THE ROLE OF THE OBGYN HOSPITALIST IN PLACENTA ACCRETA SPECTRUM

No Disclosures

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Objectives

- Define the various roles of the OBGYN Hospitalist in the care of placenta accreta spectrum patients
- Recognize system and practice factors which can lead to increased morbidity and mortality in PAS patients
- Describe how screening, training and collaborative management of PAS patients can improve patient outcomes
- Recognize the importance of collaboration between MFM specialists and OBGYN hospitalists in the care of PASD patients

The Role of the OBGYN Hospitalist

OBGYN Hospitalist Role in PASD

- Institutional high-acuity settings
- Rural communities
  - *Knowledge of when to transfer*
  - *Basic knowledge to handle emergent situations*

MORBIDITY & MORTALITY

FOR PAS CASES

FAILURE TO DIAGNOSE

Identifying the “At Risk” Patient

Who has PASD?

INEXPERIENCE OF SURGEON*

Not following correct protocol or surgical procedure

Unfamiliarity with PASD

LACK OF TEAM SUPPORT/RESOURCES

There needs to be a process and available resources

Interprofessional Practice Competencies

FAILURE TO DIAGNOSE

THE IMPORTANCE OF SCREENING

AND HOW

THE OBGYN HOSPITALIST CAN HELP

PAS 2024

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The Role of the OBGYN Hospitalist

- **Identifying at risk patients**
  - Triage (Algorithm)
    - Appropriate Screening
  - Transfer (from smaller communities)

SCREENING

- **Awareness of risk factors**
  - Placenta previa after previous cesarean section
  - History of uterine surgeries
  - ART
- **Basic US diagnosis**
  - 1st Trimester
  - 2nd/3rd Trimesters
- **Screening protocols**

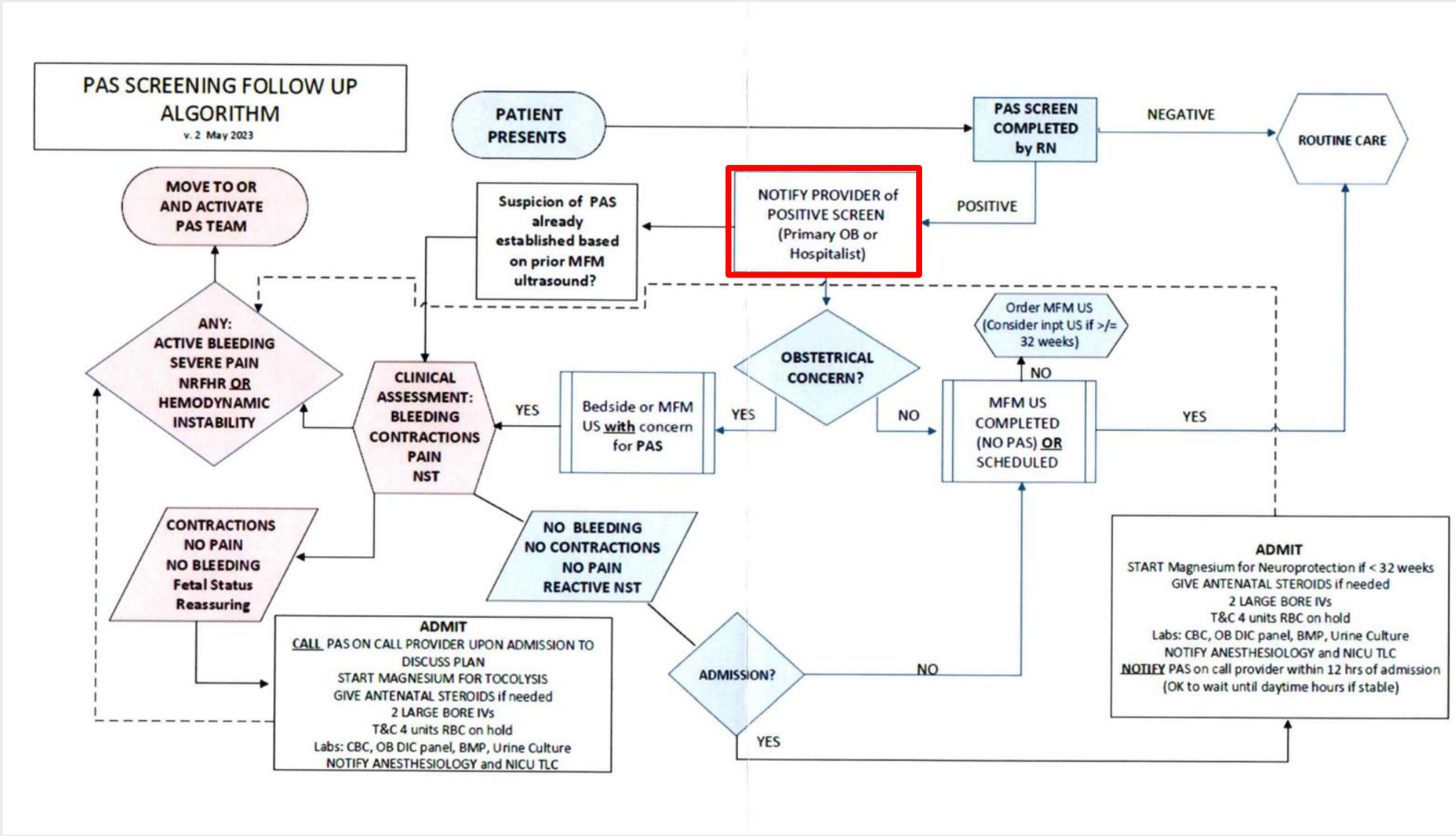
SCREENING FOR PASD RISK FACTORS

Screening of all patients who arrive to triage ≥20 0/7 weeks

- Have you ever had a cesarean section?
- Have you been told in this pregnancy that your placenta covers your cervix/placenta previa?
- Have you been told in this pregnancy that there is a concern your placenta is stuck to the lining of your uterus/placenta accreta spectrum disorder?

Positive Screen

- If positive to questions 1 & 2
- If Positive to question 3


PAS SCREENING FOLLOW UP ALGORITHM
v. 2 May 2023
PATIENT PRESENTS
PAS SCREEN COMPLETED by RN
NEGATIVE
ROUTINE CARE
POSITIVE
NOTIFY PROVIDER of POSITIVE SCREEN (Primary OB or Hospitalist)
Suspicion of PAS already established based on prior MFM ultrasound?
MOVE TO OR AND ACTIVATE PAS TEAM
ANY: ACTIVE BLEEDING SEVERE PAIN NRFHR OR HEMODYNAMIC INSTABILITY
CLINICAL ASSESSMENT: BLEEDING CONTRACTIONS PAIN NST
YES
Bedside or MFM US with concern for PAS
YES
OBSTETRICAL CONCERN?
NO
Order MFM US (Consider inpt US if >/= 32 weeks)
NO
MFM US COMPLETED (NO PAS) OR SCHEDULED
YES
CONTRACTIONS NO PAIN NO BLEEDING Fetal Status Reassuring
NO BLEEDING NO CONTRACTIONS NO PAIN REACTIVE NST
ADMIT
CALL PAS ON CALL PROVIDER UPON ADMISSION TO DISCUSS PLAN
START MAGNESIUM FOR TOCOLYSIS
GIVE ANTENATAL STEROIDS if needed
2 LARGE BORE IVs
T&C 4 units RBC on hold
Labs: CBC, OB DIC panel, BMP, Urine Culture
NOTIFY ANESTHESIOLOGY and NICU TLC
ADMISSION?
NO
YES
ADMIT
START Magnesium for Neuroprotection if < 32 weeks
GIVE ANTENATAL STEROIDS if needed
2 LARGE BORE IVs
T&C 4 units RBC on hold
Labs: CBC, OB DIC panel, BMP, Urine Culture
NOTIFY ANESTHESIOLOGY and NICU TLC
NOTIFY PAS on call provider within 12 hrs of admission
(OK to wait until daytime hours if stable)

INEXPERIENCE OF THE SURGEON

THE IMPORTANCE OF TRAINING

AND HOW

THE OBGYN HOSPITALIST CAN HELP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The Role of the OBGYN Hospitalist

- **Identifying at risk patients**
  - Triage (Algorithm)
  - Transfer (from smaller communities)
- **Training & SIMS**
  - Protocol Development
  - Patient Safety Algorithms
  - Education – Ancillary Staff/Community Hospitals
  - Surgical Intervention
    - *Immediate availability*
    - *Support in the rural community/Academic Centers*
    - *Familiarity w/MTP & PPH protocols*
    - *Familiarity w/medications & treatment options*
      - Riastap/TXA/Quick clot sponges
    - *Familiarity with more advanced surgical techniques*

TRAINING

- **Protocols**
  - Hospital
  - Regional Transfer
- **Procedural Competence**
  - Cesarean hysterectomy
  - PASD specific protocols
- **SIMS**
  - Intra- and Interdivisional
  - Ancillary Staff

STEPS FOR PAS CASES:

Immediately notify 1st Call Person PAS Team.

- If Urgent/Emergent – start the case as outline below
- Otherwise, help facilitate **CARE COORDINATION.**
- **See updated list of PAS patients**
- **Review Care Coordination Notes**

1. Post case in OR
2. Call surgical team (PAS 1st call, Urology, IR if COBRA-OS planned – will need to state whether you want femoral access only or balloon in place.
3. T&C 4 units
4. Complete surgical safety checklist
5. House supervisor will notify anesthesiologist and NICU
6. Place patient in stirrups after CSE (unless GETA from the start – please defer to anesthesiologist)
7. Urology - cysto and stent placement if needed
8. Legs should be brought down from stirrups for COBRA placement if needed
9. Replace legs in stirrups after COBRA
10. After draping, place Bookwalter retractor post before incision (one less step if become emergent intraoperatively)
11. Do vertical skin with Bovie down to but not through fascia
12. Hysterotomy to avoid placenta (usually fundal)
13. Run lock suture of looped PDS for hysterotomy closure. The placenta should be left in situ unless it is thought to be a focal accreta and a wedge resection may be possible. Otherwise, do not cut/poke/pull on the placenta.
14. If no contraindications, inject intra-myometrially one amp hemabate diluted in 20 cc sterile saline.
15. If the COBRA-OS is filled, fill only to reduction in blood flow, NEVER more than 8 ml (remember "2 to 8, don't overinflate!"). **Call IR** to time balloon **UP.**
16. Perform hysterectomy as indicated.
17. Note that if the groin is accessed for COBRA, the patient needs to have the order set "IR vascular access" to get pedal pulse checks, groin checks, IR orders – IR will help if cannot find.

LACK OF TEAM SUPPORT/RESOUCES

THE IMPORTANCE OF THE MULTI-DISCIPLINARY TEAM AND HOW THE OBGYN HOSPITALIST CAN HELP

The Role of the OBGYN Hospitalist

- **Identifying at risk patients**
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- **Training & SIMS**
  - Protocol Development
  - Patient Safety
  - Education – Ancillary Staff/Community
  - Surgical Intervention
    - *Immediate availability*
    - *Support in the rural community/Academic Centers*
    - *Familiarity w/MTP & PPH protocols*
    - *Familiarity w/medications & treatment options*
      - Riastap/TXA/Quick clot sponges
    - *Familiarity with more advanced surgical techniques*
- **TEAM Approach**
  - MFM & OB Hospitalist collaboration
    - *Monitoring of IP and OP*
      - PAS Watchlist
      - PAS Team Meetings
  - Research Support

TEAM APPROACH

- **Multi-disciplinary Team**
  - MFM & OB Hospitalist
  - GYN Onc/Generalist w/surgical experience
  - Urology
  - Interventional Radiology
  - Anesthesia
- **Monitoring IP/OP Admissions**
  - PAS Watchlist
    - *Monthly meetings*
  - Patient admissions
    - *Awareness of plan of care*
    - *Care coordination notes*
- **Protocols**
  - Facility processes
  - Procedural

Hospitalist Role

PAS Team Notification Workflow

Emergent/Unanticipated Case

v. 1 May 2023

PFW Contact Numbers:
House Supervisor: 832-822-8133
9th Floor L&D Charge RN: 832-822-8913
Anesthesia: 832-822-8562
PFW 5th Floor OR: 832-826-3570
5th floor Charge RN: 832-822-8906
Blood Bank: 832-826-3648
(v) 28273
Lab: 832-826-67424
(v) 28323
Neonatology: Spok on call system
Other Services:
Urology: Spok on call system
Interventional Radiology:
(v) 832-826-8425
Page: 832-355-3010
Vascular Surgery: Spok on call system

Decision made to deliver patient -Call to discuss care with PAS on call provider

Call PAS Team
(House Supervisor to notify team)

Notify Anesthesiology
(Notification by physician or charge nurse)

1. **Book OR Case**
2. **Notify Blood Bank, Blood Bank Pathologist, and OR team**
3. **Neonatology**
4. **Notify Other Services:**
   - Urology
   - Interventional Radiology
   - Vascular Surgery
   - Other services as requested

Primary Response Team
(Arrive within 30 mins)
- Hospitalist, Obstetrics and gynecology physician or maternal fetal medicine physician
- Anesthesiologist
- Neonatologist
- Nursing staff
- Operating room personnel

Secondary Response Team
- PAS Team
- Radiologist with interventional radiology skills
- Blood bank or transfusion medicine specialist

PAS Team
Initial surgeon contact will be expected to call in other key surgeons
"Call Tree"
1. RN/HS calls PAS physician
2. PAS physician calls physician #1
3. Physician #1 calls physician #2
4. Physician # 2 calls physician #3 then
5. Physician # 1 will then call back to original caller to inform the group of arrival time.

Refer to the Call Schedules and Phone Number/Contact List on the SPOK directory to contact physicians directly

FIGURE 3
Bundle of activities to improve system and team preparedness for PAS

Activity Bundle: Optimizing Interdisciplinary Care for PAS

System and Team Preparedness

Suggested services and resources for hospital systems caring for pa

- ☐ Maternal Level of Care III (subspecialty) or higher care
- ☐ Blood bank services with unquestioned ability for massive trans
- ☐ On-site adult intensive care facilities that accept pregnant/post
- ☐ Neonatal intensive care facilities
- ☐ Adequate experience in managing complex maternal and obste like PAS
- ☐ 24-hour prompt/emergent access to all of the following
  - PAS Imaging Expertise
  - Experienced obstetrician (may be maternal-fetal medicin
  - Anesthesiologist with complex obstetric expertise (prefer Anesthesia)
  - Surgeon experienced in complex pelvic surgery (may be oncology)
  - Urologist
  - Neonatologist
  - Interventional radiologist
  - Blood bank specialist
  - Vascular surgeon
  - Colorectal or acute care general surgeon
  - Intraoperative blood salvage services

Version Date: November 2, 2023

FIGURE 3
Continued

Activity Bundle: Optimizing Interdisciplinary Care for PAS (Part 2)

☐ **Identify PAS program "champion(s)"**
- Member or members of the Department of OB/GYN committed to organizing, operationalizing PAS care
- Ideally, this person or people would have experience across the clinical spectrum of care in PAS diagnosis, delivery, pelvic surgery, and recovery.
- Willing Co-Champions from radiology, anesthesiology, gynecologic surgery, and pathology are beneficial

☐ **Build an interdisciplinary "PAS Team" with active membership from:**
- OB / MFM lead
- PAS imaging experts (radiology and/or MFM)
- OB Anesthesiology
- Pathologist with interest in PAS
- Pelvic surgical experts (eg, gynecologic oncologists)
- Interventional Radiology
- Social Support Staff (eg, social work)
- Psychological Support for perinatal grief, birth trauma, and PTSD
- Other surgical staff, depending on the site:
  (may include Trauma or General Surgery, Urogynecology, Urology, Vascular Surgery, General Obstetric, Minimally Invasive Gynecology)

☐ **Implement interdisciplinary PAS planning meetings in the form of either:**
(a) Scheduled in-person or virtual treatment planning conferences (preferred), or;
(b) Formalized, scheduled electronic communications.

Components of successful formalized PAS meetings:
- Pathology review, emphasis on correlating imaging and surgical findings with pathologic diagnosis
- Surgical debriefs
- Assessment of each case for quality and safety improvement

☐ **Organize and identify a PAS surgical team**
- Separate from OB team, if possible
- Including experts in antenatal care, cesarean delivery, and pelvic surgery

☐ **Develop a PAS care protocol**
This should be organized for the interdisciplinary meeting template in Figure 2, including consensus-derived *standardized* approaches to:
- Diagnosis, including standardized imaging protocols and reporting
- Preoperative consultations
- Antenatal management and delivery timing
- Anesthesia (eg, neuraxial versus general, vascular access, postop pain control, airway assessment)
- Delivery location (L&D, Main OR, Hybrid OR)
- Transfusion preparedness and administration (eg, number of units in the OR, use of thromboelastography, fibrinogen concentrate availability (Fibryga/RiaSTAP), cell saver, tranexamic acid use)
- Indications for endovascular intervention
- Operative management and techniques (eg, incision, ureteral stents, intra-operative ultrasound)

Version Date: November 2, 2023

SMFM Special Statement: Emergency Checklist, planning worksheet, and system preparedness bundle for placenta accreta spectrum. January 2024.

The OBGYN Hospitalist can play an integral role in:

- The identification of the “At Risk” patient and appropriately triaging them
- The development of protocols, training and SIMS to promote experienced surgeons/staff
- Facilitating/participating in a multi-disciplinary PAS team to promote the best and most up-to-date medical and surgical care of the PASD patient

CONCLUSION

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THANK YOU

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