Management of Antepartum Haemorrhage

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Summary of document:
This guideline summarises the management of pregnant women who present with antepartum haemorrhage from 24+0 weeks gestation in order to reduce fetal risks associated with the condition.

Scope:
This guideline is to provide support and guidance for Hywel Dda health care professionals working within maternity and community, who provide care for pregnant women who present with any bleeding from the genital tract from 24 +0 weeks gestation.

The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male, or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women, but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

To be read in conjunction with:
755 All Wales Guideline: Prevention and Management of Postpartum Haemorrhage -opens in a new tab
664 Management of Maternal Collapse Guideline- opens in a new tab
813 Antenatal Electronic Fetal Monitoring Guideline -opens in a new tab
644 Management of Rhesus Negative Women in Pregnancy Guideline -opens in a new tab
503 Major Haemorrhage Policy -opens in a new tab

Patient information:
Include links to Patient Information Library

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Keywords
Antepartum Haemorrhage

Glossary of terms
APH - Antepartum haemorrhage
CLC - Consultant- Led Care
CTG - Cardiotocograph
HDU - High Dependency
MEWS - Maternity Early Warning System
FHR - Fetal Heart Rate

Contents

Scope
This guideline is to provide support and guidance for Hywel Dda health care professionals working within maternity and community, who provide care for pregnant women who present with any bleeding from the genital tract from 24 +0 weeks gestation.

Aim
The aim of the guideline is to provide guidance in the management of antepartum haemorrhage in order to mitigate the risks of maternal and fetal morbidity / mortality

Objectives
The aim will be achieved by the following objective:

- Staff able to appropriately assess and recognise provide consistent high-quality management of APH.

Introduction
Antepartum haemorrhage (APH) is defined as **Bleeding from or into the genital tract, occurring from 24+0 weeks of pregnancy and prior to the birth of the baby**.

The most important causes of APH are placenta praevia and placental abruption, although these are not the most common. APH complicates 3–5% of pregnancies and is a leading cause of perinatal and maternal mortality worldwide with

Up to one-fifth of very preterm babies are born in association with APH, and the known association of APH with cerebral palsy can be explained by preterm delivery. Although a number of risk factors for APH have been described approximately 70% of cases of placental abruption occur in low-risk pregnancies.

Risk Factors for APH include:
- APH/ Placental abruption in a previous pregnancy
- Threatened miscarriage earlier in current pregnancy
- Advanced maternal age
- Multiple pregnancy
- Low BMI
- Premature rupture of membranes
- Drug misuse (cocaine and amphetamines)
- Abdominal trauma (both accidental and resulting from domestic violence
- Preeclampsia
- Polyhydramnios
- Fetal growth restriction
- Assisted reproduction technique

Causes for APH
Bleeding in pregnancy is not normal, it can be unpredictable and the causes include:

- Placenta praevia
- Antepartum abruption
- Unexplained

- Uterine rupture
- Vasa Praevia
- Abdominal trauma (both accidental and resulting from domestic violence)
- Mild trauma caused by e.g. sexual intercourse and cervical sweeps.
- Infection
- Cervical ectropion, vulval lesions, polyps
- Malignancy
- Heavy show

Complications arising from APH
Maternal complications

- Anaemia
- Infection
- Hypovolaemia /Maternal shock
- Renal tubular necrosis
- Consumptive coagulopathy (DIC)
- Postpartum haemorrhage
- Complications of blood transfusion
- Venous thromboembolism
- Maternal death

Fetal complications

- Fetal Hypoxia
- Small for gestational age and fetal growth restriction
- Prematurity
- Fetal death

Although Maternal weight and Volume Maternal weight must be considered in estimating the size of the blood loss and its consequences, maternity obesity can significantly impact blood loss estimation as the maternal blood volume is not linear to the maternal weight.

The volume of blood lost is often underestimated as blood loss may be concealed. Assess for signs of clinical shock as well as fetal compromise or fetal demise as important indicators of volume depletion.

Prompt assessment of maternal and/or fetal compromise is key to establishing if urgent intervention is necessary and will guide management.

Classification of Antepartum Haemorrhage

There are no consistent definitions of the severity of APH. It is important therefore, when estimating the blood loss, to assess for signs of clinical shock. Any bleeding antenatally and intrapartum needs thorough assessment including history and examination.

Spotting	staining, streaking or blood spotting noted on underwear or sanitary protection.
Minor Haemorrhage	blood loss <50ml (after 24 weeks gestation) that has settled
Major Haemorrhage	blood loss of 50-1000ml, with no signs of clinical shock, or when clinical signs are suggestive of significant concealed bleeding
Massive Haemorrhage	blood loss >1000ml **and**/ **OR** signs of clinical shock
Recurrent APH	episodes of APH on more than one occasion

Diagnosis and Management of Antepartum Haemorrhage
Minor APH

A minor APH will usually present as mild bleeding from the genital tract with no other clinical symptoms. Management will be dependent upon the size and cause of the APH.

Record a full medical, social and obstetric history include:

- onset, amount of bleeding, associated pain, recent intercourse, smear history, associated shortness of breath or dizziness, presence of fetal movements, risk factors for placental abruption/praevia
- Record MEWS – blood pressure, heart rate, respiratory rate, temperature
- Record urinalysis
- Gentle abdominal palpation and assessment of fundal height as well as uterine activity
- Auscultate fetal heart and commence CTG (if over 26 weeks) using Dawes Redman CTG analysis
- If unable to locate FHR with Doppler, then USS should be utilised by an appropriately trained clinician.
- Review previous USS reports for documentation of placental site.

All women should have an **obstetric review.**

- Vaginal examination should not be performed until placental site is established
- In cases of placenta praevia digital vaginal examination **should be avoided**
- Can be useful to identify cervical dilatation or cause for APH in lower genital tract
- HVS should be performed if appropriate I
- In minor APH a FBC and G&S should be performed. A coagulation screen is not indicated unless platelet count is abnormal.
- Maternal Rhesus status should be noted.
  If Women Rh negative and, if preformed, CffDNA screening results baby is Rh Positive
  Kleihauer test should be performed to quantify fetomaternal haemorrhage.
  Anti-Di should be given as required.
  In the event of recurrent vaginal bleeding after 20+0 weeks of gestation refer to the Management of Rhesus Negative Women in Pregnancy Guideline -opens in new tab

Management of minor APH

- Management will depend on severity of bleeding/cause/maternal and fetal compromise
- Involve senior obstetric consultant/clinician early if concerns
- Secure access (16G) if clinically appropriate and secure IV fluids.(If no placenta praevia and spotting only Iv access not indicated)
- Consider antenatal corticosteroid therapy
- Women presenting with spotting who are no longer bleeding and where placenta praevia has been excluded can go home if initial clinical assessment is reassuring with appropriate consideration to patient's geographically location.
- All women with APH heavier than spotting and women with ongoing bleeding should remain in hospital at least until bleeding has settled, usually for 24 hours.
- In women with APH >37 weeks gestation considers expediting delivery

NOTE: Decision regarding admission or discharge to home must only be made without the involvement of an experienced obstetrician (middle grade or consultant).

On discharge

- The woman should be advised to contact Triage if she has any further bleeding, pain, altered fetal movements or any concerns.
- If known to have placenta praevia advise these women to avoid penetrative sexual intercourse

Ongoing plan of care

- Following a single episode of APH or recurrent episodes thought to be from a cervical ectropion, subsequent antenatal care need not be altered.
- Following APH from placental abruption or unexplained causes, the pregnancy may require reclassification as High Risk and antenatal care should be consultant-led with serial growth scans.

Management of Major/ Massive APH

- When taking a triage call and it is identified that a woman has PV bleeding triage assessment support the decision of where the most appropriate place of review/ admission is.
- All significant APH must be admitted via labour ward.
- Ensure the labour ward coordinator and all appropriate staff are aware of the pending admission of a woman with significant PV bleeding.
- Prepare for worst case scenario and de-escalate rather than treat as a benign cause and delay emergency treatment and escalation.

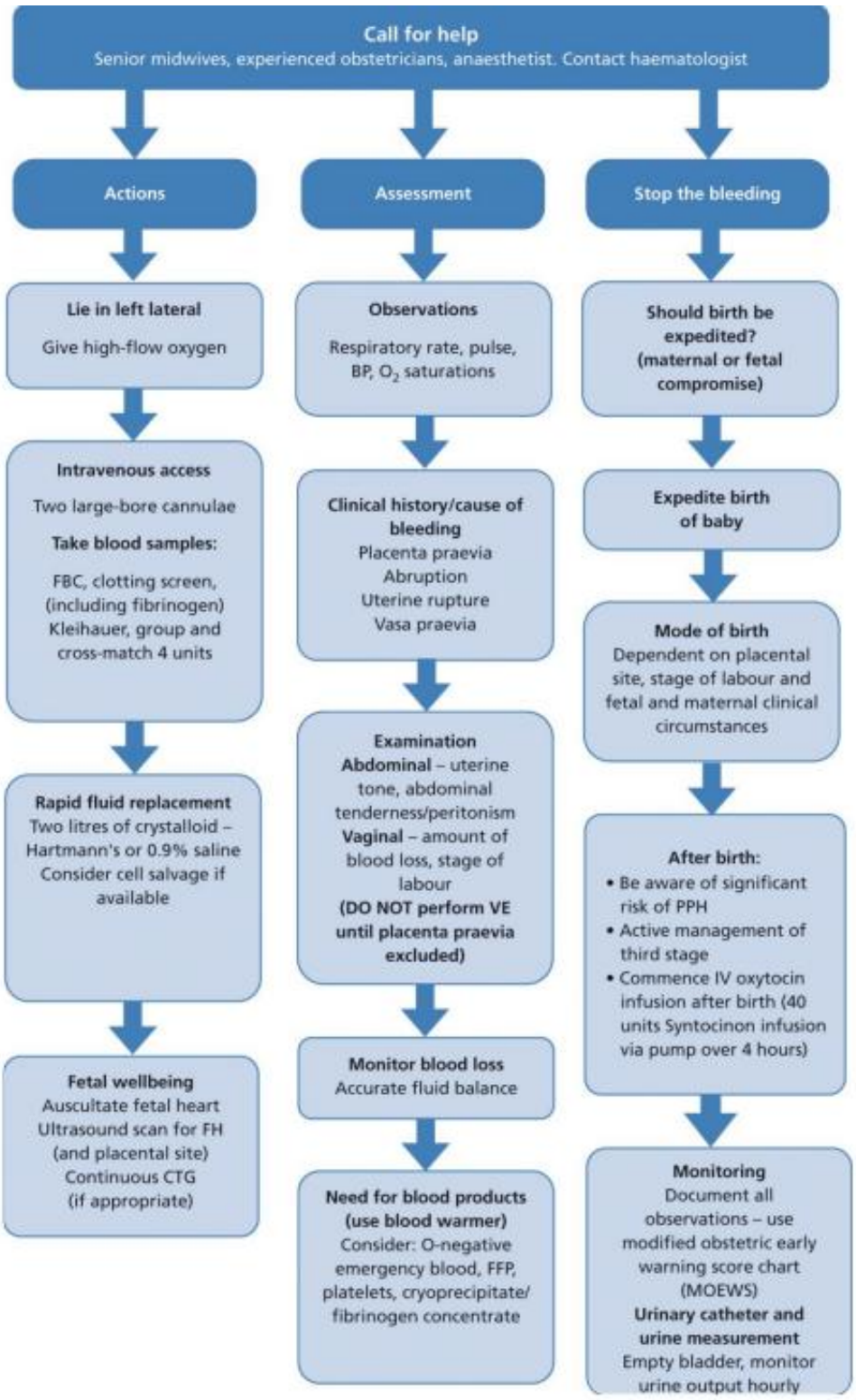
The aims of management of a major or massive APH are:

- Assessment (Remember ABC)
- Resuscitation
- Birth and management of Third Stage

- Correct Coagulation

Follow PROMPT Algorithm for Management Major APH below:

POMPT Algorithm. Management of Major APH



Speed is of the essence, so clear lines of communication between the midwifery, obstetric, anaesthetic and the blood transfusion staffs is essential.

Where feasible it is important to keep the patient and her birthing partner informed of what is happening and proposed management.

A senior paediatrician/ neonatologist should be involved in the counselling of women when extreme preterm birth is likely

Should Major APH result in the need to expedite the birth then use OBSCYMRU Postpartum Haemorrhage Management Checklist and ROTEM Protocol for ongoing care.

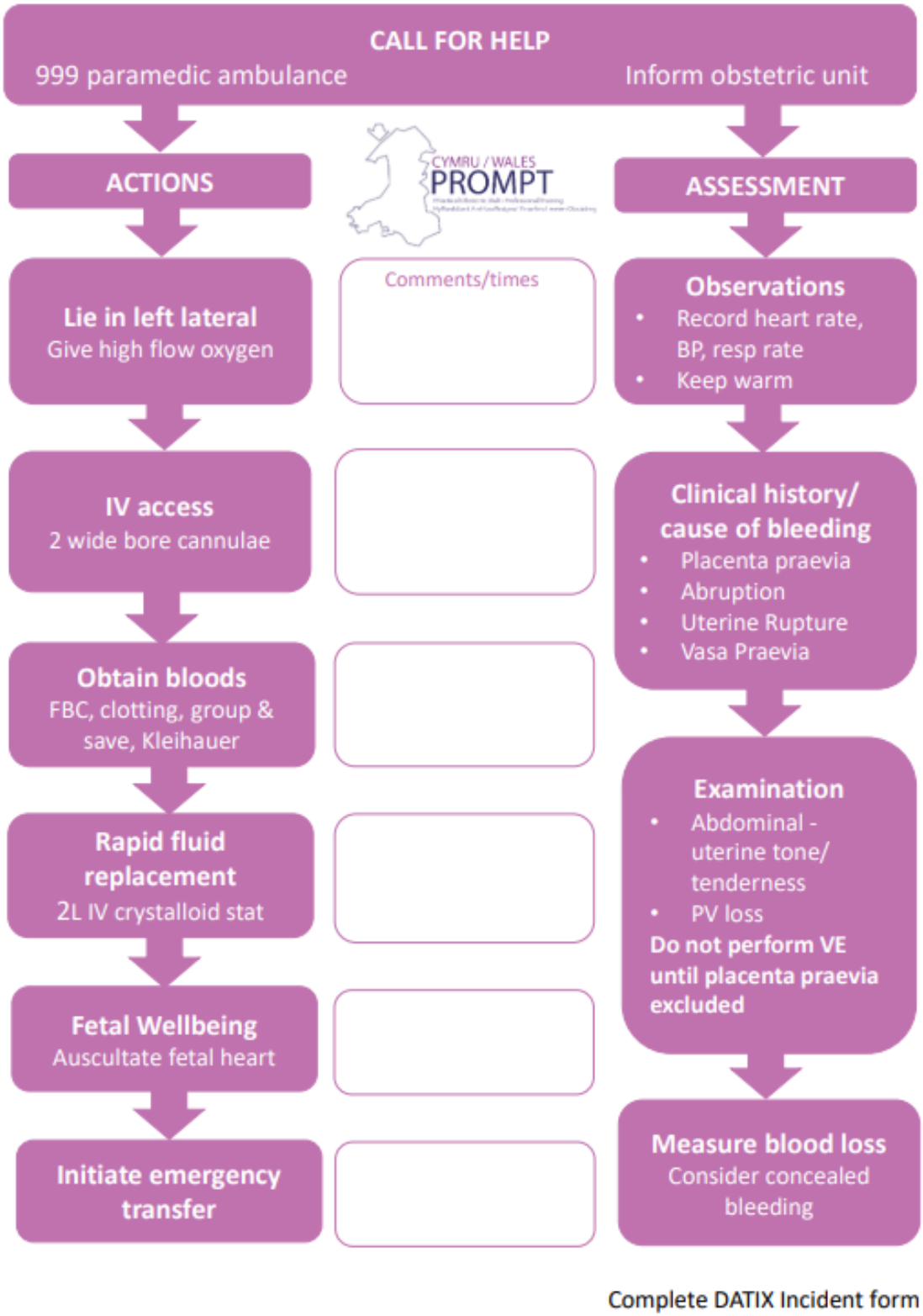
A scribe should be allocated to ensure that all events are recorded as contemporaneously as possible

APH in the community setting -Community Midwifery Management

- The Midwife should phone 999 or give instructions to someone else to phone 999 for an ambulance: Request a Paramedic and state "*Major Maternal Antenatal Haemorrhage. It is an obstetric emergency and requires an immediate emergency transfer to nearest hospital with attached obstetric led unit."*
- Community Midwife should administer high flow facial oxygen via a non-rebreathe mask.
- Commence observations of vital signs and document on MEWS chart.
- Position woman in left lateral tilt and manually displace the uterus to the left using one or two hands to reduce aortocaval obstruction
- On arrival of ambulance declare the emergency and support paramedic to site 2 wide bore cannula.
- The midwife/Paramedic should administer IV Hartmann's solution fluid replacement rapidly.
- Collect and bring all blood soiled materials to aid blood loss estimation.
- Liaise with Band 7 Midwifery Co-ordinator regarding expected ETA and approximate blood loss.

Follow the PROMPT Community Algorithm for Management of Antepartum Haemorrhage below

Community Algorithm for Management of Antepartum Haemorrhage



The postnatal management of pregnancies complicated by major or massive APH

The postnatal management of pregnancies complicated by major or massive APH should include; thromboprophylaxis, debrief or women, her family and staff involved.

Communication

- The mother and her family must be debriefed following the event. After experiencing an APH the woman should be provided with accurate and accessible information about the risks associated with the condition.
- Maternal wishes and concerns should be discussed and documented
- Debrief and support of staff.

Record keeping

- All documentation and risk assessments must be recorded on Badger net (when appropriate and available) or filed in the All-Wales Maternity Handheld Record, Labour and Delivery Record and ancillary Health Board documentation.
- HDU chart to be used for all major APHs
- MEWS to be completed for all women diagnosed with an APH
- Complete DATIX report as appropriate e.g. If Major APH.

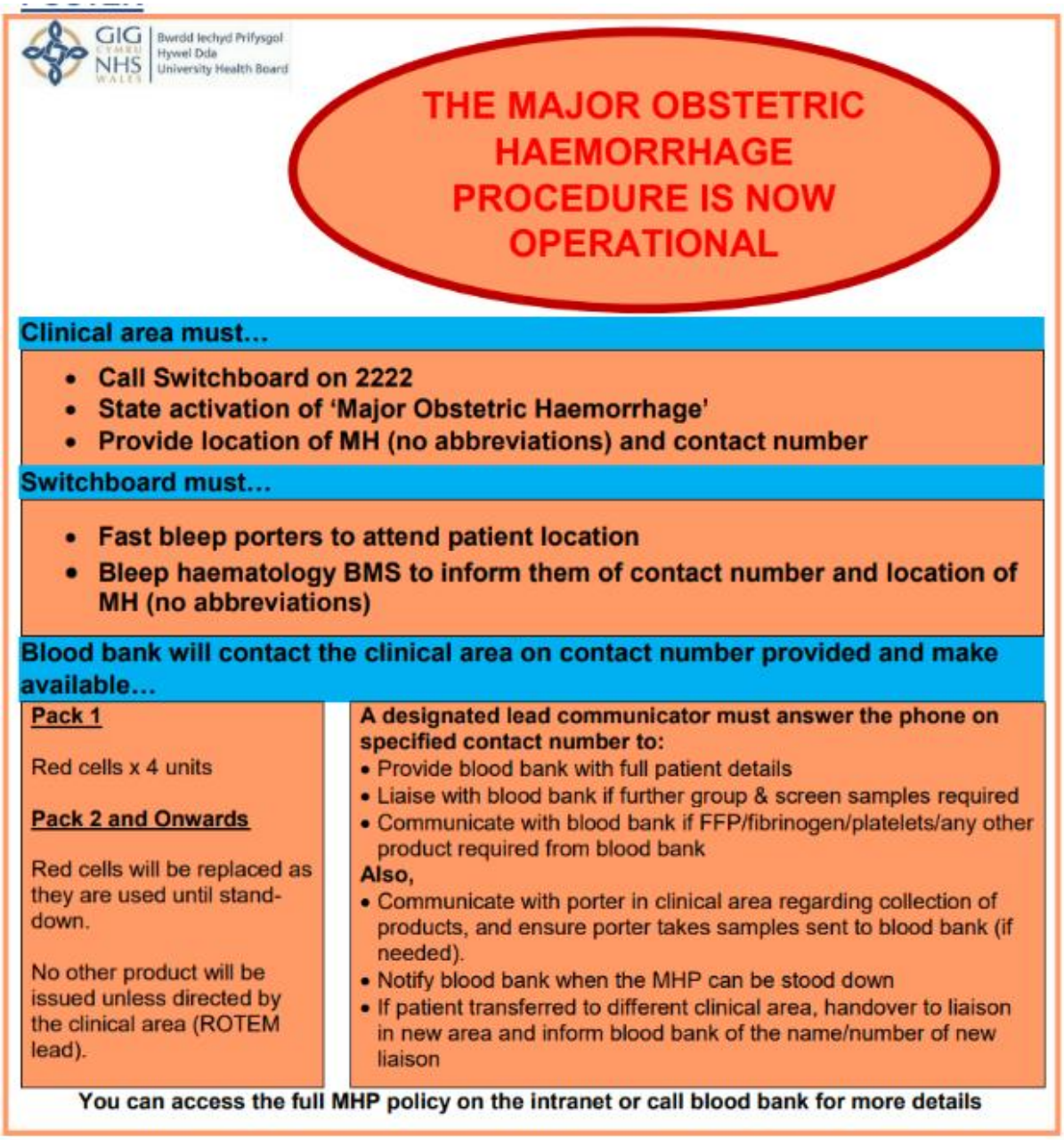
Auditable Standards

- Number of women diagnosed with an antepartum haemorrhage.
- The number of women with on-going blood loss>1500mls
- All major obstetric haemorrhages >1500mls will be Datix reported.
- Monitoring of all major obstetric haemorrhages will be monitored through the Maternity Dashboard
- Perinatal outcome of cases with a diagnosis of APH.
- Percentage of women with postnatal follow-up documented

References

- Royal College of Obstetricians and Gynaecologists. Antepartum Haemorrhage. Green top guideline no. 63 (November 2011)gtg_63 RCOG APH.pdf -opens in new tab.
- Practical Obstetric Multi-Professional Training (PROMPT).
- Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008 Royal college of Obstetricians and Gynaecologists RCOG press London March 2011

Appendix 1. Major Obstetric Haemorrhage Procedure.



503 - Major Haemorrhage Policy -opens in new tab.