Aneurin Bevan University Health Board

Management of Pregnancy with Placenta Praevia Guideline

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 This is to avoid the risk of out of date printed versions of the document.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.

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Contents:

Executive Summary

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

Scope of policy

This guideline applies to all clinicians working within maternity services

Essential Implementation Criteria

Auditable standards are stated where appropriate

Aims

To provide support for clinical decision making

Responsibilities

The Gynaecology and Maternity Management team

Training

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

References

Appendix 1

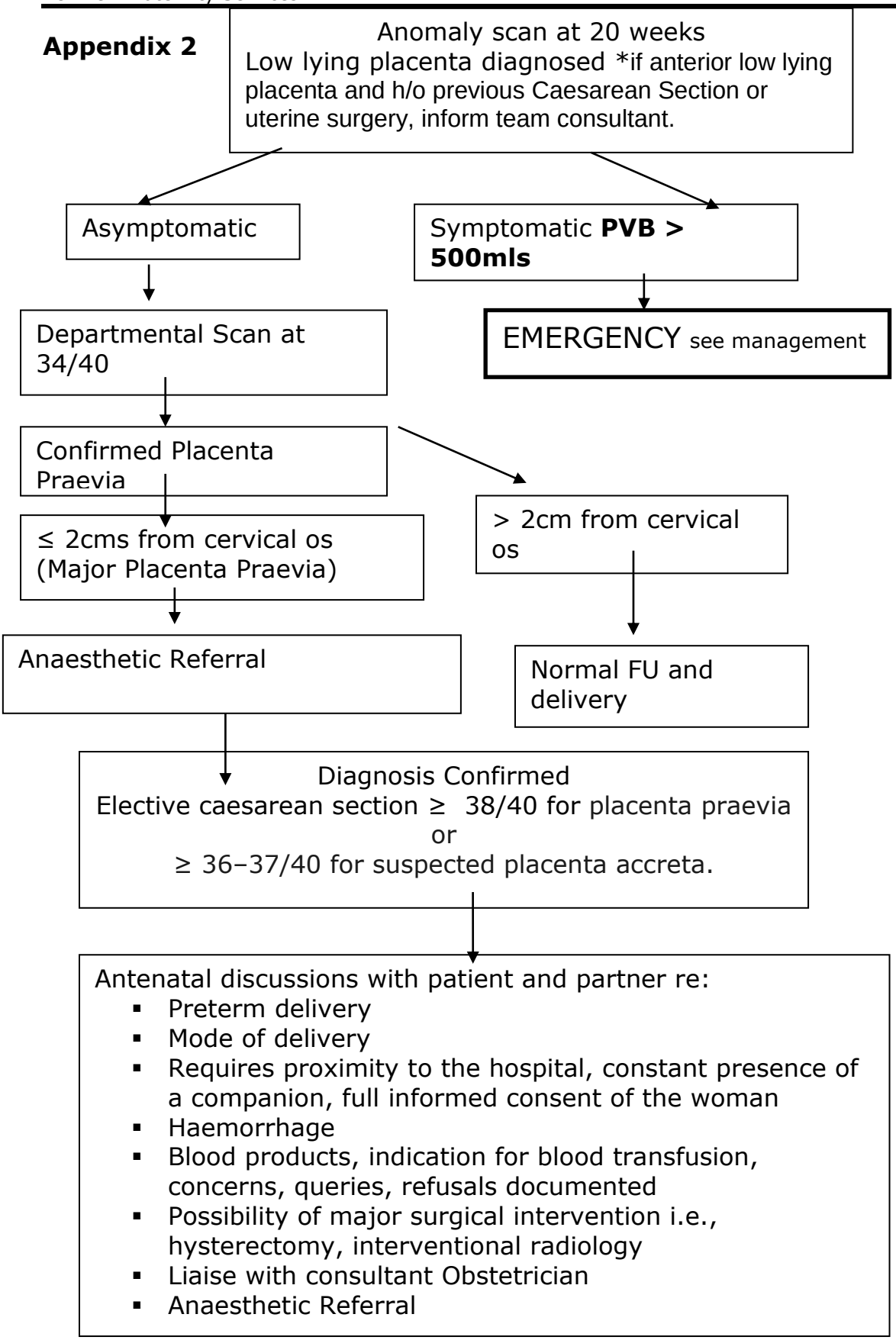
Management of Pregnancy with Placenta Praevia

Incidence: Placenta praevia: Singleton 2.8/1000
Twins 3.9/1000
Vasa previa 1 in 2000 to 1 in 6000

Risk factors: Multiple pregnancy
Multiparity
Previous LSCS/myomectomy/ placenta praevia
Age >40
Smoking

Any patient after 20 weeks of gestation with high presenting head, abnormal lie, painless or provoked bleeding irrespective of previous scan results is suggestive of low lying placenta and definitive diagnosis should be obtained depending on ultrasound imaging

Appendix 2


Anomaly scan at 20 weeks
Low lying placenta diagnosed *if anterior low lying placenta and h/o previous Caesarean Section or uterine surgery, inform team consultant.
Asymptomatic
Symptomatic **PVB > 500mls**
Departmental Scan at 34/40
EMERGENCY see management
Confirmed Placenta Praevia
≤ 2cms from cervical os (Major Placenta Praevia)
> 2cm from cervical os
Anaesthetic Referral
Normal FU and delivery
Diagnosis Confirmed
Elective caesarean section ≥ 38/40 for placenta praevia
or
≥ 36–37/40 for suspected placenta accreta.
Antenatal discussions with patient and partner re:
Preterm delivery
Mode of delivery
Requires proximity to the hospital, constant presence of a companion, full informed consent of the woman
Haemorrhage
Blood products, indication for blood transfusion, concerns, queries, refusals documented
Possibility of major surgical intervention i.e., hysterectomy, interventional radiology
Liaise with consultant Obstetrician
Anaesthetic Referral

Appendix 3 - Antenatal and Intra-operative Management of women with suspicion of Placenta accrete/percreta in ABUHB

PLANNED – In women with high risk of Haemorrhage suspected by antenatal investigations **i.e.**

- **20 week scan Placentation on a uterine scar (previous CS scar or myomectomy scar)**

Give : RCOG patient information leaflet on Placenta Praevia
Check: FBC- ensure >11.5, low threshold for oral Fe therapy
Ensure : Antenatal MRI for evidence of abnormal placental adherence between 24 and 28 weeks of gestation

- Request MRI (RGH) c/o Fiona Brook and Khulood AL-Rawi

Images to be discussed with Sarah Flemming Consultant Radiologist in Norfolk *sarahfleming2@nhs.net*

- Disc with images to be sent to S Flemming (d/w HoM for funding) *Dr Sarah Fleming Consultant radiologist, Radiology department, Queen Elizabeth Hospital Kings Lynn, Gayton Road, Kings Lynn, NORFOLK, PE30 4ET*

- S Flemming to report back to Obstetrician image upload to CWS
- Inform and arrange availability of interventional radiologist for c/s.

32-34 weeks: Formulate a birth plan and inform anaesthetists and labour ward

- Check Hb from 28 week FBC – correct if low
- MRSA Swabs
- Book CS date (37-38 weeks with preop steroids)
- Arrange to deliver in **RGH (not NHH)**

Day before CS : normal pre-op review,

- Cross match 4 units or ensure suitable for electronic issue
- Confirm with Radiology department about availing necessary equipment

Day of CS: Pre op balloons to be inserted in the Radiology suit scheduled for 9:00 am
Caesarean section will take place in the LW theatre
Consider having second senior obstetrician to assist
Intraop- use cell saver, named person to arrange blood

Use **surgical techniques** to minimise blood loss (consider upper uterine midline incision if anterior previa, haemostatic sutures to placental base, Bakri balloon, B lynch suture for atony, stepwise devascularisation and hysterectomy as writtien in the LW guideline . If Placenta percreta consider wedge

EMERGENCY- unanticipated placenta accrete/percreta at LSCS in a patient not bleeding...

If placenta percreta is noted on opening the abdomen- **STOP**.

Note for op team:

STOP-

- Call for Senior Help
- Feasibility of interventional radiology
- Rethink the type of anaesthetic
- Cell Salvage
- Order blood
- Involve 2nd consultant
- Low threshold for hysterectomy

POST OP

Ensure adequate replacement of blood products

If major haemorrhage- follow major Haemorrhage pathway + use audit tool

Care in ITU/HDU or POSW depending on complications at surgery

Debrief of patient and family by the team.

Datix for risk management

Management of Pregnancy with Placenta Praevia with PV Bleeding

Anomaly scan at 20 weeks Low lying placenta diagnosed

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Symptomatic with PV bleed >500mls

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- Do not perform V/E
- Maternal resuscitation
  - O2 via facemask
  - Left Lateral tilt
- 2 large bore IV Cannula
- Take bloods for
  - FBC
  - clotting studies, fibrinogen
  - cross match 2- 4 units of blood
- Administer bloods/fluids through a warmer
- Record maternal HR, BP, SaO2, RR
- Monitor Fetal Heart continuously
- Catheterise and measure urine output hourly
- Estimate blood loss/pain
- Examine patients abdomen for
  - tense and tender uterus
  - measure abdominal girth
- Nil by Mouth
- Inform Duty Registrar, Anaesthetist and Haematologist
- Plan to deliver or continue pregnancy will depend on type of placenta praevia and amount of bleeding