Management of Antepartum Haemorrhage Guideline

Guideline Number:	627	Supersedes:		Classification	Clinical
LOCSSIP Reference:		NATSSIP Standard:	List standard (NATSSIPS Standards)		

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1	N/A	Obstetric Guideline and Audit Group	23.04.2019	23.04.2019	01.03.2022
		Obstetric Group - Extended whilst review is undertaken	23.03.2022	23.03.2022	23.09.2022
		Extended whilst review is finalised – Obstetric Group	11.10.2022	12.10.2022	11.04.2023

Brief Summary of Document:	To provide safe care and management of women presenting with antepartum haemorrrhage
Scope	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. 'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.'

To be read in conjunction with:	755Guideline for Management of Postpartum Haemorrhage 664Guideline for Management of Maternal Collapse 813 Guideline for Antenatal Electronic Fetal Monitoring 664Guideline for Administration of Anti D
Patient Information:	Include links to Patient Information Library

Owning committee/ group	Obstetric Guideline and Audit Group

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	23.04.2019

Glossary of terms

Term	Definition
APH	Antepartum haemorrhage
CLC	Consultant-led care
CTG	Cardiotocograph
EFM	Electronic fetal monitoring
FHR	Fetal heart rate
HDU	High Dependency Unit
MEOWS	Maternity Early Obstetric Warning System
PV	Per vaginam
U/O	Urine output
VE	Vaginal examination

Keywords	Antepartum haemorrhage, vaginal blood loss, massive obstetric haemorrhage

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1. Aim of Guideline

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

2. Objectives

The objective of standardised guidance in the management of antepartum haemorrhage is to mitigate any risks to maternal and fetal mortality and morbidity arising from haemorrhage during pregnancy.

3. Scope

This guideline has been developed for obstetricians, anaesthetists, midwives and maternity care assistants caring for pregnant women who present with any bleeding from the genital tract from 24 +0 weeks gestation.

4. Introduction

Antepartum haemorrhage (APH) is defined as bleeding from or in to 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.
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.

5. Causes

Severe antepartum haemorrhage (APH) occurs in 3-5% of pregnancies. The main differential diagnoses to consider in all APHs are:
• Placenta praevia
• Placental abruption
• Vasa praevia
• Local conditions of cervix, vagina and vulva including malignancies
and benign lesions such as polyps and cervical ectropion
• Mild trauma caused by e.g. sexual intercourse and cervical sweeps.

5.1 Predisposing risk factors for Antepartum Haemorrhage

APH: RISK FACTORS		
General	**Placenta Praevia**	**Placental Abruption**
Increased maternal age	**previous caesarean section (10-15%)**	**Pregnancy Induced Hypertension/PET**
Parity	**TOP & D&C**	**FGR**
Multiple pregnancy	**MROP**	**Preterm rupture of membranes**
Smoking	**Myomectomy/TCRE**	**Fibroids**
Cocaine abuse		**Previous abruption**
		External trauma
		Substance abuse
		Polyhydramnios
		Low BMI
		Assisted reproductive techniques
		Maternal thrombophilia

5.2 Definitions of Antepartum Haemorrhage

4.2.1 **Minor Antepartum Haemorrhage**

Episode of bleeding of less than 500mls from the genital tract during pregnancy (after 24 weeks gestation) and prior to birth of the baby.

5.1.2 Major Antepartum Haemorrhage

Episode of bleeding of more than 500mls from the genital tract during pregnancy (after 24 weeks gestation) and prior to birth of the baby or when clinical signs are suggestive of significant concealed bleeding.

6. Diagnosis and Management

6.1 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.
- On presentation the midwife should take a full medical, social and obstetric history, documenting risk factors. A MEOWS chart should be commenced and fetal movements and CTG performed after 28 weeks (earlier only at Consultant Obstetrician's request) using Dawes Redman CTG analysis.
- All women should have obstetric review with no decision regarding admission or discharge to home made without the involvement of an experienced obstetrician (middle grade or consultant).

- Obstetric review should include the following:
- History and risk assessment
- Review scan for placenta site
- Examination to include speculum for lower genital tract lesion (if not placenta praevia)

- Review observations and CTG
- Secure IV access (unless spotting only) and consider IV fluids
- Take blood for FBC and G&S (and Kleihauer if rhesus negative)
- Commence / continue CTG Women presenting with spotting who are no longer bleeding and where placenta praevia has been excluded can go home after a reassuring initial clinical assessment. All women with APH heavier than spotting and women with ongoing bleeding should remain in hospital at least until the bleeding has stopped, usually for 24 hours.
- Anti-Di should be given to non-sensitised RhD-negative women. In the event of recurrent vaginal bleeding after 20+0 weeks of gestation refer to the Anti D Clinical Guideline.

6.2. Diagnosis and Management: Major APH (Appendix 1)

6.3 Antepartum Haemorrhage in the Community Setting – Community Midwifery Management

- Arrange for immediate transfer to the obstetric unit; via 999 ambulance request emergency transfer.
- Community Midwife should administer high flow facial oxygen via a non-rebreathe mask.
- Commence observations of vital signs and document on MEOWS chart.
- Position woman in left lateral tilt/manually displace uterus
- On arrival of paramedic support paramedic to site 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
- Support paramedic to liaise with Band 7 Midwifery Co-ordinator regarding expected ETA and approximate blood loss.

7. Complications of APH

- Anaemia
- Infection
- Maternal shock
- Renal tubular necrosis
- Consumptive coagulopathy
- Postpartum haemorrhage
- Complications of blood transfusion
- Fetal hypoxia
- Small for gestational age and fetal growth restriction
- Prematurity
- Fetal death
- Venous thromboembolism

8. Record Keeping

- All documentation and risk assessments must be recorded and 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
- MEOWS to be completed for all women diagnosed with an APH
- Care plans are to be inputted onto Welsh PAS for women with risk factors for APH as .

9. Communication

- All pregnant women who experience an APH should be provided with accurate and accessible information about the risks associated with the condition.
- **Maternal wishes and concerns should be discussed and documented.**

10. 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.

11. References

- Royal College of Obstetricians & Gynaecologists (2011). Green top guideline 63: Antepartum Haemorrhage.
- All Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. December 2015
- https://pathways.nice.org.uk/pathways/antenatal-care-for-uncomplicated-pregnancies
- All Wales Midwife-led Care Guidelines (5th Edition)

Appendix 1- Diagnosis and Management: Major APH