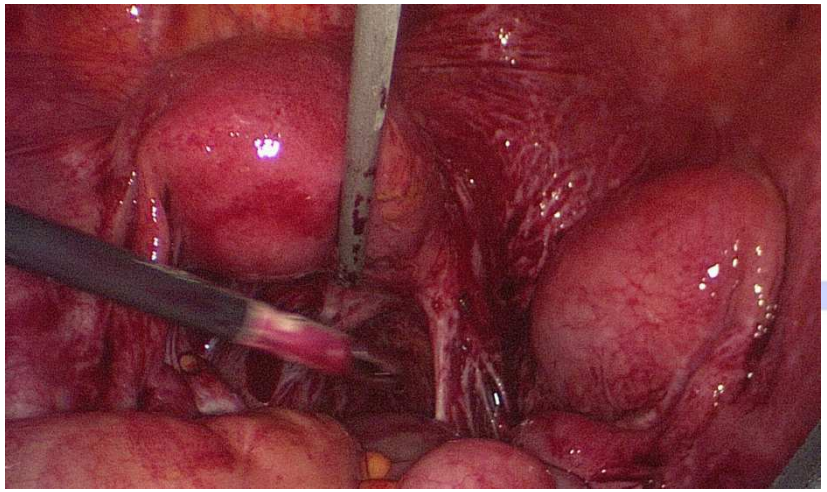
1. **AFS 1988**
2. **Embriológica 2004**
3. **VACUAM 2010**
4. **ESRHE 2014**

ESHRE/ESGE classification
Female genital tract anomalies

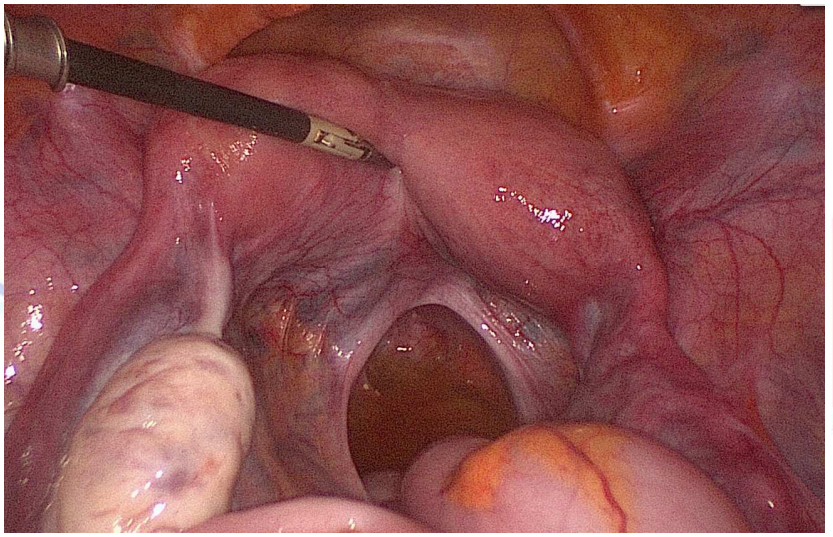
	Uterine anomaly		Cervical / Vaginal anomaly
	Main class	***Sub-class***	***Co-existent class***
U0	Normal uterus		
U1	Dysmorphic uterus	**a.** T-shaped **b.** Infantilis **c.** Others	
U2	Septate uterus	**a.** Partial **b.** Complete	
U3	Bicorporeal uterus	**a.** Partial **b.** Complete **c.** Bicorporeal septate	
U4	Hemi-uterus	**a.** With rudimentary cavity (communicating or not horn) **b.** Without rudimentary cavity (horn without cavity / no horn)	
U5	Aplastic	**a.** With rudimentary cavity (bi- or unilateral horn) **b.** Without rudimentary cavity (bi- or unilateral uterine remnants / Aplasia)	
U6	Unclassified Malformations		
U			***C*** ***V***

C0	*Normal cervix*
C1	*Septate cervix*
C2	*Double "normal" cervix*
C3	*Unilateral cervical aplasia*
C4	*Cervical Aplasia*
V0	*Normal vagina*
V1	*Longitudinal non-obstructing vaginal septum*
V2	*Longitudinal obstructing vaginal septum*
V3	*Transverse vaginal septum and/or imperforate hymen*
V4	*Vaginal aplasia*

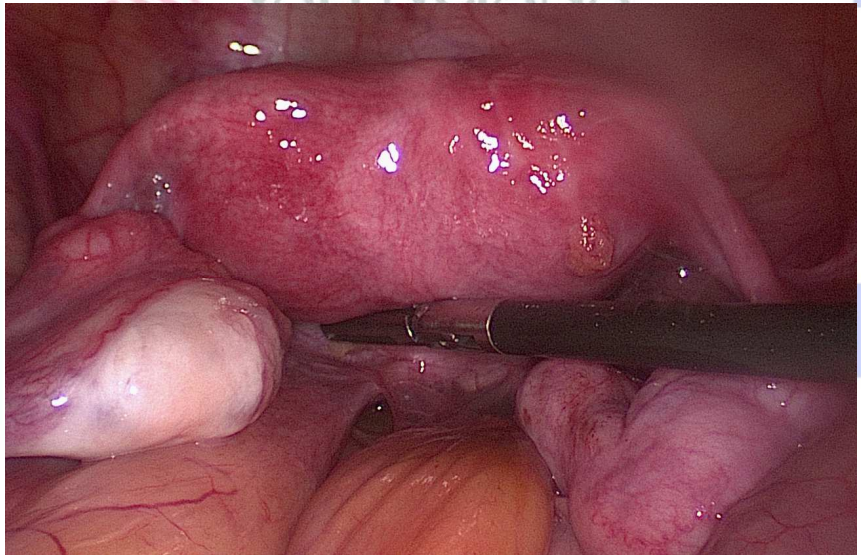
Útero unicorne (U4)



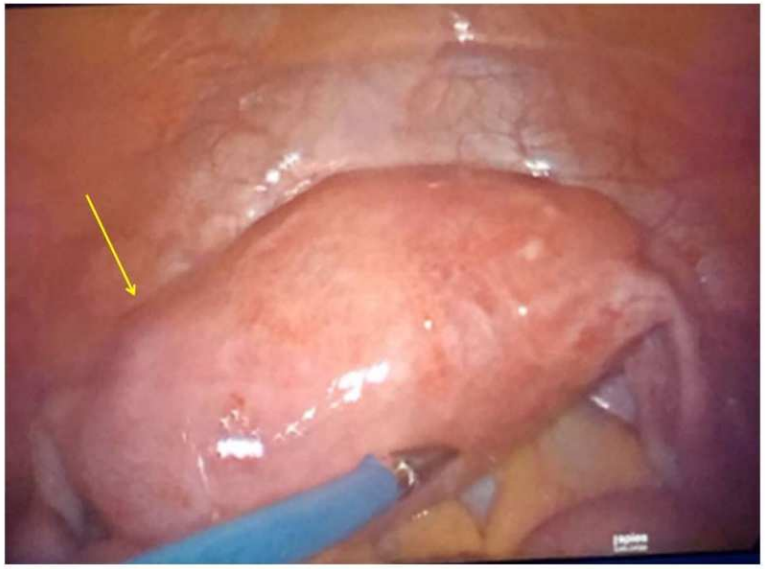
Útero didelfo (U3)

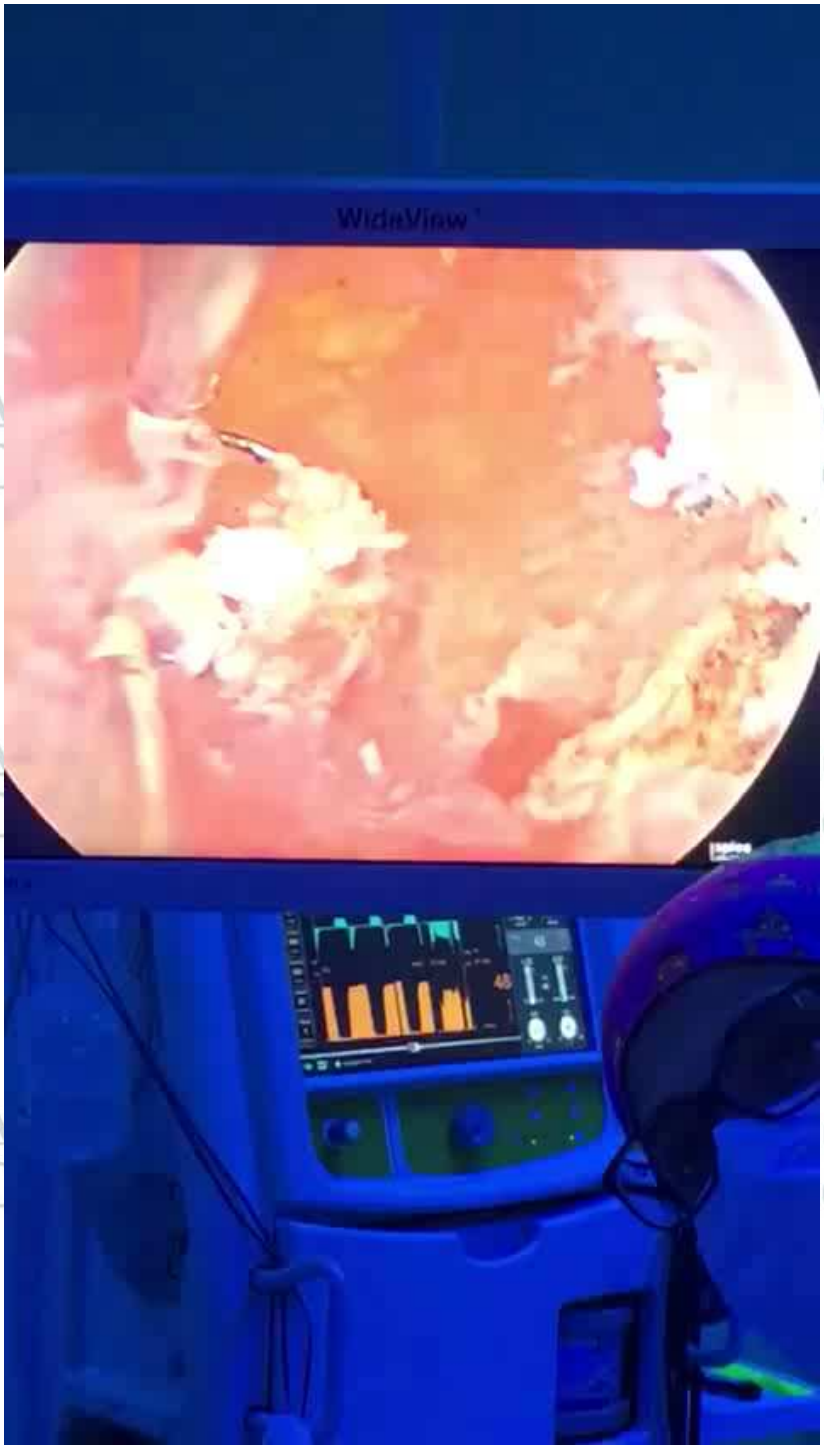


Útero bicorne (U3)



Útero septo (U2)





RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

Estabilidad hemodinámica + **Deseo genésico NO cumplido**

WAIT AND SEE!

RETO: **convencer a la paciente, familia y todo el equipo médico de que la mejor actitud es ESPERAR.**

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

- **Actitud expectante: 13,5 SG involución placentaria**

→ 78% éxito

Placenta Accreta Spectrum

Check for updates

The Society of Gynecologic Oncology endorses this document. This document was developed jointly by the American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine with the assistance of Alison G. Cahill, MD, MSCI; Richard Beigi, MD, MSc; R. Phillips Heine, MD; Robert M. Silver, MD; and Joseph R. Wax, MD.

- **MTX: división celular trofoblasto más limitada en III trimestre**

→ ¿ riesgo/beneficio?

- **Legrado: vs HSC : resección no selectiva afectando endometrio adyacente**

→ Menor éxito con legrado

Infertility Following Retained Products of Conception: Does the Timing of Surgical Intervention Matter?

Yaakov Melcer MD, Noam Smorgick MD MSc, David Schneider MD, Moty Pansky MD, Reuvit Halperin MD PhD and Ido Ben-Ami MD PhD

Department of Obstetrics and Gynecology, Assaf Harofeh Medical Center, Zerifin, affiliated with Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Long-term complications and reproductive outcome after the management of retained products of conception: a systematic review

Angelo B. Hooker, M.D.,[a,b] Humeyra Aydin, M.D.,[b] Hans A. M. Brölmann, M.D., Ph.D.,[b] and Judith A. F. Huirne, M.D., Ph.D.[b]

[a] Department of Obstetrics and Gynaecology, Zaans Medisch Centrum, Zaandam; and [b] Department of Obstetrics and Gynaecology, VU University Medical Center, Amsterdam, the Netherlands

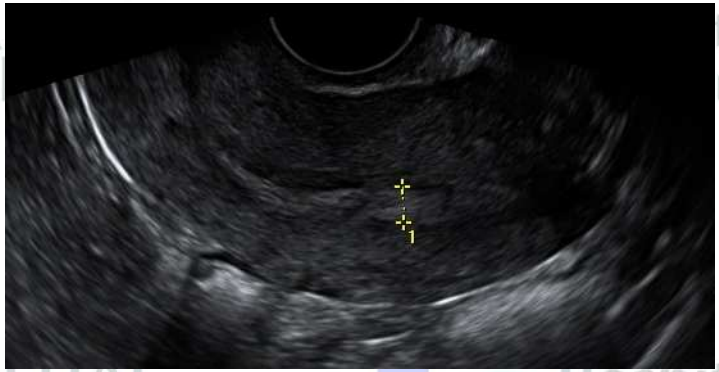
- **HSC Qx: resección RPOC con visión directa : seguro/hemostasia**

→ De elección

Capote S, Cubo-Abert M, Castellas- Caro M. Role of office hysteroscopic morcellation and 3-dimensional transvaginal ultrasound in conservative management of retained placenta accreta. Eur J Obstet Gynecol 2018.

CASO CLÍNICO

Control post-Qx:



Un año después… **mujer de 34 años con útero.**

Nueva gestación… lamentablemente aborto espontáneo a las 7 SG.

Próxima gestación **ALERTA** con signos ecográficos de **PAS.**

RETENCIÓN DE PRODUCTOS DE LA CONCEPCIÓN

CONCLUSIONES

- Ante paciente con cirugía uterina previa, es importante sospechar acretismo placentario. Alerta por aumento de su incidencia.
- Aunque lo ideal es realizar diagnóstico anteparto, la mayoría se realiza intraparto.
- El *gold standard* para el diagnóstico es la ecografía. La RMN es útil como prueba complementaria para valorar infiltración e invasión.
- El manejo debe llevarse en un hospital de tercer nivel con equipo multidisciplinar.
- El tratamiento es la cesárea e histerectomía.
- **En mujeres estables hemodinámicamente y con deseo genésico no cumplido se puede realizar tratamiento conservador histeroscópico. Convencer a la paciente, familia y equipo médico que la mejor actitud es esperar es el mayor reto en estos casos.**

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MUCHAS GRACIAS