Management of Antepartum Haemorrhage

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Contents

Disclaimer: The term woman is used through this guideline, but covers people identifying as any gender who are pregnant.

Definitions:

Antepartum Haemorrhage (APH) traditionally refers to any vaginal bleeding occurring after 24 weeks gestation. However as the age of viability has reduced can be considered for any bleeding occurring after 20 weeks gestation. APH complicates 3-5% of pregnancies, and is a major contributor to preterm deliveries with the associated morbidity and mortality.

The amount of bleeding can be described in the following ways:

- Spotting: streaking or staining or a spot of blood on underwear or on wiping
- Minor: blood loss <50mls that has stopped
- Moderate: blood loss between 50mls and 200mls
- Major: blood loss 200mls – 1000mls with no signs of shock
- Massive: blood loss >1000mls and/or clinical signs of shock
- Recurrent APH: more than 1 episode after 24 weeks gestation

Causes of APH: often unexplained, but main differentials are placental abruption, placenta praevia, vasa praevia, or local causes such as cervical ectropion.

Placenta Previa

Risk Factors:

- Previous placenta praevia (OR 9.7)
- Previous caesarean section (OR 2.2 with 1 previous, 4.1 with 2 previous, 22.4 with 3 previous)
- Maternal age >40
- Multiple pregnancy
- smoking
- Endometrium deficiencies (history of previous manual removal of placenta, surgical removal of pregnancy tissue, endometriosis or endometrial curettage, resection of fibroids)

Presentation:

- Painless bleeding
- Soft uterus
- Malpresentation
- Placenta over or within 2cm of cervix on ultrasound scan.

Management:

- Avoid digital vaginal examinations
- Delivery by LSCS at 38 weeks gestation
- If previous LSCS / uterine surgery consider risk of accrete – refer for USS / MRI from 32/40 gestation. Consider referral to tertiary obstetric unit for delivery.
- Consider admission near term depending on maternal wishes and considering locality to hospital, any admission with APH this pregnancy, and any co-morbidity or risk factors for birth.

Placental Abruption

Risk Factors:

- Previous abruption (OR 7.8)
- Pre-eclampsia
- Smoking / Substance use (especially cocaine or amphetamines)
- Premature Prelabour rupture of membranes
- Thrombophilias especially factor V Leiden and prothrombin
- Low BMI
- Polyhydramnios

Presentation:

- Painful bleeding (visual bleeding may not represent true amount of bleeding if concealed abruption)
- Firm and / or tender uterus
- Shock (hypotension, tachycardia)
- Abnormal CTG / Intrauterine fetal death
- Coagulopathy

Management:

- In the presence of fetal and / or maternal compromise immediate delivery by caesarean section is required.

Vasa Praevia

Incidence of 0.1%

Presentation:

- Bleeding following rupture of membranes
- Abnormal CTG

Management:

- Delivery as soon as possible.
- Preparation for neonatal resuscitation and blood transfusion. Communication between obstetricians and neonatal team critical. Total circulating volume of a term infant is around 250mls.

Local Causes

Local causes include cervical ectropion, cervical cancer, and vaginal trauma (Sexual assault, domestic violence).

Whilst bleeding tends to be of smaller amounts and so managed conservatively, unexplained APH is associated with small for gestational age babies and preterm birth.

Management Principles

Women with an APH are advised to contact the antenatal assessment unit for assessment. If the bleeding is described as major then the woman should be advised to ring 999 for an ambulance to bring her to labour ward for assessment. Initial assessment should determine the severity of bleeding, maternal observations and fetal wellbeing. For women with moderate, major or massive bleeding a multidisciplinary approach should be taken as with post-partum haemorrhage. Initial resuscitation and stabilisation of the mother is the priority, followed by the need for urgent delivery. Clear and effective communication between health care professionals and with the woman is essential.

References

1. RCOG Green-top guideline 63 Antepartum Haemorrhage Nov 2011
2. NICE Guideline NG201 Antenatal Care August 2021

Management FLOWCHART

Woman contacts AAU reporting APH over 20/40

EBL <100mls

Advise to attend AAU for review

EBL >100mls

If stopped to attend AAU for review

If ongoing advise woman dials 999 and ask for an ambulance. Inform co-ordinator on labour ward to prepare for arrival. Co-ordinator to alert obstetric and anaesthetic teams.

On arrival assess maternal observations (pulse, Bp, RR)

Auscultate fetal heart – if >26/40 start CTG

Maternal and Fetal Condition stable

Check blood group

Check last scan for placental location

Obstetric review including smear history, and routine enquiry

Abdominal examination

Speculum examination

FBC Group and save

Kleihaur if appropriate

Ultrasound scan for fetal growth and placenta site

If spotting / minor bleed allow home

Moderate bleed admit for observation until bleeding stopped – 4 hourly Obs

Recurrent APH: For Obstetric led care and serial growth scans

Maternal / Fetal Condition not stable

Large bore IV access

FBC, UE, X Match, Coagulation screen, Rotem, venous blood gas

Kleihauer if appropriate

Hartmans fluid resuscitation

Consider MOH call and need for urgent blood transfusion

Consider need for urgent delivery

If delivery not indicated admit for observation until bleeding stopped – 4 hourly obs

Ultrasound scan for fetal growth and placenta site

Obstetric led care and serial growth scans

Maternity Services

Checklist for Clinical Guidelines being submitted for Approval

Title of Guideline:	Management of Antepartum Haemorrhage
Name(s) of Author:	Antenatal forum
Chair of Group or Committee approving submission:	Rhiannon Griffiths
Brief outline giving reasons for document being submitted for ratification	Document update.
Details of persons included in consultation process:	Antenatal forum
Name of Pharmacist (mandatory if drugs involved):	
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Date approved by Group:	October 2023
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