SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Title: **Management of pregnancies complicated by abnormal placentation or other obstetric conditions requiring complex surgery**				**Policy**	
Patient Age Group:	( ) N/A	( ) All Ages	( ) Newborns	( ) Pediatric	( ) Adult

PURPOSE:

To facilitate a multidisciplinary approach to the perinatal, obstetric and surgical management of patients with significant risk of major peripartum hemorrhage most commonly due to abnormal placentation.

APPLICABILITY

This policy applies to the following providers:

- UNM OB/GYN attending physicians (including members of the Benign Gynecology and Family Planning divisions)
- MFM consultant physicians
- Gynecologic Oncology consultant physicians
- Obstetrical care providers: Family Medicine physicians, Maternal Child Health physicians and Certified Nurse Midwives
- Residents and fellows who provide care with these provider groups.

PROCEDURES

Antepartum period > 1 month from anticipated delivery

- Patient is identified by MFM consultant service with potential abnormal placentation or condition that may result in a complicated surgical case. If an obstetrical care provider identifies a case, a consult will be made to MFM for higher-level ultrasound and evaluation of maternal-fetal co-morbidities.
- Patient will have obstetric care established with or transferred to a general OB/GYN attending physician at UNM. That referral will be made by the first MFM consultant who identifies the diagnosis.
- The patient will be added to the "abnormal placentation" list on PowerChart and in Special Deliveries.
- MFM consultant team will initially determine the approximate time of recommended delivery based on maternal-fetal issues. The MFM consultant will contact the general OB/GYN attending physician who will function as the primary surgical obstetrician and a consult with GYN Oncology will be made by the MFM team managing the maternal-fetal situation.
- An initial multidisciplinary care conference will be coordinated and led by the MFM fellow who has taken responsibility for the patient. The conference should be arranged as promptly as possible and at a time where the following attendings can be present: MFM / General OB/GYN and Gynecology Oncology. The fellow should decide on additional attending participation in the initial meeting (ie radiology, NICU, etc). The meeting between the MFM consultant, general OB/GYN attending physician and Gyn Oncology consultant should all occur within 1-2 weeks of the diagnosis of suspected abnormal

placentation. MFM will also include NICU representatives if the fetus is deemed viable at the time of diagnosis of suspected abnormal placentation.

- Based on the anticipated delivery date, the Gyn Oncology consultant will schedule the Cesarean delivery in the main OR requesting 2 rooms – one for the mother and one for the newborn. The general OB/GYN attending physician will be included in the scheduling decisions. Decisions regarding whose block time is utilized will be made by the surgical attendings involved.
- MFM consultants will initially discuss findings with the patient including the possible need for C-hyst at delivery.
- MFM team or the general OB/GYN attending physician will perform additional ultrasounds per maternal-fetal indications and order an MRI for additional evaluation of the placental site

Antepartum period ≤ 1 month from anticipated delivery

- MFM consultants will confirm the best range of delivery times for the fetus and the GYN Oncology and the general OB/GYN attending physician will notify the MFM team of the scheduled surgery date.
- The general OB/GYN attending physician will review the delivery procedure as well as the c-hyst procedure with the patient and obtain consent for all procedures anticipated. Please see procedure list detailed below.
- A Care Conference will be scheduled to occur 2 weeks before the planned delivery. MFM consultants and GYN Oncology consultants will jointly schedule the conference which will include, but may not be limited to, the following services:
    a. Anesthesia
    b. Transfusion services
    c. NICU
    d. General OB/GYN attending physician
    e. Interventional radiology
    f. OR Staff (GYN surgical coordinator if deemed necessary by GYN Onc)
    g. Gyn Onc will assess the needs for Urology, IR or any other surgical based consultant services on a case by case basis.
- The patient information will be placed on the Alerts Board in L&D by the MFM fellow at 32 weeks or earlier if deemed necessary.
- The Gyn Oncology attending will meet with the patient once admitted to review the surgical planning and possible massive transfusion needs and management of the bladder or other anticipated problems. If the patient is not admitted to the hospital prior to delivery, a consultation with the GYN Onc consultant in the Women's Health Clinic will be arranged by the OB/GYN attending physician as desired by the Gyn Oncology consultant and the patient. The general OB/GYN and/or the Gyn Oncology consultants will fully counsel the patient on the operative procedure anticipated and the potential complications and post-operative management. The OB/GYN attending should obtain the basic consent for delivery and hysterectomy – additional procedures such as partial bladder resection, stents, etc should be added based on the discussions from the care conference.

Day of Surgery

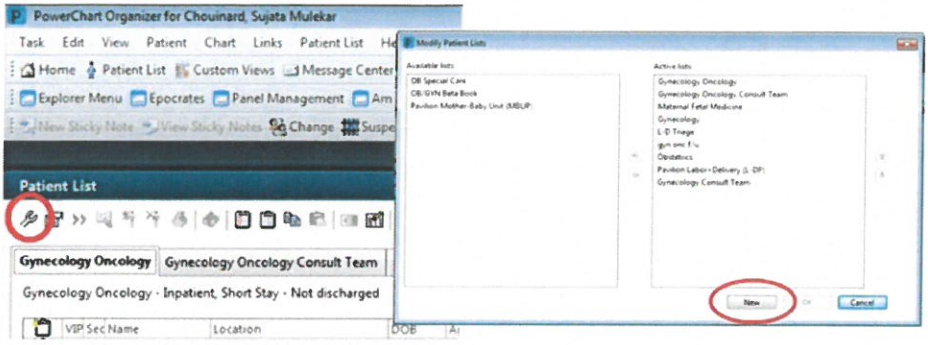
- The multidisciplinary team will huddle prior to the case and perform an internal review of the checklist (see below).
- The general OB/GYN attending physician will perform the cesarean delivery and close the uterus.

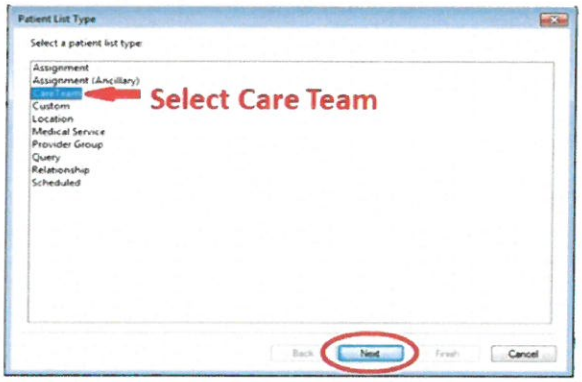
- The Gyn Oncologist will assume surgical management after delivery of the infant and closure of the uterus. All operative management from this time forward will be under the direction of the Gyn Oncology Attending.
- The MFM fellow involved in the care of the patient will be encouraged to scrub in the surgery as the 1st or 2nd surgical assistant. Except when the severity of the invasive placentation is such that the gynecologic oncology attending physicians must assist each other, the maternal-fetal medicine fellow and the 4th year resident on the gynecologic oncology service will alternate in the role of first assistant on these cases.
- The patient's post-operative care will be managed on the Gynecologic Oncology Service under the explicit direction of the Gynecologic Oncology Attending.
- The gynecologic oncology faculty will serve in a supervisory role to the maternal-fetal medicine fellows involved in the case and will provide written evaluation of the fellows' performance in care planning and in the operating room using New Innovations.

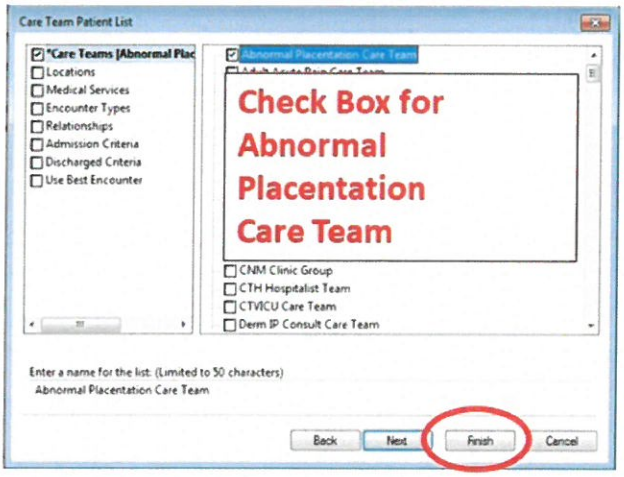
References:

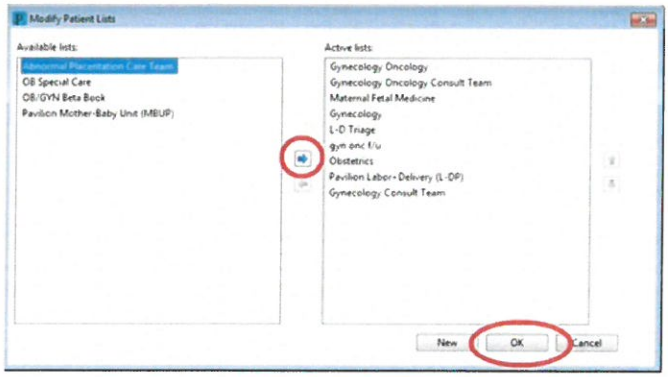
Placenta accreta. Committee Opinion No. 529. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:207–11

Placenta accreta. Belfort, Michael A. American Journal of Obstetrics & Gynecology , Volume 203 , Issue 5 , 430 - 439


PowerChart Organizer for Chouinard, Sujata Mulekar
Patient List
Gynecology Oncology
Gynecology Oncology Consult Team
Gynecology Oncology - Inpatient, Short Stay - Not discharged
Modify Patient Lists
New
Cancel


Patient List Type
Select a patient list type:
Assignment
Assignment (Ancillary)
Care Team
Custom
Location
Medical Service
Provider Group
Query
Relationship
Scheduled
Select Care Team
Back
Next
Finish
Cancel


Care Team Patient List
*Care Teams [Abnormal Plac
Locations
Medical Services
Encounter Types
Relationships
Admission Criteria
Discharged Criteria
Use Best Encounter
Abnormal Placentation Care Team
Check Box for Abnormal Placentation Care Team
CNM Clinic Group
CTH Hospitalist Team
CTVICU Care Team
Derm IP Consult Care Team
Enter a name for the list: (Limited to 50 characters)
Abnormal Placentation Care Team
Back
Next
Finish
Cancel


Modify Patient Lists
Available lists:
Abnormal Placentation Care Team
OB Special Care
OB/GYN Beta Book
Pavilion Mother-Baby Unit (MBUP)
Active lists:
Gynecology Oncology
Gynecology Oncology Consult Team
Maternal Fetal Medicine
Gynecology
L-D Triage
gyn onc f/u
Obstetrics
Pavilion Labor - Delivery (L-DP)
Gynecology Consult Team
New
OK
Cancel

APPROVAL

Prepared and Approved by: Executive Committee

Approval: _____ 8/1/2018

Chair, Department of Obstetrics and Gynecology Date

SOP # / Version #	Effective Date	Supersedes	Review Date	Summary of Change(s)
Version 2	6/29/2018	Version 1	6/29/2018	No significant changes
Version 3	7/30/2018	Version 2	7/30/2018	Added Powerchart guide for referral to Abnormal Placentation Care Team

Checklist for the care conference:

- ❑ MFM Fellow: Review of patient history including all prior surgeries, any medical co-morbidities, admissions during pregnancy, outcomes of prior pregnancies (ie any complications with prior C/S)
- ❑ Radiology: Review of images
- ❑ GYO, Gyn, MFM, surgical consultants: Discussion of surgical approach (regional anesthesia with conversion; lithotomy; vertical midline incision; involvement of consultants)
  - Verify who will obtain surgical consent – *must* include a discussion of
    - Hysterectomy
    - Massive transfusion
    - Need for prolonged intubation
    - TSI stay
    - Possible IR procedures
    - Possible involvement of other organs, plans to include consulting services
    - Possible need for prolonged catheterization, possible need for surgical drains, lines
    - Prolonged hospitalization
    - Possibility that the patient will be on a surgical floor where she can not room with the baby.
- ❑ Anesthesia: Review of plans for regional with conversion vs general anesthesia; lines; special considerations
- ❑ Bloodbank, MFM: Verify plans for updated type and cross – *must* ensure that T&C will be current on the morning of surgery so blood is in the room *prior to starting the case.* ******If the patient is not admitted, she will need to be admitted the night before surgery******
- ❑ Postpartum care – if a hysterectomy is performed, the patient will be managed by GYO. She will likely stay in the TSI or be roomed on 5E for at least the first 24-48 postpartum.
- ❑ Discussion of plans in the event of an unscheduled C/S:
  - Call plan for GYO, consulting services; location (L&D vs main depending on patient stability); equipment (have a tray and retractor on L&D); anesthesia (general at the time of incision?); blood availability;

****** Delivery will be staffed by the MFM resident and Gyn attending. Surgical assistant for the hysterectomy will be assigned following a discussion between MFM attending and GYO attending staffing the case and will not be part of the care conference******