

Uterus preserving surgery for placenta accreta spectrum: some clarifications

Shigeki Matsubara^{1, 2}, Hironori Takahashi¹

¹Department of Obstetrics and Gynecology, Jichi Medical University, Tochigi, Japan

²Department of Obstetrics and Gynecology, Koga Red Cross Hospital, Shimoyama, Koga, Ibaraki, Japan

This correspondence comments on the clinical article from Kaba M. "Invasion anomaly or neovascularization? A new surgical approach for cesarean delivery in pregnant women with invasive placenta accreta spectrum disorder accompanied by placenta previa". Ginekol Pol. 2023 Aug 7. doi: 10.5603/GP.a2023.0072. Online ahead of print. PMID: 37548499

Dear Editors,

Kaba's article [1] regarding a "new" uterus-preserving surgery for placenta accreta spectrum (PAS) is highly significant. Undoubtedly, the author's abundant experience in PAS surgery made this possible. However, we believe that the significance may not be stated in a manner that the journal readers can fully grasp. We have some clarifications, which we believe facilitate better understanding.

We respectfully ask a question to the author, Kaba: what is new regarding this surgery? The author considered three questions: 1) whether cesarean hysterectomy (CH) is always necessary, 2) which should be employed for abdominal incision, midline or transverse, and 3) which incision should be employed for uterine entry, fundal or lower uterine segment. Kaba's answers were: 1) uterus-preserving surgery may be better than planned CH, 2) transverse abdominal incision can be used, and 3) lower segment incision is employable. We fully agree with Kaba's view; however, all three have already been widely discussed among specialists [2, 3]. These three are employable depending on the situation. We believe that Kaba's new points, and thus significances, exist elsewhere. They may exist in the following two points.

The first involves Kaba's procedural concept regarding the indication for this surgery. We believe that Kaba's concept is this surgery can be employed even in women without desire for future pregnancy. Three out of eight patients underwent CH: (1) these three did not desire future pregnancy, (2) the placenta was first removed, and (3) the

situation necessitated CH. Thus, Kaba's concept is that "even in patients without desire for pregnancy"; this surgery may, or had better, be employed. Kaba stated that the undelivered placenta occupied the pelvis, which prevents surgery, and thus the placenta should be removed. We totally agree with this. This is why we proposed the "amputation first" technique (Matsubara), in which the upper part of the uterus, with the placenta attached, should be first removed in CH [4]. This facilitates better surgical field visibility, making the surgery much easier. Thus, we believe that Kaba's first significance (and thus new point) exists in this concept.

Second, Kaba has revived PAS surgery based on an old concept. Placenta accreta spectrum surgeries and/or treatment strategies can be classified into four: i) placental removal and hemostasis, ii) partial resection of the uterine wall (with the PAS area attached to this wall) and repair, iii) placenta left *in situ* strategy, and iv) CH [3]. The former three (i–iii) are referred to as "uterus-preserving surgery/strategy". Strategy i) is the oldest and sometimes referred to as "forcible" placental removal, and fundamentally has been abandoned. Kaba's procedure can be classified into strategy i). Kaba identified two types of vessels that may cause massive bleeding, and developed methods to stop bleeding from them. We believe that Kaba's second significance, a new point, exists here.

In summary, we interpret Kaba's procedural significances (new points) as follows. Uterus-preserving surgery is worthwhile considering even in women without desire for future

Corresponding authors:

Hironori Takahashi

Department of Obstetrics and Gynecology, Jichi Medical University, 3311–1 Yakushiji, Shimotsuke, Tochigi 329–0498, Japan

phone.: +81-285-58-7376, fax: +81-285-44-8505

e-mail: hironori@jichi.ac.jp

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pregnancy. This is because: (1) the presence of a uterus is important for women's mental health, even for those not desiring future pregnancy, and (2) uterus-preserving surgery might cause less morbidity/mortality than CH. The other significance is: Kaba has revived "placental removal and hemostasis", an old procedural concept for PAS. Vessel identification has made this possible.

We wish Kaba to emphasize these two points and thereby make the concept clearer and concrete. With such efforts, a surgical procedure may survive and be revived [5].

Article information and declarations

Author contributions

SM identified the significance and wrote the manuscript. HT identified the significance and edited the manuscript. SM and HT meet the ICMJE guidelines for authorship. SM and HT have provided final approval for the submitted manuscript and agreed to be accountable for all aspects of the work.

Conflict of interest

The authors have no conflict of interest.

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