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Eric Jauniaux, MD, PhD, Jonathan L. Hecht, MD, Ahmed M. Hussein, MD

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Eric Jauniaux, MD, PhD; Jonathan L. Hecht, MD; Ahmed M Hussein, MD

From the EGA Institute for Women's Health, Faculty of Population Health Sciences, University College London (UCL), London, UK (Dr Jauniaux); Department of Pathology, Beth Israel Deaconess Medical Center, Harvard University, Boston, MA, USA (Dr Hecht); Department of Obstetrics and Gynecology, University of Cairo, Cairo, Egypt (Dr Hussein)

The authors have no conflict of interest to declare.

Corresponding author: *Eric Jauniaux, MD, PhD, FRCOG*

Institute for Women's Health, *University College London, 86-96 Chenies Mews, London WC1E 6HX, UK.*

e.jauniaux@ucl.ac.uk

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We thank Drs Calvache and Benavides for their comments on our study and for sharing their views on the diagnosis and management of Placenta Accreta Spectrum (PAS). Their overall intention is to minimize the importance of histopathologic examination in the diagnosis of PAS in their studies. Although we understand that access to expert perinatal pathologists may not be available in most countries, including high-income countries, any clinical trial should stratify outcomes based on post-operative histologic confirmation of PAS and an assessment of the extent of condition.

Point #1: We agree that ultrasound imaging is useful in the preoperative evaluation and surgical planning. However, imaging in general is not diagnostic of PAS. In expert hands it can accurately identify high risk patients but imaging signs of uterine scarification (loss of clear zone, myometrial thinning, placental bulge, bladder wall interruption) and superficial intraoperative features of dehiscence are not pathognomonic of accreta placentation.[1] If the placenta can be fully detached digitally during delivery i.e. without the need for partial myometrial resection (PMR), it should not be reported as PAS.

Point #2: In our study, expert intraoperative assessment mischaracterized a subset of patients with simple uterine dehiscence as percreta.[2] All our cases clinically classified as percreta, were either abnormal placental attachment (creta or increta) associated with dehiscence, or were not PAS (simple dehiscence) on final pathology. Our point was that true percreta i.e. transmural uterine villous invasion reaching the serosa and/or beyond the uterine wall, probably does not exist. This Pandora's box was open by Lukes et al 50 years ago who suggested that there were three grades of villous invasiveness but the authors did not describe the histologic changes associated with placenta percreta.[3]

Points #3&4: We did not design our study to compare outcomes based on type of management. Primary surgical outcomes in placenta previa, such as blood transfusion, are entirely dependent on the expertise of the surgical team and not directly related to a diagnosis of PAS. The vast majority of clinical studies do not describe intraoperative or pathology findings. We showed that most if not all such cases are complex dehiscence with adjacent accreta areas or dehiscence without PAS. Although this opens the possibility of PMR in cases of localized dehiscence, studies of that approach must be evlauated with account of the presence of PAS on post-operative pathology. This can be done easily on PMR specimens in cases of conservative management.[4]

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