Aneurin Bevan University Health Board

Antepartum Haemorrhage Guidelines

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 3 | Issue date: 5 December 2019
Approved by: Clinical Effectiveness Forum | Review by date: 5 December 2022
Owner: Maternity Services | Policy Number: ABUHB/0682/F&T

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Introduction

This document is a clinical guideline designed to support safe and effective practice.

Aims

To provide support for clinical decision making.

Scope

This guideline applies to all clinicians working within maternity services.

Roles and Responsibilities

The Maternity management team are responsible to ensure that these guidelines are carried out.

Individual health care providers are responsible for ensuring that they are aware and adherent to up to date guidelines.

Training

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical supervision.

Further Information Clinical Documents

Antepartum Haemorrhage – Green-top guideline No. 63, RCOG

ABHB Good Practice in consent: Implementation guide, model policy and reference guide for consent to examination or treatment (0004 pp 19)

"An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so."

List of Abbreviations

ANC	Antenatal Clinic
APH	Antepartum Haemorrhage
BMI	Body Mass Index
Coag	Coagulation Screen
CTG	Cardiotocograph
C/S	Caesarian Section
DIC	Disseminated Intravascular Coagulation
EBL	Estimated Blood Loss
FBC	Full Blood Count
FFP	Fresh Frozen Plasma
FH	Fetal Heart
G&H	Group & Hold
Hx	History
IU	International Units
IV	Intravenous
IVF	In Vitro Fertilisation
LFT	Liver Function Tests
MROP	Manual Removal of Placenta
OLC	Obstetric Led Care
PPH	Postpartum Haemorrhage
PRBC	Packed Red Blood Cells
PROM	Prolonged Rupture of Membranes
Rh	Rhesus
SCBU	Special Care Baby Unit
SROM	Spontaneous Rupture of Membranes
TOP	Termination of Pregnancy
USS	Ultrasound Scan
U&E	Urea & Electrolytes
VE	Vaginal Examination

Antepartum Haemorrhage

Introduction

Affects 3-5% of pregnancies
Difficult to quantify amount of blood lost – e.g. placental abruption

- Need to assess for signs of clinical shock
- Fetal compromise / demise indicates volume depletion

Causes

- Placenta praevia
- Placental abruption
- Vasa praevia
- Localised bleeding to vulva, vagina or cervix

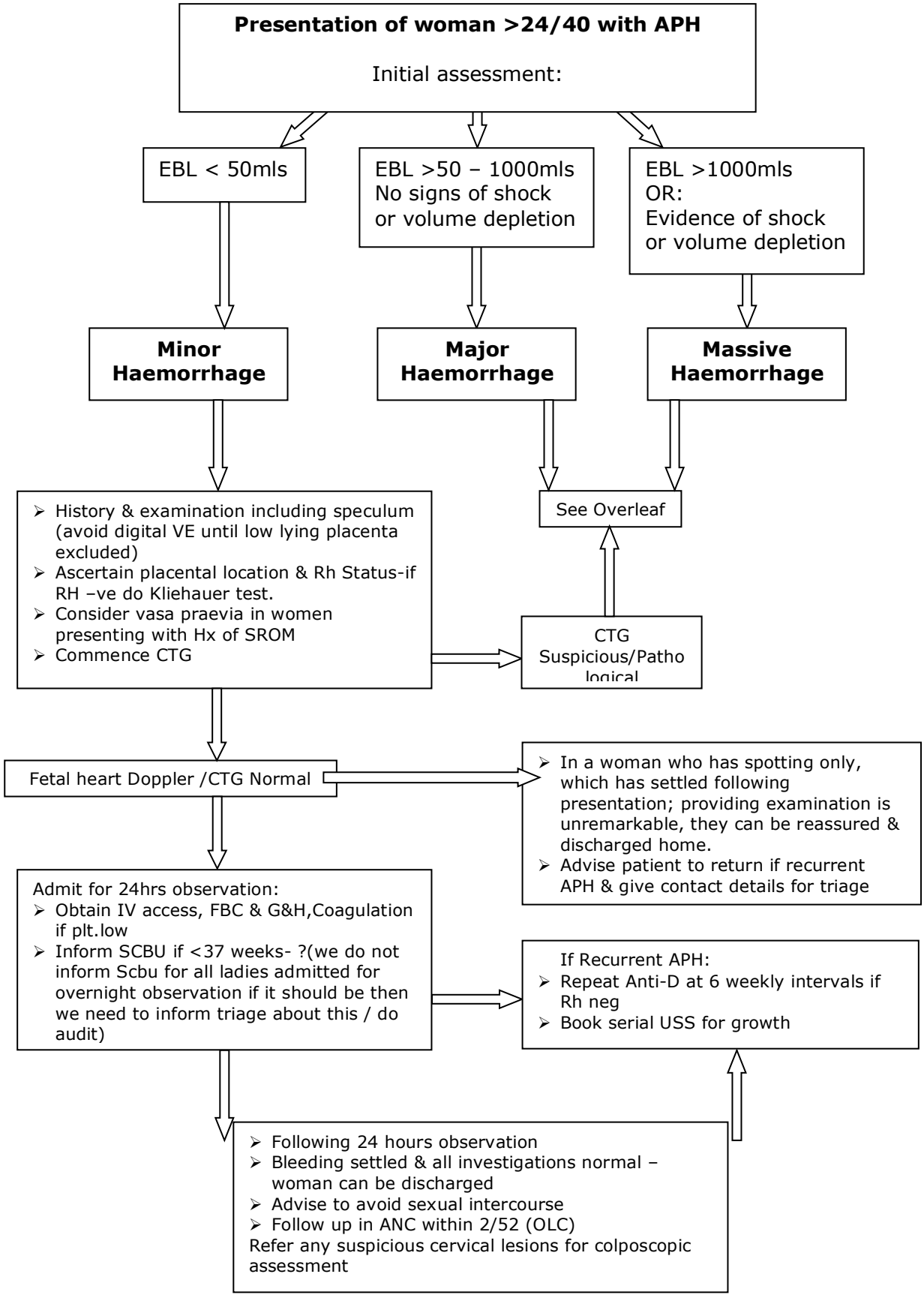
Definition

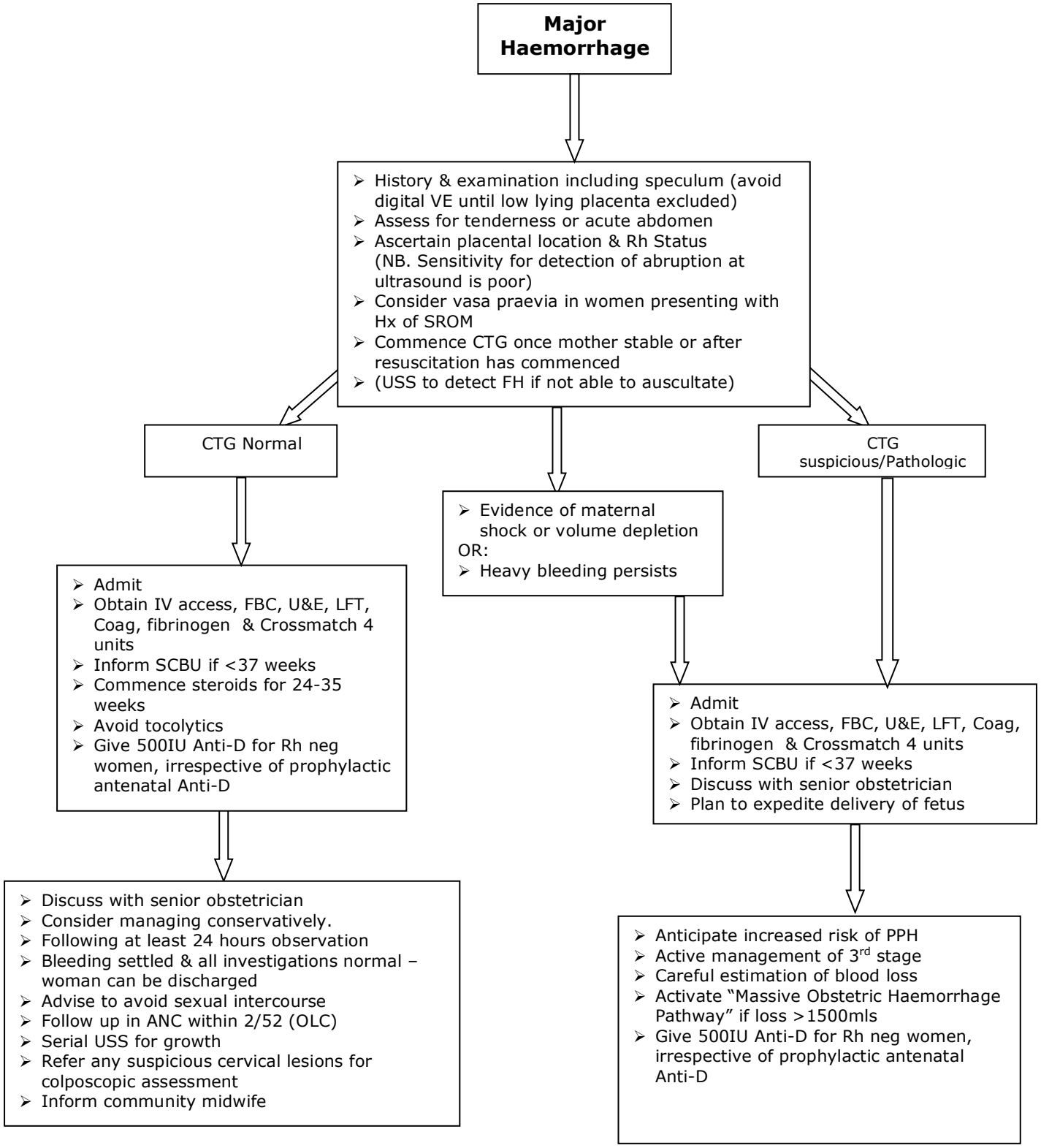
Spotting – streaking, staining or blood spotting on underwear
Minor Haemorrhage – EBL <50mls that has settled
Major Haemorrhage - EBL 50-1000mls with no signs of clinical shock
Massive Haemorrhage – EBL >1000mls and/or signs of shock
Recurrent APH - >1 occasion of APH

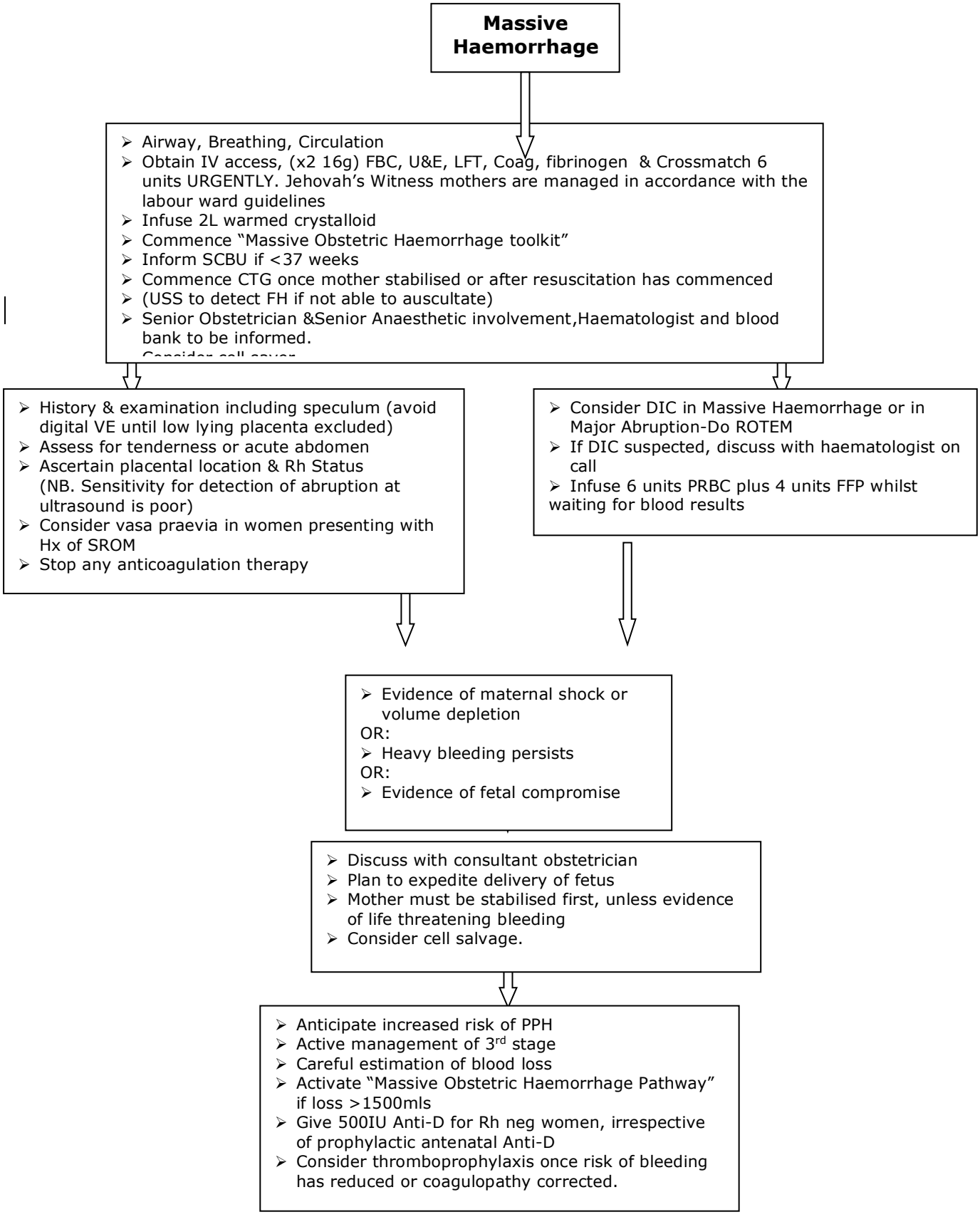
Risk Factors

Placental abruption	Placenta Praevia

• Previous Hx of abruption
• Pre-eclampsia
• Fetal growth restriction
• Non-vertex presentation
• Polyhydramnios
• Advanced maternal age
• Multiparous
• Low BMI
• IVF
• Intrauterine infection
• PROM
• Abdominal trauma
• Substance misuse
• First trimester bleeding
• Maternal thrombophilia
	• Previous Hx of praevia
	• Previous C/S
	• Hx of TOP
	• Multiparous
	• >40 yrs
	• Multiple pregnancy
	• Smoking
	• IVF
	• Deficient endometrium
	  • Uterine scar
	  • Endometritis
	  • MROP
	  • Curettage
	  • Submucous fibroid


Presentation of woman >24/40 with APH
Initial assessment:
EBL < 50mls
EBL >50 – 1000mls
No signs of shock
or volume depletion
EBL >1000mls
OR:
Evidence of shock
or volume depletion
Minor Haemorrhage
Major Haemorrhage
Massive Haemorrhage
History & examination including speculum (avoid digital VE until low lying placenta excluded)
Ascertain placental location & Rh Status-if RH –ve do Kliehauer test.
Consider vasa praevia in women presenting with Hx of SROM
Commence CTG
See Overleaf
CTG Suspicious/Pathological
Fetal heart Doppler /CTG Normal
In a woman who has spotting only, which has settled following presentation; providing examination is unremarkable, they can be reassured & discharged home.
Advise patient to return if recurrent APH & give contact details for triage
Admit for 24hrs observation:
Obtain IV access, FBC & G&H,Coagulation if plt.low
Inform SCBU if <37 weeks- ?(we do not inform Scbu for all ladies admitted for overnight observation if it should be then we need to inform triage about this / do audit)
If Recurrent APH:
Repeat Anti-D at 6 weekly intervals if Rh neg
Book serial USS for growth
Following 24 hours observation
Bleeding settled & all investigations normal – woman can be discharged
Advise to avoid sexual intercourse
Follow up in ANC within 2/52 (OLC)
Refer any suspicious cervical lesions for colposcopic assessment


Major Haemorrhage
History & examination including speculum (avoid digital VE until low lying placenta excluded)
Assess for tenderness or acute abdomen
Ascertain placental location & Rh Status (NB. Sensitivity for detection of abruption at ultrasound is poor)
Consider vasa praevia in women presenting with Hx of SROM
Commence CTG once mother stable or after resuscitation has commenced
(USS to detect FH if not able to auscultate)
CTG Normal
CTG suspicious/Pathologic
Evidence of maternal shock or volume depletion
OR:
Heavy bleeding persists
Admit
Obtain IV access, FBC, U&E, LFT, Coag, fibrinogen & Crossmatch 4 units
Inform SCBU if <37 weeks
Commence steroids for 24-35 weeks
Avoid tocolytics
Give 500IU Anti-D for Rh neg women, irrespective of prophylactic antenatal Anti-D
Admit
Obtain IV access, FBC, U&E, LFT, Coag, fibrinogen & Crossmatch 4 units
Inform SCBU if <37 weeks
Discuss with senior obstetrician
Plan to expedite delivery of fetus
Discuss with senior obstetrician
Consider managing conservatively.
Following at least 24 hours observation
Bleeding settled & all investigations normal – woman can be discharged
Advise to avoid sexual intercourse
Follow up in ANC within 2/52 (OLC)
Serial USS for growth
Refer any suspicious cervical lesions for colposcopic assessment
Inform community midwife
Anticipate increased risk of PPH
Active management of 3rd stage
Careful estimation of blood loss
Activate "Massive Obstetric Haemorrhage Pathway" if loss >1500mls
Give 500IU Anti-D for Rh neg women, irrespective of prophylactic antenatal Anti-D



NB – Complete Datix incident report