Guidelines for the Management of Antepartum Haemorrhage

Specialty: Maternity
Date Approved: March 2011
Approved by: W&CH Quality & Safety Group
Date for Review: March 2014
Definition

Vaginal bleeding after 24 weeks gestation. Occurs in 3% pregnancies

Aims

To reduce risk of maternal and perinatal morbidity and mortality

- Identify high risk cases
- Identify cause of bleeding
- Accurately estimate blood loss
- Adequate resuscitation including management of coagulopathy
- Expedite delivery if indicated

Differential Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Placental Abruption</th>
<th>Placenta Praevia</th>
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<tbody>
<tr>
<td><strong>Incidence</strong></td>
<td>1-2%</td>
<td>0.5% at term</td>
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<tr>
<td><strong>Presentation</strong></td>
<td>Abdominal pain</td>
<td>Painless bleeding, may be heavy</td>
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<tr>
<td></td>
<td>Tender, tense uterus</td>
<td>Soft uterus</td>
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<tr>
<td></td>
<td>Haemorrhage may be</td>
<td>Coagulopathy less common</td>
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<tr>
<td></td>
<td>concealed</td>
<td>Usually stable</td>
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<tr>
<td></td>
<td>May be shock</td>
<td></td>
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<tr>
<td></td>
<td>Coagulopathy</td>
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<tr>
<td><strong>Fetal Assessment</strong></td>
<td>May be abnormal CTG or IUD</td>
<td>CTG usually normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May be malpresentation</td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
<td>PIH/PET</td>
<td>Previous LSCS</td>
</tr>
<tr>
<td></td>
<td>High parity</td>
<td>High parity</td>
</tr>
<tr>
<td></td>
<td>Previous abruption</td>
<td>Previous placenta praevia</td>
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<tr>
<td></td>
<td>Polyhydramnios</td>
<td>Advanced maternal age</td>
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<td></td>
<td>Smoking</td>
<td>Previous instrumentation of uterus</td>
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<td></td>
<td>Substance Misuse</td>
<td>Multiple gestation</td>
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<td></td>
<td>Trauma</td>
<td>Malpresentation</td>
</tr>
</tbody>
</table>

Vasa praevia

- Incidence 0.1%
- Bleeding with onset of membrane rupture
- Fetal distress common
- Immediate delivery indicated as high risk of perinatal mortality from exsanguination (total blood volume of infant at term approx 250ml)
Active Significant Haemorrhage (see major obstetric haemorrhage guidelines)

- Admit to labour ward for observation and review by Obstetric registrar or consultant. Inform anaesthetist early.
- Large Bore IV access – Hartmanns/colloid as indicated
- Blood for FBC, X-match (minimum 4 units and confirm Rh status), clotting screen, Kleihauer
- Maternal assessment including BP, pulse, temperature, abdominal palpation, consider speculum if placenta not low lying
- Assess fetal wellbeing (CTG/USS)
- Confirm gestation and history
- Differentiate placental abruption and praevia
- Expedite delivery if maternal or fetal compromise (emergency LSCS if SVD not imminent)
- Inform Consultant Obstetrician and anaesthetist, if placenta praevia, placental abruption or coagulopathy suspected
- If coagulopathy will need to liaise with haematology for appropriate blood products – blood, FFP, fibrinogen concentrate.

Following diagnosis/delivery

- 15 minute observations or more frequently depending on clinical condition documented on high dependency chart.
- Strict fluid balance monitoring. Consider Foley's catheter.
- Check FBC, U+Es and clotting as clinically indicated.

*IUD usually signifies major abruption and therefore increased risk of DIC therefore at least 6 unit crossmatch and consideration of immediate transfusion

If high risk of placenta accreta consider delivery in main theatre (Princess of Wales Hospital). Consider use of interventional radiology.

Mild APH of Unknown Significance

- Full history
  - Colour, consistency, quantity and rate of blood loss
  - Precipitating factors ie sexual intercourse, vaginal examination
  - Pain – site, type, intensity
- Examination
  - Abdominal palpation
  - Speculum examination to visualise cervix
- Admit for observation
- Investigations
  - Bloods – FBC, G&S (confirm Rh status), clotting
  - USS to confirm placental site
- Consider steroids if less than 34 weeks gestation
• Tocolysis not routinely recommended

**Non-acute antenatal management of placenta praevia/accreta**

• Trans-vaginal USS to confirm placental site
• Colour flow Doppler if risk of accreta – if not available locally to treat as if accreta
• Patient advised to attend hospital if any abdominal pain, tightening or bleeding
• Antenatal discussion with woman regarding:
  o Delivery
  o Haemorrhage
  o Risks
  o Transfusion
  o Surgical management including hysterectomy
  o Blood transfusion / cell salvage
• Antenatal discussion with Interventional Radiologist in relation to possible catheterisation
• Blood X-match
• If placenta <2cm from internal os, likely to need LSCS for delivery
• Anaesthetic referral to discuss mode of anaesthetic (likely regional). If suspected accreta refer early to anaesthetic clinic for multidisciplinary plan.
• Most senior obstetrician and anaesthetist should at the very least be available on labour ward if intervention required as either elective or emergency
• Where possible elective LSCS performed after 38 weeks gestation to minimise neonatal morbidity
• All staff should be aware of major haemorrhage guideline and drills performed at regular intervals

**REFERENCES**

ALSO – Provider manual, 4th Edition

CEMACH Saving Mothers Lives 2003-2005

Guidelines for the Management of Antepartum Haemorrhage, Princess of Wales Hospital


Protocol for Management of Antepartum Haemorrhage (2006) Singleton Hospital

RCOG Guideline (2005) Placenta Praevia and Placenta Accreta: Diagnosis and Management