



# Royal College of Obstetricians and Gynaecologists

## Consent Advice No. 12

December 2010

### CAESAREAN SECTION FOR PLACENTA PRAEVIA

This is the first edition of this guidance. This paper provides additional advice for clinicians in obtaining consent of a woman to undergo caesarean section in the specific circumstance of current pregnancy with placenta praevia with or without previous caesarean section. It is designed to be used in conjunction with Consent Advice No. 7: *Caesarean section*.<sup>1</sup>

The aim of this paper is to highlight the additional and specific consequences of caesarean section performed in the presence of placenta praevia. The information should, where possible, be provided during the antenatal period in the form of an information sheet to allow the woman to understand the situation and to provide ample opportunities for her to ask any questions she may have and to antenatally meet providers of additional services that may become necessary, such as interventional radiologists.

Depending on local clinical governance arrangements, an additional consent form may be used with the additional risks highlighted, or the additional risks may be incorporated in a specific consent form for the whole procedure.

## CONSENT FORM

### 1. Name of proposed procedure or course of treatment

Caesarean section for placenta praevia.

### 2. The proposed procedure

Describe the nature of caesarean section and emphasise how a procedure in the presence of placenta praevia varies in comparison with one performed in the presence of a normally sited placenta. Explain the procedure as described in the patient information.

### 3. Intended benefits

The aim of the procedure is to secure the safest route of delivery to avoid the anticipated risks to the mother and/or baby of the heavy bleeding that would occur during labour and attempted vaginal delivery owing to the position of the placenta. These would be much greater than the risks of routine elective caesarean section.

### 4. Serious and frequently occurring risks<sup>3-8</sup>

It is recommended that clinicians use this document alongside Consent Advice No. 7: *Caesarean section*.<sup>1</sup> The following risks are known risks that differ from those of a caesarean section performed in the presence of a normally sited placenta.

#### 4.1 Serious risks

Serious risks include:

##### Maternal

In all women with placenta praevia:

- emergency hysterectomy, up to 11 in 100 women (very common)
- need for further laparotomy during recovery from the caesarean, 75 in 1000 women (common)

- thromboembolic disease, up to three in 100 women (common)
- bladder or ureteric injury, up to six in 100 women (common)
- future placenta praevia, 23 in 1000 women (common)
- massive obstetric haemorrhage, 21 in 100 women (very common).

In women with placenta praevia and previous caesarean section:

- emergency hysterectomy, up to 27 in 100 women (very common).

In women with an abnormally adherent placenta (e.g. placenta accreta):

- the woman should be advised that hysterectomy is highly likely.

If the placenta is found to be abnormally adherent to the wall of the uterus, it may be safer to leave the placenta inside the uterus or to perform a planned caesarean hysterectomy to avoid heavy bleeding than to attempt removal. Excessive bleeding may require blood transfusion and other procedures, including emergency hysterectomy, to control it. Admission to a critical care unit may then be necessary.

#### 4.2 Frequent risks

Frequent risks include:

##### Maternal

- Admission to intensive care.
- Infection.
- Blood transfusion.

##### Fetal

- Admission to neonatal intensive care.

#### 5. Any extra procedures which may become necessary during the procedure

- Repair of damage to bowel, bladder or blood vessels.
- Specifically, where placenta praevia accreta is suspected owing to the combination of placenta praevia and previous caesarean section and/or imaging information, discussion concerning the following (where available) should take place:
  - ◆ Cell salvage: this reduces the small risk of transmission of infection and transfusion reactions associated with the use of donated blood; however, there is a theoretical risk of maternal sensitisation to the baby's blood and, rarely, amniotic fluid embolism. Neither of these complications has yet been confirmed by published research.
  - ◆ Interventional radiology: this occludes the uterine blood vessels by cannulation of the femoral artery under X-ray screening. Foam plugs, balloons or coils are passed through these cannulas to block the vessels and control bleeding, either temporarily or permanently. The risks of this intervention should be discussed with the woman by the radiologist in advance.

#### 6. What the procedure is likely to involve and the benefits and risks of any available alternative treatments, including no treatment

The procedure is likely to involve delivery of the baby/babies and placenta/placentas through an open approach using an abdominal incision and an incision into the uterus. Both incisions are usually transverse. If either a midline abdominal incision or a classic uterine incision is being considered, the woman must be informed of the reasons and the added risks. Sometimes forceps are used to deliver the head, especially with breech presentations. The reason for the caesarean section must be clearly discussed and documented, as must the great risk to mother and baby of not performing the caesarean section. An informed, competent pregnant woman may choose the no-treatment option, i.e. she may refuse caesarean section, even when this would be detrimental to her own health or the wellbeing of her fetus. In such a situation every attempt must be taken to ensure the woman and her birth partner realise the critical importance of the caesarean section in this specific situation.

## 7. Statement of patient: procedures which should not be carried out without further discussion

Other procedures which may be appropriate but not essential at the time, such as ovarian cystectomy/oophorectomy, should be discussed and the woman's wishes recorded.

## 8. Preoperative information

A record should be made of any sources of information (e.g. RCOG or locally produced information leaflets/tapes) given to the woman prior to surgery.

## 9. Anaesthesia

The woman must be aware of the form of anaesthesia planned and be given an opportunity to discuss this in detail with the anaesthetist before surgery. It should be noted that with obesity there are increased risks, both surgical and anaesthetic. The surgeon and anaesthetist should decide the optimal anaesthesia before the woman is approached. There should be no disagreement between surgeon and anaesthetist as this may further distress the woman.

## References

1. Royal College of Obstetricians and Gynaecologists. Consent Advice No. 7: *Caesarean section*. London: RCOG; 2009 [http://www.rcog.org.uk/womens-health/clinical-guidance/caesarean-section-consent-advice].
2. Royal College of Obstetricians and Gynaecologists. Clinical Governance Advice No. 7: *Presenting information on risk*. London: RCOG; 2008 [http://www.rcog.org.uk/womens-health/clinical-guidance/presenting-information-risk].
3. Choi SJ, Song SE, Jung KL, Oh SY, Kim JH, Roh CR. Antepartum risk factors associated with peripartum cesarean hysterectomy in women with placenta previa. *Am J Perinatol* 2008;25:37-41.
4. Crane JM, Van den Hof MC, Dodds L, Armson BA, Liston R. Maternal complications with placenta previa. *Am J Perinatol* 2000;17:101-5.
5. Frederiksen MC, Glassenberg R, Stika CS. Placenta previa: a 22-year analysis. *Am J Obstet Gynecol* 1999;180:1432-7.
6. Yaegashi N, Chiba-Sekii A, Okamura K. Emergency postpartum hysterectomy in women with placenta previa and prior cesarean section. *Int J Gynaecol Obstet* 2000;68:49-52.
7. Bahar A, Abusham A, Eskandar M, Sobande A, Alsunaidi M. Risk factors and pregnancy outcome in different types of placenta previa. *J Obstet Gynaecol Can* 2009;31:126-31.
8. Hasegawa J, Matsuoka R, Ichizuka K, Mimura T, Sekizawa A, Farina A, et al. Predisposing factors for massive hemorrhage during Cesarean section in patients with placenta previa. *Ultrasound Obstet Gynecol* 2009;34:80-4.

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The final version is the responsibility of the Consent Group of the RCOG

The Consent Advice review process will commence in 2013 unless otherwise indicated.

### DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces consent advice as an aid to good clinical practice. The ultimate implementation of a particular clinical procedure or treatment plan must be made by the doctor or other attendant after the valid consent of the woman in the light of clinical data and the diagnostic and treatment options available. The responsibility for clinical management rests with the practitioner and their employing authority and should satisfy local clinical governance probity.

**Patient identifier/label**

**Name of proposed procedure or course of treatment**

(include brief explanation if medical term not clear) *Caesarean section for placenta praevia (where the placenta covers the entrance to the womb).*

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient, in particular, I have explained: *I have explained the procedure to the patient. In particular, I have explained:*

The intended benefits: *Owing to the position of your placenta the risks of vaginal delivery are greater than those of a normal caesarean section operation. Delivery of the baby/babies through a cut in the abdomen (tummy) and uterus (womb) avoids the risks to you and your baby of heavy bleeding which would occur before or during labour.*

**Serious risks:**

- *Emergency hysterectomy, up to 11 in 100 women (very common). If you have had a previous caesarean section, this risk increases to 27 in 100 women (very common). If your placenta is suspected to be stuck to the wall of the womb, it is almost inevitable that you will require an emergency hysterectomy to prevent life-threatening bleeding.*
- *Heavy bleeding requiring transfusion, 21 in 100 women (very common).*
- *Need for further open operation at a later time or date, 75 in 1000 women (common).*
- *Developing a blood clot, up to 3 in 100 women (common).*
- *Injury to the urinary system, up to 6 in 100 women (common).*
- *Increased risk of a tear in the womb in future pregnancies, 2–7 in 1000 women (uncommon).*
- *Stillbirth in future pregnancies, 1–4 in 1000 women (uncommon).*
- *In a future pregnancy the placenta covers the entrance to the womb (placenta praevia), 23 in 1000 women (common).*
- *For all caesarean sections the risk of death is approximately 1 in 12 000 women (very rare).*

**Frequent risks:**

*Common: persistent wound and abdominal discomfort, repeat caesarean section in subsequent pregnancies, readmission to hospital, minor cuts to the baby’s skin, blood transfusion and infection requiring antibiotics. Both you and your baby are at a higher risk of needing admission for intensive care.*

**Any extra procedures which may become necessary during the procedure**

- Cell salvage (where blood lost is collected, processed and replaced into the circulation). Cell salvage reduces the small risk of transmission of infection and transfusion reactions associated with use of donated blood.*
- Interventional radiology (blocking the blood vessels to the uterus by passing fine tubes through the artery in the groin under X-ray vision). Foam plugs or coils are passed through these tubes to block the vessels to control heavy bleeding. The radiologist will discuss the benefits and risks of this procedure with you.*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided:

This procedure will involve:

- general and/or regional anaesthesia
- local anaesthesia
- sedation

Signed ..... Date .....

Name (PRINT)..... Job title.....

**Contact details** (if patient wishes to discuss options later)

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand

Signed ..... Date .....

Name (PRINT).....

**Top copy accepted by patient: yes/no** (please ring)