Management of Antepartum Haemorrhage

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Approved by: Antenatal forum/Labour ward forum

Approval Date: 6 December 2019

Review Date: 6 December 2022

Document No:

Contents

Antepartum Haemorrhage

1. **DEFINITION**
   Vaginal bleeding after 24 weeks gestation. Occurs in 3-5% of pregnancies

2. AIMS
To reduce risk of maternal and perinatal morbidity and mortality

- Identify high risk cases
- Identify cause of bleeding
- Accurately estimate blood loss
- Adequate resuscitation including management of coagulopathy
- Expedite delivery if indicated

3. **CAUSES**

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

4. 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

5. DIFFERENTIAL DIAGNOSIS

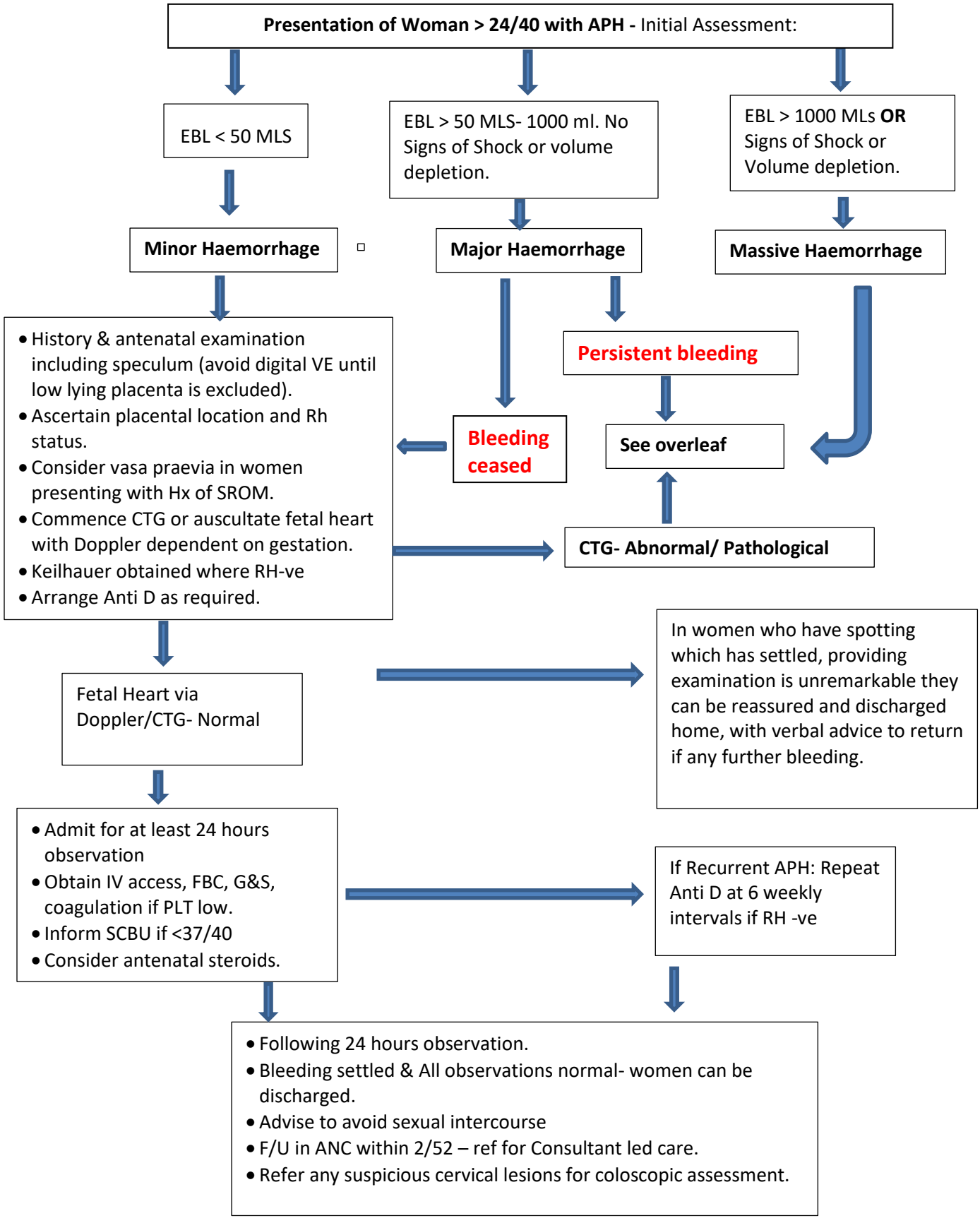
	Placental Abruption	**Placenta Praevia**
Incidence	1-2%	0.5% at term
Presentation	Abdominal pain Tender, tense uterus Haemorrhage may be concealed May be shock Coagulopathy	Painless bleeding, may be heavy Soft uterus Coagulopathy less common Usually stable
Fetal Assessment	May be abnormal CTG or IUD	CTG usually normal May be malpresentation
Risk Factors	• Previous Hx of abruption • Pre-eclampsia • Fetal growth restriction • Non-vertex presentation • Polyhydramnios • Advanced maternal age • Multiparous • Low BMI • IVF • Intrauterine infection	• Previous Hx of praevia • Previous C/S • Hx of TOP • Multiparous • >40 yrs • Multiple pregnancy • Smoking • IVF • Deficient endometrium • Uterine scar

	• PROM • Abdominal trauma • Substance misuse • First trimester bleeding • Maternal thrombophilia	• Endometritis • MROP • Curettage • Submucous fibroid

6. VASA PRAEVIA

- Incidence 0.1%
- Bleeding with onset of membrane rupture
- Fetal distress is a common feature
- Immediate delivery indicated as high risk of perinatal mortality from exsanguination (total blood volume of infant at term approx 250ml)

7. PRESENTATION OF WOMAN >24/40 WITH APH PATHWAY



8. MAJOR HAEMORRHAGE PATHWAY

- Admit to labour ward.
- Inform senior obstetrician and anaesthetist.
- History & examination including speculum (Avoid digital VE until low lying placenta is excluded)
- Assess for tenderness or acute abdominal pain.
- Consider vasa praevia in woman with Hx of SROM.
- Commence CTG once the woman is stable or after resuscitation has commenced.
- USS performed if fetal heart is not auscultated. NB sensitivity for detection of abruption via USS is poor.
- Inform consultant obstetrician if placenta praevia, abruption or coagulopathy is suspected.
- Ascertain placental location & Rh Status

CTG normal

- Admit
- Obtain IV access, FBC, U&E,LFT, Coag, Fibrinogen, cross match 4 units, consider if Kleihauer is required.
- Inform SCBU if less than 37/40
- Commence steroids if 24-35/40
- Avoid tocolytics
- Anti-D administration 500iu where required.

- Discuss with Senior Obstetrician
- Consider managing conservatively
- Following at least 24 hours of observation, where bleeding has settled and observations are normal- women can be discharged home, this will require individual assessment.
- Advise women to avoid sexual intercourse
- Follow up in ANC in two weeks
- Serial USS for growth
- Refer any suspicious cervical lesions for colposcopic assessment
- Inform community midwife

Evidence of maternal shock/hypovolaemia **OR** heavy bleeding persists

CTG – Abnormal/Pathological

- Lie left lateral
- Give high-flow oxygen
- Obtain IV access, Point of care test- ROTEM, Venous lactate,Venous Hb Lab test-FBC, U&E, LFT,Coag, Xmatch 4 units.
- Inform Scbu if <37/40
- Senior obstetric and anaesthetic opinion.
- Expedite delivery of the fetus.

- Anticipate increased risk of PPH
- Active management of 3rd stage
- Ongoing blood loss measurement and uterotonic management as per OBS CYMRU.
- Oxytocin infusion after birth.
- Activate the “Massive obstetric haemorrhage protocol” if loss over 1500ml or before dependent on maternal condition.
- Where high risk of placenta accrete consider interventional radiology.

- Monitoring
- Document all observations on MOEWS/HDU chart
- Consider Urinary catheter and urometer
- Fluid balance
- VTE risk assessment

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9. MASSIVE HAEMORRHAGE PATHWAY

Senior Obstetrician & Senior anaesthetic involvement, haematologist and blood bank to be informed. Activate "Massive obstetric haemorrhage protocol" on clinical opinion or where EBL/MBL reaches 1500ml.

- Airway, Breathing, Circulation- commence high flow oxygen.
- Lie left lateral
- Ongoing assessment of maternal observations including Oxygen saturation and respiration
- Obtain IV access (2x 16g), Point of care test- ROTEM, venous lactate, venous Hb. Lab test- FBC, U&E, LFT, Coag, Xmatch 6 units urgently. Women who are Jehovah's witness are managed in line with Labour ward guidelines.
- Infuse 2L warmed crystalloid (Hartmanns or 0.9% Normal Saline)
- Commence CTG once mother stabilised or after resuscitation has commenced.
- USS should be performed if unable to auscultate the fetal heart. NB sensitivity for detection of abruption via USS is poor.
- Inform SCBU

- History & examination including all observations and speculum (avoid digital VE until low lying placenta is excluded).
- Assess for tenderness or acute abdominal pain.
- Ascertain placental location and Rh status (NB. Sensitivity for detection of abruption ultrasound is poor).
- Consider vasa praevia in women presenting with Hx of SROM
- Stop any anticoagulation therapy.
- Measure ongoing bleeding.

- Consider DIC in major/massive haemorrhage. Undertake ROTEM
- If DIC suspected, discuss with haematologist.
- Infuse 6 units PRBC plus 4 units of FFP whilst waiting for blood results.

- Evidence of maternal shock or volume depletion OR
- Heavy bleeding persists OR
- Evidence of fetal compromise.

- Discuss with consultant obstetrician.
- Plan to expedite delivery of fetus
- Woman must be stabilised first, unless evidence of life threatening bleeding.
- Consider cell salvage

- Anticipate increased risk of PPH
- Active third stage
- Manage ongoing bleeding and uterotonics as per OBS CYMRU.
- Oxytocin infusion after birth.
- Contemporaneous blood loss measurement
- Activate "massive obstetric haemorrhage protocol" if loss >1500 mls or signs of hypovolemic shock.

Ongoing Monitoring

Document all observations on HDU/MOEWS
Consider Urinary catheter and urometer
Strict fluid balance
VTE risk assessment
Bloods as clinically indicated
Consider need for kleihauer and Anti D.

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10. NON-ACUTE ANTENATAL MANAGEMENT OF PLACENTA PRAEVIA/ACCRETE

- Trans-vaginal USS to confirm placental site
- Colour flow Doppler if risk of accreta – if not available locally to treat as if accreta
- Patient advised to attend hospital if any abdominal pain, tightening or bleeding
- Antenatal discussion with woman regarding:
- Delivery Haemorrhage
    - Risks
    - Surgical management including hysterectomy
    - blood transfusion / cell salvage
- Antenatal discussion with Interventional Radiologist in relation to possible catheterisation
- Blood X-match
- If placenta <2cm from internal os, likely to need LSCS for delivery
- Anaesthetic referral to discuss mode of anaesthetic (likely regional). If suspected accreta refer early to anaesthetic clinic for multidisciplinary plan.
- Most senior obstetrician and anaesthetist should at the very least be available on labour ward if intervention required as either elective or emergency
- Where possible elective LSCS performed after 38 weeks gestation to minimise neonatal morbidity
- All staff should be aware of major haemorrhage guideline and drills performed at regular intervals
- Tailor antenatal care, including hospitalisation, to individual woman's needs e.g. distance between home and hospital and availability of transportation, previous bleeding episodes, haematology laboratory results, and acceptance of receiving donor blood or blood products.
- Where hospital admission has been decided, an assessment of risk factors for venous thromboembolism in pregnancy should be performed. This will need to balance the risk of developing a venous thromboembolism against the risk of bleeding from a placenta praevia or low lying placenta.

REFERENCES:

RCOG (2011*) Antepartum Haemorrhage – Green-top guideline No. 63, RCOG.*

ABMU (2011*) Guideline for the Management of Antepartum Haemorrhage.* ABMU HB.

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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:	Carolyn Williams
Brief outline giving reasons for document being submitted for ratification	Document update.
Details of persons included in consultation process:	Antenatal forum/Labour ward forum members.
Name of Pharmacist (mandatory if drugs involved):	
Issue / Version No:	
Please list any policies/guidelines this document will supercede:	Guideline for the management of antepartum Haemorrhage.2011
Date approved by Group:	6 December 2019
Next Review / Guideline Expiry:	December 2022
Please indicate key words you wish to be linked to document	APH, Antepartum Haemorrhage, massive obstetric haemorrhage,
File Name: Used to locate where file is stores on hard drive	