ANTEPARTUM HAEMORRHAGE

Definition

Bleeding from or into the genital tract, occurring from 24w0d of pregnancy and prior to the birth of the baby.

Causes

- Abruptio Placentae
- Placenta praevia / vasa praevia
- Local causes (from cervix, vagina or vulva)
- Unknown origin
- Show

Risk factors for placental abruption

- Previous abruption placentae
- Pre-eclampsia
- Fetal growth restriction
- Non-vertex presentations
- Polyhydramnios
- Advanced maternal age
- Multiparity
- Low BMI
- Pregnancy following assisted reproduction
- Intrauterine infection
- Premature rupture of membranes
- Abdominal trauma
- Smoking/ drug misuse

Risk factors for placenta praevia

- Previous placenta praevia
- Previous caesarean section(s)
- Previous uterine surgery
- Previous termination of pregnancy
- Multiparity
- Advanced maternal age (> 40y)
- Smoking
- Deficient endometrium (previous endometritis, uterine scar, manual removal of placenta, curettage, submucous fibroid)
- Assisted conception

Assessment of Antepartum Haemorrhage

1. MATERNAL STATUS:

Unstable/shocked

- BP(BP ≤ 90/60mmHg)
- Pulse (≥120bpm)
- HB (≤ 8g/dl)

- **Call for help!!**
- 2 x large bore IV lines (one should be a blood giving set in Cubital fossa)
- Elevate legs
- Facemask O2
- Call doctor (alert Emergency Doctor if no Obstetrician on site)
- Keep patient warm

Stable

- Check for fetal heart
- If ≥27w0d gestation do CTG – if no fetal distress, continue with assessment
- If gestation 24w – 26w6d, await doctor's orders before doing CTG
- Consider giving steroids from 26w6d

2. QUICK HISTORY

- Placental position (check antenatal history)
- Associated pain, continuous or intermittent
- Any fetal movements felt? Listen for fetal heart
- Look for risk factors of both praevia or abruption
- If SROM, consider vasa praevia
- Ask about coitus last 24hrs

3. CLINICAL ASSESMENT

- Aim is to first establish whether urgent intervention is required to manage maternal or fetal compromise
- Record vitals
- Abdomen palpation (hard/painful? Contractions felt? High presenting part?)
- Carefully do a vaginal speculum examination to identify cervical dilatation or visualise a lower genital tract cause or bleeding from placenta praevia.
- Even if placental position known and NOT placenta praevia or vasa praevia, do ultrasound to confirm before digital exam to assess cervix for dilatation
- Fetal heart rate should be determined once mother is stable. CTG monitoring is indicated where knowledge of the fetal condition will influence the timing and mode of delivery

4. BLOOD TESTS NECESSARY

If major bleeding:

- FBC
- Coagulation screen (INR, PTT, Fibrinogen)
- U + E
- LFT
- Cross match and order 2 Units of packed cells and 2 Units of FFP.
- Activate the major transfusion protocol at blood bank

If minor bleeding:

- FBC
- Type and screen
- If mother known to be unsensitised RH negative do Kleihauer-Betke test to quantify Fetomaternal Haemorrhage (FMH) in order to gauge the dose of anti-D required

Further management

Abruptio Placentae (confirmed or clinically suspected)

Non-viable fetus (24w-26w)

- Mother compromised – deliver with senior paediatrician/neonatologist present
- Mom and baby stable and bleeding subsided – consider discharge with proper counselling and further follow up as high risk patient

Viable fetus (>26w or when steroid mature)

Stable mom and baby

- Patient not in active labour – admit as an antenatal patient. Keep on continuous CTG monitoring for at least 12 hours and await doctor for further investigation
- Any APH (except that from local lesions), consider corticosteroids (<34w)
- If fetal and maternal status normal and CTG normal for 12 hours, continue with 4 hourly vitals, 6 hourly CTG's
- If irritable uterus, keep on CTG longer – individualise
- If woman presents after > 37w gestation, and both fetus and mom stable, consider Induction of labour with the aim of vaginal delivery to avoid adverse consequences potentially associated with a placental abruption. Continuous CTG in labour.
- If woman presents before 37w gestation, without any sign of maternal or fetal compromise and bleeding has settled, no evidence to support elective preterm delivery.
- If no bleeding for 24hrs and CTGs remain normal, the patient may be discharged with proper counselling
- If <32 weeks consider MgSO4 for neuroprotection of the fetus if delivery anticipated within 24 hours. See BetterObs protocol P8 for dosage etc.

On discharge, the patient should be reclassified as high risk and antenatal care should include serial fetal growth monitoring.

Unstable mom and/or baby

Live fetus:

- If mom or fetus unstable – should just stabilise mother and take for urgent CS! No need for MgSO4 or CTG, just confirm FH still present in theatre
- In case of fetal or maternal compromise - deliver immediately once mother stabilised (usually via caesarean section unless vaginal delivery is imminent and not contra-indicated) – Obstetrician contact paediatrician (or ask the midwife to contact paediatrician)

Intrauterine death

- Aim for vaginal delivery if no contra indications
- Attempt AROM ASAP
- Maternal compromise and delivery not imminent – stabilise mother, resuscitate aggressively, optimise blood results and get induction of labour going

Placenta praevia and Vasa praevia

(Also see guidelines related to placenta praevia spectrum disorders)

Asymptomatic:

- Placenta NOT reaching or covering os and no praevia accreta suspected – reassess with transvaginal scan at 36 weeks – allow NVD if 2 cm away from os
- Placenta reaching or covering os and no praevia accreta suspected – elective Caesarean Section at 37-38w gestation
- Confirmed praevia accreta – elective Caesarean Section at 34 – 36w gestation
- Confirmed vasa praevia – admit between 28w -32w, administer steroids and deliver via Caesarean Section at 35w – 37w gestation

Symptomatic (antepartum haemorrhage):

- Administer steroids if <34w6d
- Admit
- If bleeding stops or not life threatening, keep in hospital till delivery via Caesarean Section at 37w if not adherent, 34-36 weeks if morbidly adherent, or when excessive bleeding is encountered
- Life-threatening bleed – deliver immediately via Caesarean Section

Postpartum care

- Prevent postpartum haemorrhage
- Active management of 3rd stage labour. Administer Syntometrine® stat (if no hypertensive disease or cardiac disease contra-indication), or Oxytocin (Syntocinon®) IMI/IVI stat and continuous infusion of Oxytocin 20units in 1 litre saline at 100ml per hour.
- Regularly check for uterine atony by rubbing up uterus and keeping bladder empty.
- If patient RH negative and not sensitised, administer 500 IU Anti- D immune globulin and await Kleihauer-Betke test. Additional Anti D immune globulin should be administered according to recommendation from Blood bank.

- Record vitals and pad checks half hourly x 2hrs, if stable then hourly for 4 hours. If stable, convert to routine vital checks.
- Repeat Hb 6 hours after delivery.
- Debrief patient and family and in case of adverse outcome for baby, offer formal support. (psychologist/social worker)

Antepartum haemorrhage – local causes

Cervicitis

- Send urine for MC&S
- Do cervical swab for gonococcus, chlamydia, etc.
- Administer oral antibiotics
- Advise no coitus for at least 2 weeks

Definitions

Term, Acronym or abbreviation	Definition
Vitals	This includes vital signs – temperature, heart rate, respiratory rate, blood pressure and saturations
SROM	Spontaneous Rupture of Membranes
AROM	Artificial Rupture of Membranes
CTG	Cardiotocograph

References

1. Adam, S. Soma-Pillay, P. Obstetric Essentials. 2018. 3rd Edition. University of Pretoria
2. Antepartum Haemorrhage. RCOG Green-top Guideline No. 63
3. Placenta Praevia and Placenta Accreta. Diagnosis and Management. RCOG Green-top Guideline No. 27a
4. Vasa Praevia. Diagnosis and Management. RCOG Green-top Guideline No. 27b

Authorship

These guidelines were drafted by a clinical team from Mediclinic and were reviewed by a panel of experts from SASOG and the BetterObs clinical team. All attempts were made to ensure that the guidance provided is clinically safe, locally relevant and in line with current global and South African best practise. Succinctness was considered more important than comprehensiveness.

All guidelines must be used in conjunction with clinical evaluation and judgement; care must be individualised when appropriate. The writing team, reviewers and SASOG do not accept accountability for any untoward clinical, financial or other outcome related to the use of these documents. Comments are welcome and will be used at the time of next review.

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