Placenta previa

Patient Information Series – What you should know, what you should ask.

What is placenta previa?

Placenta previa refers to a placenta that overlies or is close to the cervix (the neck of the womb), obstructing delivery. However, strictly speaking the term *previa* should be limited to cases where the placenta is covering the cervix, whereas those in which the placenta lies in proximity should be referred to as low lying placenta. Combined, these two presentations affect around 5 in 1000 deliveries.

What causes placenta previa?

The underlying cause of placenta previa has not been fully understood. There is a clear association between previous damage of the uterine wall for example by performing a caesarean section and subsequent placenta previa. Many of the placentas identified as low-lying mid-trimester will no longer be close to the cervix by the time of delivery. This is thought to occur due to a process called trophotropism in which the placenta favours growth toward the areas of the uterus with better supply i.e., fundus (top) rather than towards the cervix (bottom). The presence of a caesarean section scar might altern this growth pattern and prevent this “migration”.

How is placenta previa diagnosed?

The classic presentation of placenta previa is that of painless bleeding which might -or might not- be provoked by labour, sexual intercourse and/or digital vaginal examination. The diagnosis of placenta previa is usually made during the second trimester using a transvaginal (internal) scan -an examination which is safe even if the placenta is low. As very few low-lying placentas will remain low at the end of the pregnancy, the initial suspicion must be followed up with further scans in the third trimester (at 32 and 36 weeks). Placentas that are fully or partly covering the cervix are less likely to “move up”. Other factors that increase the likelihood of a persistent low-lying placenta at term include the thickness of the placental edge, the presence of a caesarian section scar and advanced gestational age at diagnosis.

Should I have more tests done? When and how should I deliver?

If a placenta is thought to be low-lying at the second trimester scan, a further ultrasound examination should be offered at 32 weeks to confirm placental localization. In those cases where the placenta remains covering the cervix (previa) and/or low-lying a further scan at 36 weeks should be performed to finalize time and mode of delivery. Women with a placenta previa and previous uterine surgery, such as a caesarean section, should be further assessed by a skilled operator to assess the risk of abnormally invasive placentation.
Women with uncomplicated placenta previa should undergo scheduled delivery at 36-38 weeks by caesarean section. The caesarean section should be carried out by an experienced obstetrician within an adequately equipped theatre suite suitable for management of massive obstetric haemorrhage.

What is the prognosis?

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Placenta previa is associated with an increased risk of perinatal and maternal adverse outcomes especially in the context of maternal haemorrhage. Bleeding is associated with an increased risk of premature birth, blood transfusion, admission to intensive care, need for having a hysterectomy at the time of birth and even maternal death.

Will this happen again?

Women who have placenta previa are more likely to experience it again with a recurrence risk of approximately 5:100.

What other questions should I ask?

- Are there any other abnormalities on the ultrasound?
- How often should I have ultrasound examinations?
- Where, when and how should I deliver?

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