3 CENTRES COLLABORATION ANTEPARTUM HAEMORRHAGE: QUICK REFERENCE GUIDE

APH DEFINITION

Bleeding from the genital tract after the 20th completed week of pregnancy

APH CAUSES

Placenta Praevia – 31%. Abruption – 27%
Vasa Praevia – Rare. Unclassified – 47%

APH EMERGENCY MANAGEMENT

Control bleeding, restore circulating blood volume, diagnose and treat the underlying cause of the bleeding.

- Obs. Pulse, B/P, Resps, O_2 saturation.
- History-EDD, pregnancy history, trauma, blood group, Rhesus & antibodies, scan report, blood loss.
- Call for help –additional staff.
- Bloods-FBE, group & crossmatch, coagulation profile, Kleihauer, consider arterial blood gas and blood products.
- Gentle palpation for presentation and lie. Assess uterine activity and pain.
- Speculum to observe bleeding.
- CTG and scan to assess fetal well being and possible cause of bleeding.
- Corticosteroids if < 34 weeks.
- Give Anti-D if required.
- Consider $MgSO_4$ for fetal neuroprotection if <30 weeks.
- Give Analgesia if required.
- Consider expediting delivery.
- Documentation completed as contemporaneously as possible.
- Communicate clearly with woman and her attendants.

VASA PRAEVIA

The umbilical vessels, unsupported by either the umbilical cord or placental tissue, traverse the fetal membranes of the lower segment above the cervix.

VASA PRAEVIA PRESENTATION

- Detected by transvaginal ultrasound
- Bleeding on amniotomy or spontaneous rupture of membranes
- Palpable vessel on vaginal examination
- Abnormal CTG.

VASA PRAEVIA MANAGEMENT

- Antenatal diagnosis is the ideal.
- Consider hospitalisation from 32 weeks, according to individual circumstances.
- Test vaginal blood for fetal Hb.
- Elective caesarean section 35-36 weeks. (Experienced clinician's judgement)
- Urgent caesarean section as indicated.
- For fetal demise - induction and vaginal birth is appropriate.

PLACENTA PRAEVIA

Major praevia- Placenta lying wholly over the cervical os. Minor praevia – Placenta not lying over the cervical os but encroaching on the lower uterine segment.

PLACENTA PRAEVIA DIAGNOSIS

- Is by transvaginal ultrasound.
- In minor praevia, scan at 36 weeks.
- In asymptomatic major praevia, scan at 32 weeks.
- In symptomatic praevia – manage on an individual basis.
- Consider praevia in a woman with bleeding, high head or abnormal lie.

HOSPITAL ADMISSION CRITERIA

- Women with a major praevia who are symptomatic –Inpatient care
- Women with a major praevia who have not bled – outpatient care within defined parameters, or inpatient care.
  Women with a minor praevia who have bled– inpatient care.
  Women with a minor praevia who are asymptomatic – Outpatient care

PRE-DELIVERY PLAN

- Discuss blood transfusion and surgery.
- If placenta >20mm after 35 weeks – Trial of labour
- If placenta 0-20mm – Possible trial of labour but high chance of caesarean.
  If placenta at or encroaching over the os – Caesarean section.

TOCOLYSIS

Tocolysis for women who are bleeding and contracting is controversial and is currently not recommended.

THROMBOPROPHYLAXIS

Thromboembolic stockings and heparin is advised for long-term hospital patients.

ANAESTHESIA

Regional anaesthesia is an acceptable choice in consultation with anaesthetist, obstetrician and the woman.

PLACENTA ACCRETA

- Higher prevalence in previous caesarean section.
- Multidisciplinary approach.
- Rapid infusion of warm blood products.
- Additional surgical manoeuvres or procedures may need to be employed.
- Conservative management may be considered to preserve fertility.

PLACENTAL ABRUPTION

The premature separation of a placenta from the uterine wall that occurs before delivery of the fetus.

PLACENTAL ABRUPTION DIAGNOSIS

Typically, abdominal pain with or without bleeding. Uterus tender or tense on palpation. Preterm labour may co-exist. Fetal demise may be evident.

TESTS AND INVESTIGATIONS

- CTG: Abnormal tracing.
- Ultrasound: Haematoma, increased echogenicity or placental thickness.
  Bloods: Hb, Hct, coagulation profile may be deranged.

INITIAL MANAGEMENT

- Detailed medical and obstetric history.
- IV access with 2 wide-bore cannula's.
- FBE for evidence of anaemia. Hct and Hb levels may be low.
- Coag. profile. Low fibrinogen levels and a prolonged PT suggest impaired coagulation may be due to DIC.
- Monitor pulse, blood pressure, fluid intake, and urine output.
- Continuous electronic fetal monitoring.
- Anti-D in Rh-negative women.
- Fluid, blood, or product replacement.

TOCOLYSIS

For women with abruption who are bleeding and contracting, tocolysis is controversial and should only be used with caution by experienced clinicians.

LIVE FETUS > 34 WEEKS

- If unstable - expedite delivery by LSCS, unless vaginal birth is imminent.
- If stable with a normal CTG, induction with continuous monitoring.

LIVE FETUS < 34 WEEKS

- If unstable - expedite delivery by LSCS, unless vaginal birth is imminent.
- If stable, no coagulopathy and a normal CTG, conservative management.
- Give corticosteroids.
- Consider $MgSO_4$ if <30 weeks gestation.

FETAL DEMISE

- If demise is due to abruption, DIC is likely and delivery should be expedited. Induction is preferable but LSCS may be necessary if unstable and worsening.

POSTNATAL

- Judicious use of uterotonic agents.
- Surgical intervention by suitably experienced personnel.
- Correction of coagulopathies.

FOLLOW-UP

- Send placenta for pathological exam.
- Maternal screen for thrombophilias
- Advise cessation of drug use and smoking.