Family-centered Cesarean Section for Placenta Accreta Spectrum: Questions and an Addition

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Dear Editor,

Nieto-Calvache et al.[1] showed that family-centered cesarean section (FCS) was possible in 53.8% of patients undergoing cesarean section (CS) for placenta accreta spectrum (PAS). Main concepts of FCS are: earlier skin-to-skin contact and cesarean delivery in a relaxed atmosphere.[2] The rationale of this study accords with this: even in PAS-CS/surgery, 1) FCS will enable earlier skin-to-skin contact, and 2) a "companion" in the surgery theater will lower the patient's stress during CS, possibly reducing the occurrence of posttraumatic stress disorder. I fully agree with the first point. Data showed that FCS enabled earlier skin-to-skin contact at CS in general.[2] Recommending earlier skin-to-skin contact even at PAS-CS is reasonable. Regarding the second point, I wish to ask two questions and make one addition.

The first question regards the meaning of "companion." Nieto-Calvache et al.[1] state the importance of the presence of a "companion" in the surgical theater. Companion has various meanings: partner (husband), pregnant woman's mother (or a relative), doula, or other person. Does a companion mean a doula? A doula is a professional who takes care of a pregnant woman during pregnancy, labor, and postpartum. Their presence is considered to lower the delivering woman's stress, facilitating comfortable labor, and reducing delivery-related psychological trauma.[3] A doula, different from a partner or a relative, is a medical or obstetric professional, and thus having a doula in the surgical theater may cause less concerns of staff and anesthesiologists.

The second question regards the follow-up system of the corresponding mother and baby. Follow-up may be important in preventing, or the early detection of, posttraumatic stress disorder. I wish to know how women after PAS-CS are followed in Nieto-Calvache et al.'s institute.[1] In many Japanese institutes, obstetric nurses or midwives psychologically support mothers during CS: I believe that this is also performed in many other countries. In our institute, we allocate a nurse or midwife to a high-risk pregnant woman (such as a woman with PAS) on an individual basis. This nurse or midwife takes care of the corresponding woman during pregnancy, labor, and postpartum. In postpartum, through a telephone interview, the attending nurse or midwife checks the mother and baby's condition. If there are signs of psychological problems, they contact a health care center in the corresponding area, and support the woman and baby. In Japan, this system works in a similar manner to the doula-system.

Another consideration is a specific aspect of PAS-CS/surgery. Women with PAS are informed that PAS-CS/surgery may sometimes cause mortality. In an advanced cancer surgery, when a patient is informed of surgery-related mortality, one may refuse surgery, depending on the mortality rate. However, in PAS, this is not an option and may cause a marked stress.[4,5]

Nieto-Calvache et al.[1] did not show that FCS at PAS-CS reduces the occurrence of posttraumatic stress disorder. They should not be blamed for this because the purpose of their study was to show that FCS can be performed even at PAS-CS. I believe that, theoretically, this system will reduce maternal psychological sequelae, and thus can be employed depending on the institutes' situation. When introducing this system, I believe that clarifying who the "companion" is may be important as the first step. Understanding the concept of the doula and/or attending obstetric nurse system may help doctors formulate a total-care and follow-up system for the PAS-mother and baby, the second step. Paying attention to stress unique to PAS-patients may be the third step for its establishment.

Lastly, regional anesthesia and stable vital signs (reduced blood loss) are prerequisites of FCS at PAS-CS. An excellent team like Nieto-Calvache et al.[1] made this possible. Less experienced teams should proceed with caution in a step-by-step manner.

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The authors have no conflicts of interest to declare.

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We appreciate Professor __'s comments regarding our paper[1] on family-centered birth for patients with placenta accreta spectrum (PAS):

- Who should be the companion during a family-centered PAS surgery?
- How to offer continuous support to the patient and her family after the surgery?
- How should risky information be delivered to the patient?
- What type of anesthesia is indicated in each case and how interdisciplinary management affects or is affected by the presence of a companion in the operating room?

Professor _____ points out several questions that go far beyond the usual questions when facing PAS and we agree with him that experience is required to answer these questions, but above all, having overcome the basic problems that most reference hospitals are concerned with in regard to PAS (reduce bleeding and serious complications, prevent mortality and provide hospitals with the basic resources for optimal care).

Having overcome those "priority" problems, it is easier to think about offering the highest quality during the management of PAS, including key dimensions but generally overshadowed by the risk of dying, such as the psychological impact on the patient and her family,[2] the decrease in care costs, fertility preservation, the opinion of the patients about losing her uterus[3] and humanization of birth.

Training in the management of PAS is difficult; multiple factors are required, including personal and group will, a hospital with a high flow of patients that supports the improvement, and the inclusion of quality policies such as self-assessment, research, and inter-institutional collaboration. Additionally, the support of other hospitals in the region is required, that choosing to transfer patients to the reference center instead of admitting with them and trying to solve the problem themselves.

Addressing the concept of "center of excellence" for PAS is almost impossible for hospitals in settings with limited resources. Requirements such as more than 5 years of experience, 100 patients (2–3 per month) treated and availability of many human and technological resources,[4,5] seem unattainable for most hospitals,[6] at least in Latin America.[7] In this context, joining efforts between hospitals in the same region is perhaps the only feasible strategy to improve the results of PAS management.

Most interdisciplinary groups choose to go through their "training curve" alone, without sharing their successes and failures with other groups, and even more serious, without being advised (and less supervised) by other groups with more experience. This is shown by the multiplicity of management options published,[8,9] each one defended by the group that applies it, and the small number of multicenter prospective studies evaluating the same management strategy in different hospitals (which would require that at least one hospital gives in, and applies the surgical technique used in another hospital) or by comparing two different management strategies head-to-head (which implies that several hospitals apply at least two different surgical techniques, which requires training in the technique preferred by another group).

Our group has experienced the difficulties of the traditional individualistic approach. In our city (with 2.2 million inhabitants), there were 10 hospitals that considered themselves reference centers for PAS, operating around 3 cases per year, without sharing any type of information with the other hospitals. Additionally, there was no clear pathway of care for PAS in our country, nor education or research initiatives at the regional level. Considering the economic and cultural limitations of our region, we have invested time in evaluating the usefulness of sharing knowledge,[10] with an emphasis on mistakes made, improvement opportunities[11] and collaborative research. To our surprise, very inexpensive strategies such as informal telemedicine,[12] virtual education and communication facilitated by free or low-cost platforms[13] have

had a positive impact on the diagnostic and therapeutic performance of various PAS teams.

Of course, our appreciations must be confirmed with additional studies, but we cannot stop emphasizing the importance of collaborative work to travel faster on the path to excellence and address elements such as patient preferences (choosing who accompanies her in elective surgery, deciding whether to preserve her uterus or her fertility in selected cases, etc.) and the family psychological impact of this serious diagnosis; without neglecting strategies to make the management of PAS increasingly safer.

Conflicts to Interest

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