Objectives: The Spectrum of Placenta Accreta Disorders is an increasingly frequent iatrogenic entity whose prevalence is closely linked to Caesarean section rates. This entity is burdened with very significant maternal and fetal morbidity and mortality.

This study describes the epidemiological characteristics of the Spectrum of Placenta Accreta Disorders in a level III delivery unit.

Methods: This is a descriptive cross-sectional study conducted in a level III maternity hospital. We included all parturients with a diagnosis of Spectrum of Placenta Accreta Disorders based on the FIGO 2018 classification, that delivered in the unit between January 2015 and December 2020.

Results: The study included 61 cases of the Spectrum of Placenta Accreta Disorders out of 56816 deliveries, i.e. an incidence of the Spectrum of Placenta Accreta Disorders of 1.07/1000 deliveries. This incidence remained stable over the 6 years of the study ($p = 0.4$). Of all our cases, 42 were placentas accreta (68.9%), 17 placentas percreta (27.9%) and 2 placentas increta (3.3%). The average age of parturients was 35.5 ±4 [26 -45] years. The mean parity was 2.44 ± 1.08 [0–5]. A history of Caesarean was found in 93% of cases. A history of postpartum hemorrhage was reported in 5 patients (8.19%) including two related to uterine rupture. The diagnosis was made antenatally in 43 cases (70.49%): by ultrasound in 18 patients (29.50%) and by MRI in 12 cases (19.76%). A hysterectomy was necessary in 53 cases (86.88%). A preventive ligation of the hypogastric arteries was performed in 9 cases (14.75%). No maternal deaths were recorded. Maternal complications were related to transfusions of blood and bladder products respectively in 14.75% and 13.11%. For the fetal prognosis, we identified one stillborn and 6 premature babies, only one of whom was intubated.

Conclusions: The Spectrum of Placenta Accreta Disorders complicate 1 childbirth/1000 with antenatal diagnosis based on ultrasound and MRI. It is burdened with maternal morbidity related to hysterectomies with fetal morbidity mainly related to prematurity.

EP16.18
Abstract withdrawn

EP16.19
Determinants of emergency delivery in pregnancies complicated by placenta previa or placenta accreta spectrum disorders

F. D'Antonio

Center for Fetal Care and High-Risk Pregnancies, University of Chieti, Chieti, Italy

Objectives: To report the rate and the outcomes of unplanned Caesarean delivery (CD) delivery in women with placenta accreta spectrum disorders (PAS) and placenta previa without PAS, and to elucidate the diagnostic accuracy of ultrasound in predicting this outcome.

Methods: Multicentre study including women with women with a low-lying placenta (< 20 mm from the internal cervical os) or placenta previa (covering the os), a The primary outcome was to report the occurrence of emergency CD.

Results: 450 women (97 with PAS and 353 with placenta previa but not PAS) were included in the analysis. In women with PAS disorders, emergency CD was required in 21% (95% CI 14-30%) and 60% women delivered before 34 weeks of gestation. At multivariate analysis, only maternal BMI (OR: 0.83. 95% CI 0.69-0.99, $p = 0.045$) was independently associated with emergency delivery in women with PAS. However, ultrasound signs of PAS, including presence of interrupted retroplacental space, bladder line and placental lacunae, were not associated neither predictive of emergency CD.

In women with placenta previa but not PAS, emergency CD was required in 31.1% (95% CI 26.6-36.2) and 32.8% delivered before 34 weeks of gestation. Pregnancies complicated by emergency CD, had newborns with a lower birthweight (2330 ± 620 g vs. 2800 ± 620 g, $p < 0.001$) and had a higher risk of receiving blood transfusions (22.7% vs. 10.7%, $p = 0.003$) compared to those who underwent elective CD. At multivariate analysis, only placental thickness ($p = 0.046$) and a cervical length < 25 mm (OR: 3.89, 95% CI 3.89-11.33, $p = 0.01$) were associated with emergency CD. However, a short CL showed a low diagnostic accuracy for predicting emergency CD in these women.

Conclusions: Emergency CD complicated about 20% of women with PAS disorders and 30% of those with placenta previa and not PAS and is associated with a worse maternal and perinatal outcome compared to elective intervention. Prenatal ultrasound cannot entirely predict the risk of emergency delivery in women with these disorders.

EP16.20
Consensus protocol for diagnosis and management of singleton pregnancies with vasa previa: interim findings from a Delphi study

Y. Oyelese[2,1], A. Javinani[1], C. Lees[17], R. Silver[3], A. Odibo[19], R. Akolekar[5], E. Jauniaux[20], A. Rebarber[4], F. Prefumo[6], R. D'Souza[9], V. A. Catanzarite[8], J. Hasegawa[10], D. Tachibana[13], R. Cincotta[7], G. Duncombe[11,12], Y. Meltcer[14], M. A. Scheier[15,16], R. Bronsteen[22], S. A. Shainker[2], D. Srinivasan[21], E. Daly-Jones[18], A. Shamshirsaz[1]

[1]*Maternal Fetal Care Center, Boston Children's Hospital, Boston, MA, USA;* [2]*Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Boston, M, USA;* [3]*Obstetrics and Gynecology, University of Utah Health, Salt Lake City, UT, USA;* [4]*Obstetrics and Gynecology, Icahn School of Medicine at Mount Sinai, New York, NY, USA;* [5]*Medway NHS Foundation Trust, Gillingham, United Kingdom;* [6]*Obstetrics and Gynecology, Istituto Giannina Gaslini, Genoa, Italy;* [7]*Maternal-Fetal Medicine, Mater Mothers' Hospital, Brisbane, QLD, Australia;* [8]*Maternal-Fetal Medicine, Childrens Specialists of San Diego, San Diego, CA, USA;* [9]*Obstetrics and Gynecology, McMaster University, Hamilton, ON, Canada;* [10]*Obstetrics and Gynecology, Sei Marianna Ika Daigaku, Kawasaki, Kanagawa, Japan;* [11]*Obstetrics and Gynecology, Beaudesert Hospital, Beaudesert, QLD, Australia;* [12]*Obstetrics and Gynecology, Logan Hospital, Loganholme, QLD, Australia;* [13]*Obstetrics and Gynecology, Osaka City University Graduate School of Medicine, Osaka City, Japan;* [14]*Obstetrics and Gynecology, Shamir Medical Center Assaf Harofeh, Tzrifin, Israel;* [15]*Obstetrics and Gynecology, Medical University Innsbruck, Innsbruck, Austria;* [16]*Ambulatorium für Fetalmedizin Feldkirch, Feldkirch, Austria;* [17]*Imperial College Healthcare NHS Trust, London, United Kingdom;* [18]*Women's, Children's and Clinical Support, Imperial College Healthcare NHS Trust, London, United Kingdom;* [19]*Obstetrics and Gynecology, Washington University in St Louis, St Louis, MO, USA;* [20]*EGA Institute for Women Health, University College London, London, United Kingdom;* [21]*Fetal Medicine, Imperial College London, London, United Kingdom;* [22]*Maternal-Fetal Medicine, BHSH Beaumont Health, Royal Oak, MI, USA*

Objectives: In this study, we have aimed to establish consensus on the diagnosis and management of vasa previa using Delphi methodology.

Methods: We conducted four rounds of focus group discussions (FGD) using a semi-structured questionnaire, with experts in the field of vasa previa and thematically analysed the data to generate statements for the first round of Delphi under four domains – definition, screening, management and timing of delivery. Experts were identified based on their publications on the subject of vasa previa. In the first round, participants rated each statement on a Likert scale, and consensus was defined as a median score of five.

Results: Thematic analysis of the FGDs generated 59 unique statements. In the first round, 57 experts (83.8% response rate) provided complete responses and consensus was reached on 12 statements. In the "definition" domain, the expert panel agreed that vasa previa can be diagnosed at any gestational age but should be confirmed later in pregnancy. For "screening," the panel agreed on universal screening at the time of the routine anatomy scan. For admission criteria, the panel agreed on admitting patients with variable decelerations on the outpatient cardiotocogram, bleeding or rupture of membranes, and special social circumstances, including the patient's willingness to be admitted, anxiety, and difficult access to the medical centre. For "management", consensus was reached on not routinely recommending fetoscopic laser ablation and performing this only as an experimental therapy. Experts also recommended against bed rest. 91.2% of experts recommended delivering between 35^{+0} and 36^{+6} weeks and agreed against routine delivery before 34^{+0} or after 38^{+0} weeks.

Conclusions: In the first round of our Delphi study, the international expert panel established a consensus on the universal screening of vasa previa at the time of the routine anatomy scan. The subsequent round of our study is underway and will provide further insight.

EP16.21
Giant umbilical cord secondary to patent urachus

S. R. Satarkar

Antarang Sonography and Colour Doppler Center, Aurangabad, India

Giant Umbilical cord (GUC) is a rare but easy prenatal diagnosis. Allantoic cysts with Wharton's jelly edema and a patent urachus leads to GUC. Reflux of hypoosmotic fetal urine into the cord may result in swelling of Wharton's jelly and formation of pseudocysts. On prenatal sonography, the presence of a connection between the fetal bladder and the umbilical cord (UC) confirms the diagnosis of a patent urachus.

We present a case of 24 years primigravida with GUC. At 13 weeks a cystic lesion at the base of UC showed a small tubular intraabdominal extension. This was suspected as Allantoic cyst (AC) with patent urachus. At 22 weeks the size of AC increased and multiple small cystic areas suggestive of pseudocysts were seen in edematous Whartons jelly.10 cm of the cord segment was edematous. At 26 weeks the size of the AC, cord edema and length of swollen cord segment still increased. A small tubular anechoic connection between AC and UB was seen, confirming diagnosis of patent urachus. Oligohydramnios with amniotic fluid index of 10 noted. Due to lockdown she shifted to her village and telephonic enquiry revealed stillbirth at 36 weeks with delivery of a thick cord with blebs.

A close fetal monitoring is indicated with GUC because of possible vascular compression by the cystic mass particularly near term and during labour, resulting in fetal compromise, as occurred in our case.

Supporting information can be found in the online version of this abstract

EP16.22
Conservative management in retained product of conception: a retrospective cohort study

E. Bertucci, A. Tramontano, M. Benuzzi, M. Longo, G. Grandi, F. Monari, A. La Marca, F. G. Sileo

Department of Obstetrics and Gynecology, Faculty of Medicine and Surgery, University of Modena and Reggio Emilia, Modena, Italy

Objectives: To evaluate the clinical course of Retained Products of Conception (RPOC) managed with expectant management or with contraceptive therapy.

Methods: retrospective cohort study conducted at Policlinico di Modena (2018- 2022) including women with sonographic diagnosis of RPOC and managed conservatively with serial ultrasound (US) up to resolution. All women were offered contraceptive therapy (estroprogestin or progestin-only) but only some of them accepted. The type of management (expectant vs. medical management) was recorded and a comparison between them was made. Continuous variables were presented as mean ± standard deviation (SD), binary or categorical variables were presented as number and percentage. Continuous variables were compared using T-test student while the Chi-square test or Fisher's test were used for categorical variable. A p-value of < 0.05 was considered statistically significant.

Results: Twenty-four patients were included: 5 (20.8%) after first trimester termination of pregnancy (TOP) (2 and 3 with surgical and pharmacological TOP respectively) and 19 (79.2%) after delivery (14 after vaginal delivery and 5 after Caesarean section). 7 deliveries were complicated by early PPH. The mean interval from the first assessment to the last one was of 123.04 days (±SD 117,3). All women were offered contraceptive therapy; 66.7% (16/24) accepted. Table 1 shows the comparison between expectant vs. contraceptive treatment: no differences in terms of length of follow-up, need for readmission/ surgery or vaginal blood loss requiring A&E evaluation was found.

Conclusions: Conservative management of RCOPs may include contraceptive therapy without additional complications compared to expectant management.

EP16.22: Table 1. Contraceptive therapy versus expectant management

General characteristics	*Contraceptive therapy (n = 16)*	*Expectant management (N = 8)*	*p-value*
Age, mean +/- SD	35,6+/-4,4	32,9+/-4,9	0,349
Nulliparity, n (%)	11 (68,7%)	5(62,5%)	0,759
BMI	22,3+/-4,8	22,8+/-5,1	0,983
ARTs, n (%)	4 (25%)	0 (0%)	0,121
Third trimester delivery, n (%)	14 (87,5%)	5 (62,5%)	0,155

EP16.23
Effective diagnosis of uterine septum and retained placenta accreta using 3D ultrasonography

S. Park[1], J. Lee[2], K. Jeong[2], H. Chung[2], H. Moon[1], M. Park[1]

[1]*Department of Obstetrics and Gynecology, Ewha Womans University Seoul Hospital, College of Medicine, Seoul, Republic of Korea;* [2]*Department of Obstetrics and Gynecology, Ewha Womans University Mokdong Hospital, College of Medicine, Seoul, Republic of Korea*

A 40-year-old primigravida underwent termination at 21 weeks due to intrauterine fetal death complicated by a retained placenta. During her routine postpartum visit at 1 weeks, the patient reported persistent vaginal bleeding with occasional heavy episodes. An ultrasound revealed a 10 x 10cm hypoechoic, hypervascular mass with possible myometrial invasion consistent with retained placental tissue was observed (figure 1). First, DCB was attempted to remove the remaining placenta tissue, but it failed because it was not accessible by uterine anomaly. To better delineate the findings, an 3D ultrasound of the uterus was performed, and it confirmed a vascular lesion with marked thinning of the adjacent myometrium but without extension through the serosa and uterine suptum was observed (figure 2). The patient was then taken to the operating