



AMOSS Condition Form

PLACENTA ACCRETA

Section 1: Previous pregnancies

1.1 Did the woman have a placenta praevia in a *prior* pregnancy?

YES NO NOT KNOWN

1.2 Has this woman ever had a classical caesarean section?

YES NO NOT KNOWN

Section 2: Previous medical history

2.1 What previous uterine surgery has the woman undergone?

- Nil
- Evacuation of retained products of conception (ERPC)
- Dilatation and curettage
- Surgical termination of pregnancy
- Myomectomy
- Manual removal of placenta
- Other

If other please specify

Section 3: This pregnancy

3.1 Were there any episodes of antenatal haemorrhage? YES NO

If yes, how many episodes before birth event?

3.2 Was placenta praevia diagnosed prior to delivery? YES NO

If yes, please specify grade

3.3 Was placenta accreta/increta/percreta suspected prior to delivery? YES NO

3.4 Did the birth occur in the planned hospital, where the woman was 'booked' into?

YES NO NOT KNOWN

3.5 What was the estimated volume of any acute immediate antepartum blood loss?

mL

Section 4: Details of placenta accreta

4.1 At what gestation was the diagnosis of placenta accreta made?

completed weeks gestation

4.2 Please indicate if and when the following investigations were conducted

	Tick all that apply	Please list the dates of procedures
Transabdominal ultrasound	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Transvaginal ultrasound	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

4.3 What diagnosis was made?

Placenta accreta	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Placenta increta	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Placenta percreta	YES <input type="checkbox"/>	NO <input type="checkbox"/>

4.4 What organs were infiltrated by placenta?

Myometrium	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bladder	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Ureter	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Other	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If other, please specify

Section 5: Treatment

5.1 Surgical Approach

5.1a Were intra-arterial balloons inserted pre-operatively? YES NO

Were the balloons inflated? YES NO

Time elapsed from delivery to inflation minutes

5.1b What incision was made for the skin?

Transverse

Midline

Other

5.1c What incision was made on the uterus?

Lower Segment

Classical

Other

5.1d How long did the operation take? (total in minutes)

5.2 What was the lowest recorded Hb during hospital admission for birth? g/L

5.3 Did the woman undergo a hysterectomy? YES NO

If the woman had a hysterectomy, *please continue filling in details on the peripartum hysterectomy form*

If she did not have a hysterectomy, *please fill in the following details*

5.4 Was the placenta left in-situ? YES NO

If yes, please specify any medical treatment given e.g. methotrexate?

5.5 Please specify the management plan for the woman discharged home with the placenta in-situ? _____

5.6 What was the estimated blood loss at caesarean section? mL

5.7 Did the woman receive any blood products? YES NO

If yes, please record the number of units received by this woman

Whole blood or packed red blood cells units

Fresh frozen plasma units

Platelets units

Cryoprecipitate units

Fibrinogen units

Cell saver blood mL

