

Information for you

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Placenta praevia, placenta accreta and vasa praevia

About this information

This information is for you if you have placenta praevia (a low-lying placenta after 20 weeks of pregnancy) and/or placenta accreta (when the placenta is stuck to the muscle of your womb). It also includes information on vasa praevia. It may also be helpful if you are a partner, relative or friend of someone in this situation.

A glossary of all medical terms used is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms.

Key points

- Placenta praevia happens when your placenta (afterbirth) attaches in the lower part of your uterus (womb), sometimes completely covering the cervix (neck of the womb).



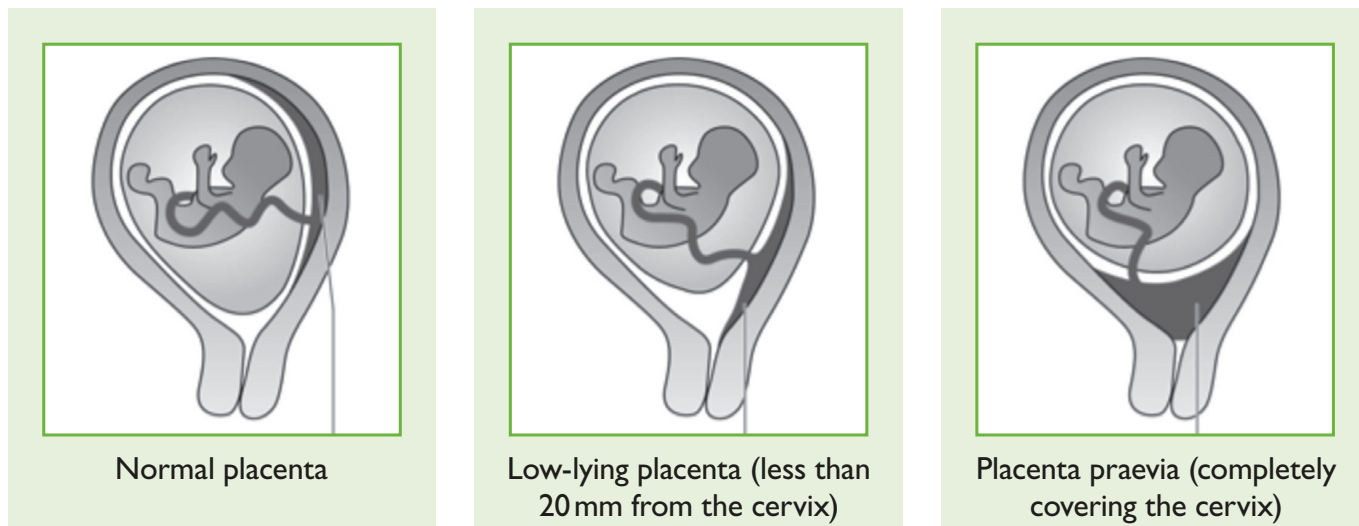
- This can cause heavy bleeding during pregnancy or at the time of birth.
- If you have placenta praevia, your baby will probably need to be born by caesarean.
- Placenta accreta is a rare but serious condition when the placenta is stuck to the muscle of your womb and/or to nearby structures such as your bladder. This is more common if you have previously had a caesarean. It may cause heavy bleeding at the time of birth.
- Vasa praevia is a very rare condition where blood vessels travelling from your baby to your placenta, unprotected by placental tissue or the umbilical cord, pass near to the cervix. If these blood vessels tear, this can be very dangerous for your baby.

What is placenta praevia?

The placenta develops together with the baby in your uterus during pregnancy. It attaches to the wall of your uterus and provides a connection between you and your baby. Oxygen and nutrients pass from your blood through the placenta into your baby's blood. The placenta is delivered shortly after the baby is born and it is sometimes called the afterbirth.

In some women, the placenta attaches low down in the uterus and may cover part of or all of the cervix (the neck of the womb). In most cases, the placenta moves upwards and out of the way as the uterus grows during pregnancy. For some women, however, the placenta continues to lie in the lower part of the uterus as the pregnancy continues. This condition is known as low-lying placenta if the placenta is less than 20 mm from the cervix or as placenta praevia if the placenta completely covers the cervix.

Placenta praevia is more common if you have had one or more previous caesarean births, if you had had fertility treatment in order to fall pregnant, or if you smoke.



What are the risks to me and my baby?

There is a risk that you may have vaginal bleeding, particularly towards the end of the pregnancy, because the placenta is low down in your uterus. Bleeding from placenta praevia can be very heavy, sometimes putting both your and your baby's life at risk.

Your baby may need to be born by caesarean because the placenta may block the birth canal, preventing a vaginal birth.

How is placenta praevia diagnosed?

A low-lying placenta is checked for during your routine 20-week ultrasound scan. Most women who have a low-lying placenta at 20 weeks will not go on to have a low-lying placenta later in the pregnancy: 9 out of 10 women with a low-lying placenta at their 20-week scan will no longer have a low-lying placenta when they have their follow-up scan, and only 1 in 200 women overall will have placenta praevia at the end of their pregnancy. If you have previously had a baby by caesarean, the placenta is less likely to move upwards.

Placenta praevia is confirmed by having a transvaginal ultrasound scan (where the probe is gently placed inside the vagina). This is safe for both you and your baby and it may be used towards the end of your pregnancy to check exactly where your placenta is lying.

Placenta praevia may be suspected if you have bleeding in the second half of pregnancy. Bleeding from placenta praevia is usually painless and may occur after having sex.

Placenta praevia may also be suspected later in pregnancy if the baby is found to be lying in an unusual position, for example bottom first (breech) or lying across the womb (transverse).

What extra antenatal care can I expect if I have a low-lying placenta?

If your placenta is low lying at your 20-week scan, you will be offered a follow-up scan at 32 weeks of pregnancy to see whether it is still low lying. This may include a **transvaginal scan**. You should be offered a further ultrasound scan at 36 weeks if your placenta is still low lying.

The length of your cervix may be measured at your 32-week scan to predict whether you may go into labour early and whether you are at increased risk of bleeding.

If you have placenta praevia, you are at higher risk of having your baby early (less than 37 weeks) and you may be offered a course of steroid injections between 34 and 36 weeks of pregnancy to help your baby to become more mature. See the RCOG patient information *Corticosteroids in pregnancy to reduce complications from being born prematurely* (www.rcog.org.uk/en/patients/patient-leaflets/corticosteroids-in-pregnancy-to-reduce-complications-from-being-born-prematurely/).

If you go into labour early, you may be offered a type of medication (known as tocolysis) that is given to try to stop your contractions and to allow you to receive a course of steroids.

Additional care, including whether or not you need to be admitted to hospital, will be based on your individual circumstances. Even if you have had no symptoms before, there is a small risk that you could bleed suddenly and heavily, which may mean that you need an emergency caesarean.

If you know you have a low-lying placenta, you should contact the hospital straight away if you have any vaginal bleeding, contractions or pain. If you have bleeding, your doctor may need to do a **speculum** examination to check how much blood loss there is and where it is coming from. This is a safe examination and you will be asked for your consent beforehand.

You should try to avoid becoming anaemic during pregnancy by having a healthy diet and by taking iron supplements if recommended by your healthcare team. Your blood haemoglobin levels (a measure of whether you are anaemic) will be checked at regular intervals during your pregnancy.

How will my baby be born?

Towards the end of your pregnancy, once placenta praevia is confirmed, you will have the opportunity to discuss your birthing options with your healthcare professional.

Your healthcare team will discuss with you the safest way for you to give birth based on your own individual circumstances.

If the edge of your placenta is less than 20 mm from the entrance to the cervix on your scan at 36 weeks, a caesarean will be the safest way for you to give birth. If the placenta is further than 20 mm from your cervix you can choose to have a vaginal birth.

Unless you have heavy or recurrent bleeding, your caesarean will usually take place between 36 and 37 weeks. If you have had vaginal bleeding during your pregnancy, your caesarean may need to take place earlier than this.

If you are having a caesarean, a senior **obstetrician** and **anaesthetist** should be present at the time of birth and you should give birth in a hospital with facilities available to care for you if you experience heavy bleeding. This is particularly important if you have had one or more caesareans before.

Your anaesthetist will discuss the options for anaesthesia if you are having a caesarean birth.

During your caesarean, you may have heavier than average bleeding. There are many different things that your doctors can do to stop the bleeding, but if it continues and cannot be controlled in other ways, a hysterectomy (removal of your uterus) may be needed.

If you have heavy bleeding before your planned date of delivery, you may be advised to have your baby earlier than expected.

If you have placenta praevia, you are more likely to need a blood transfusion, particularly if you have very heavy bleeding. During a planned caesarean, blood should be available for you if needed. If you feel that you could never accept a blood transfusion, you should explain this to your healthcare team as early in your pregnancy as possible. This will give you the opportunity to ask questions and to discuss alternative plans as necessary. For more information, see the RCOG patient information *Blood transfusion, pregnancy and birth* (www.rcog.org.uk/en/patients/patient-leaflets/blood-transfusion-pregnancy-and-birth/).

What is placenta accreta?

Placenta accreta is a rare (between 1 in 300 and 1 in 2000) complication of pregnancy. This is when the placenta grows into the muscle of the uterus, making delivery of the placenta at the time of birth very difficult.

Placenta accreta is more common in women with placenta praevia who have previously had one or more caesarean births, but it can also occur if you have had other surgery to your uterus, or if you have a uterine abnormality such as fibroids or a bicornuate uterus. It is more common if you are older (over 35 years old) or if you have had fertility treatment, especially in vitro fertilisation (IVF).

Placenta accreta may be suspected during the ultrasound scans that you will have in your pregnancy. Additional tests such as magnetic resonance imaging (MRI) scans may help with the diagnosis, but your doctor will

only be able to confirm that you have this condition at the time of your caesarean.

If you have placenta accreta, there may be bleeding when an attempt is made to deliver your placenta after your baby has been born. The bleeding can be heavy and you may require a hysterectomy to stop the bleeding. There is a risk of injury to your bladder during the delivery of your placenta, which depends on your individual circumstances.

If placenta accreta is suspected before your baby is born, your doctor will discuss your options and the extra care that you will need at the time of birth. It may be planned for you to have your baby early, between 35 and 37 weeks of pregnancy, depending on your individual circumstances. You will need to have your baby in a hospital with specialist facilities available and a team with experience of caring for women with this condition. Your team may discuss with you the option of a planned caesarean hysterectomy (removal of your uterus with the placenta still in place, straight after your baby is born) if placenta accreta is confirmed at delivery.

It may be possible to leave the placenta in place after birth, to allow it to absorb over several weeks or months. Unfortunately, this type of treatment is often not successful and can be associated with very serious complications such as bleeding and infection. Some women will still go on to need a hysterectomy.

Your healthcare team will discuss a specific plan of care with you depending on your individual situation.

What is vasa praevia?

Vasa praevia is a very rare condition affecting between 1 in 1200 and 1 in 5000 pregnancies. It is where blood vessels travelling from your baby to your placenta, unprotected by placental tissue or the umbilical cord, pass near to the cervix. These blood vessels are very delicate and can tear when you are in labour or when your waters break. This is very dangerous as the blood that is lost comes from your baby. Babies only

have a small amount of blood in their bodies so they don't need to lose much to become very unwell or even die. Up to 6 in 10 affected babies can die if this happens.

If your healthcare professional suspects that you may have vasa praevia when you go into labour or when your waters break, your baby needs to be born urgently. Usually an emergency caesarean would be recommended.

If your placenta is low, if you are carrying more than one baby or if your placenta or umbilical cord develops in an unusual manner, you are at higher risk of having vasa praevia. You may be offered an extra scan during your pregnancy to check whether you have this condition.

If you are found to have vasa praevia before you go into labour, you should be offered a planned caesarean at around 34–36 weeks of pregnancy. As this would mean that your baby is being born preterm, you would be offered a course of steroids (two injections, 12–24 hours apart) to help mature your baby's lungs and other organs. See the RCOG patient information *Corticosteroids in pregnancy to reduce complications from being born prematurely* (www.rcog.org.uk/en/patients/patient-leaflets/corticosteroids-in-pregnancy-to-reduce-complications-from-being-born-prematurely/).

Further information

National Childbirth Trust (NCT): www.nct.org.uk/pregnancy/low-lying-placenta

Tommy's: www.tommys.org/pregnancy-information/pregnancy-complications/low-lying-placenta-placenta-praevia

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

*

Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. *Patient Education and Counselling*, 2011;84: 379-85



<https://www.aquanw.nhs.uk/SDM>

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Guidelines No. 27(a), *Placenta Praevia and Placenta Accreta: Diagnosis and Management*, and 27(b), *Vasa Praevia: Diagnosis and Management*. The guidelines contain a full list of the sources of evidence we have used. You can find them online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg27a and www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg27b.

This information has been reviewed before publication by women attending clinics in Liverpool and Wrexham and by the RCOG Women's Network and Women's Voices Involvement Panel.