

# Letter to the editor regarding placenta accreta spectrum: treatment consensus in a resource-limited setting: classification and registration of surgeries are necessary



**TO THE EDITOR:** Nieto-Calvache et al<sup>1</sup> demonstrated that many surgical procedures for placenta accreta spectrum (PAS) are employed. Considering this use of many surgeries, I believe that a classification and registration system is necessary.

PAS surgeries are fundamentally classified into 4 types<sup>1,2</sup>: (1) forcible placental removal, (2) partial uterine wall resection and repair, (3) placenta left in situ strategy, and (4) hysterectomy (cesarean or delayed), with surgery types 1 to 3 referred to as uterus-preserving strategies. There are many procedural variations, depending fundamentally on the use or nonuse of (1) interventional radiology, (2) uterine compression sutures, (3) an intrauterine balloon, (4) vessel ligations, and (5) some other specific procedures.

My proposal for the classification and registration system is as follows: classifying surgeries into the fundamental surgery types (1–4), followed by the usage or nonusage of procedural variations 1 to 5. Simple figures illustrating the surgical points should be included. Each procedure may be registered as, for example, “publishing year, inventor’s name, and some characteristic procedures used.” To explain this, I will describe a recently published surgery by Barinov and Di Renzo<sup>3</sup> as an example.

The fundamental strategy of this new surgery<sup>3</sup> is partial uterine wall resection and repair (type 2). It consists of a combination of various techniques: use of the Zhukovsky double balloon, hemostatic external supraplaccental stitch, and ligation of descending branches of uterine arteries. Thus, this procedure is classified as type 2: (1) no, (2) yes (superficial sutures), (3) yes (Zhukovsky), (4) yes (uterine artery descending branches), and (5) yes (delicate suture for uterine repair). This surgery could be registered as “2023: Barinov and Di Renzo type 2 with a Zhukovsky balloon.”

In addition, the 1-step conservative surgery (Palacios-Jaraquemada and Nieto-Calvache)<sup>1</sup> is fundamentally classified as type 2, and it incorporates many procedural variations involving 1 to 5. Our 8-step cesarean hysterectomy<sup>4</sup> is classified as type 4, with the use of interventional radiology and various specific techniques (filling the bladder and holding the cervix). Moreover, these are classified in a manner reflecting the procedural characteristics.

PAS consists of heterogeneous conditions: degree of placental invasion and collateral circulation, presence or absence of placenta previa and involvement of surrounding tissues, and others. Some women wish to preserve fertility, and others do not. Surgeons tend to employ their accustomed procedures

and hesitate to employ new ones. These hamper randomized controlled studies, preventing us from determining the best procedure. New procedures may continue to be proposed, further preventing us from comprehensively understanding all PAS surgery procedures.

With such a classification and registration system, when doctors have devised and wish to publish novel PAS surgery, they can discern whether the procedure is new and its significance. I hope that worldwide consensus on PAS surgery will be a closer dream, which will standardize PAS surgeries. Such a classification and registration system may accelerate research on PAS surgery and contribute to determining the best procedure available. Moreover, it may facilitate establishing and updating a consensus on PAS surgery both regionally and worldwide. I hope that the leadership of the *American Journal of Obstetrics & Gynecology Global Reports* and the *American Journal of Obstetrics & Gynecology* will take this proposal under consideration. ■

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The author reports no conflict of interest.

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