418.2 ANTEPARTUM HAEMORRHAGE (APH) – MAT/LWG/Antenatal/9

Antepartum haemorrhage is vaginal bleeding after 24 weeks of pregnancy. However, all women beyond 20 weeks must be assessed along the same lines.

Causes:

- Placenta praevia
  Major or complete: placenta encroaches on the cervix.
  Minor or partial: placenta >2cm from the cervical os.
- Placental abruption.
- Other causes: e.g. local bleeding (from cervix or vagina), heavy show.

Management
Will depend on the cause and degree of bleeding, fetal well-being and gestation.

Minor or Moderate APH

Beware of large concealed abruption where the revealed vaginal bleeding may be minimal. The signs of an abruption are sudden onset of severe abdominal pain and tenderness, shock and a hard woody uterus.

1. Admit to hospital and inform registrar. Do not perform vaginal examination without first discussing with obstetric registrar.
2. Maternal pulse, blood pressure.
3. CTG if >24 weeks - repeat if further bleeding.
4. Consider cannulation if there is fresh bleeding, and take blood for:
   - Full blood count.
   - Group and save serum (cross-match 2 units if known placenta praevia).
   - Kleihauer.
5. Arrange/perform ultrasound to review placental site + baseline growth. Transvaginal ultrasound is safe in the presence of placenta praevia and is more accurate than transabdominal ultrasound in locating the placenta[1].
6. If placenta praevia is excluded - speculum examination by registrar to exclude local causes.
7. Give anti-D 500 iu if rhesus negative with no antibodies.
8. Subsequent management will depend on gestation, e.g. at term, delivery may be indicated. Discuss with on-call consultant.
9. Admit for at least 24 hours, or until bleeding has settled.

[1] Placenta praevia and placenta accreta: diagnosis and management, RCOG Guideline No 27. 2005

Major APH - (see also guidelines for **massive obstetric haemorrhage**)

1. Inform registrar, consultant, anaesthetist and blood bank.
2. Commence IV infusion (normal saline) and take blood for:
    - Cross-match 4-6 units of blood (more may be required).
    - FBC.
    - Coagulation screen, including fibrinogen level, if DIC suspected.
    - Baseline U&E, LFTs.
    - Kleihauer.
3. Commence continuous fetal heart monitoring if >24 weeks.
4. Arrange/perform ultrasound on Labour Ward to locate placental position if placental site unknown.
5. Catheterise and monitor urine output hourly.
6. Review the need and mode of delivery - discuss with consultant. The woman's welfare is paramount and her resuscitation takes priority.
    - If very heavy bleeding persists, or fetal compromise, proceed to caesarean section unless fully dilated.
    - If the fetus has died, it may be possible to achieve a vaginal delivery by inducing labour with an ARM and Syntocinon.
    - If bleeding is less severe but delivery indicated and placenta praevia has not been excluded, consider proceeding to EUA. If the placenta is not praevia at EUA, labour may be induced by ARM and Syntocinon. During labour the fetal and maternal condition must be monitored closely with a low threshold for caesarean section if bleeding continues or there is fetal compromise.

The consultant on-call must be on Labour Ward for all caesarean sections for placenta praevia or EUA to exclude praevia.

7. Commence blood transfusion, if indicated.
8. All rhesus negative women with no antibodies require anti-D 500 iu. Check Kleihauer to determine if additional doses are required.
9. A CVP line may be required if bleeding is severe.
10. Commence and maintain fluid balance chart.

Massive haemorrhage associated with caesarean section for placenta praevia

Women with higher risk of complications include those with previous uterine scars, anterior placenta praevia or placenta accreta.

The lower segment is relatively atonic and treatments for uterine atony may help (see PPH Guideline). Also consider undersuturing of the placental bed.

Asymptomatic placenta praevia

Women with major placenta praevia who may be admitted from 34 weeks gestation and have not bled, will be grouped and saved. Two units of blood will be cross-matched for caesarean section.

See also:

Guideline 105 Caesarean Section in Patients with Placenta Praevia – Guidelines for Anaesthetists
Guideline 427 Postpartum Haemorrhage
Guideline 445 Massive Obstetric Haemorrhage
Guideline 463 Caesarean Section (CS) Guideline

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