2 COMPLICATIONS OF PREGNANCY

2.3 ANTEPARTUM HAEMORRHAGE (APH)

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2.3.1 Antepartum haemorrhage – medical management
Section B
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2.3.1 MEDICAL MANAGEMENT

INTRODUCTION

Antepartum haemorrhage (APH) is defined as bleeding from the genital tract after the 20th week of pregnancy. APH is unpredictable, and at any time before, during or after presentation, the women's condition may deteriorate rapidly.

AETIOLOGY

Placenta praevia (31%) and abruptio placenta (22%) represent the most important common causes of APH and can result in both maternal and fetal death. [1, 2] The absence of pain is often regarded as a significant distinquinshing factor between placenta praevia and placental abruption, but 10% of women with placenta praevia will have a coexisting abruption. [3]

Other common causes: [1]

- Marginal bleeds - 60%
- Show - 20%
- Cervicitis - 8%
- Trauma - 5%
- Important but rarer causes include cervical cancer, vasa praevia and genital infections.

ASSESSMENT

Any women bleeding from the genital tract after 20 completed weeks gestation should be reviewed by a registrar following initial assessment.

HISTORY

This should be taken to try to elucidate the cause of bleeding.

Specific factors include:

- Onset of bleeding- spontaneous, trauma or post-coital.
- Amount and type of loss - fresh, bright red or darker, brown blood, whether it was watery, which may indicate an accompanied rupture of membranes.
- Whether the bleeding has settled/continuing.
- Nature of any associated pain - continuous, intermittent or worsening.
- Presence of fetal movement – description of fetal activity (normal or reduced).
- Check blood group and antibody screen
- Check the placental site from the most recent ultrasound scan.

All guidelines should be read in conjunction with the Disclaimer at the beginning of this manual.

EXAMINATION

When examining the woman note any pallor and perform baseline observations.

If the patient is **haemodynamically unstable** then **call "Code Blue Medical"** and commence **resuscitation**.

Note the amount of vaginal blood loss, but bear in mind the possibility of a concealed abruption.

Gentle abdominal examination note the following:

- symphysis fundal height
- lie
- presentation, level of presenting part above the pelvic brim (may indicate placenta praevia)
- uterine tenderness, irritability / activity / tone (may indicate abruption)
- auscultate fetal heart rate; the abnormality or absence of which, if confirmed, may indicate a major abruption.

MANAGEMENT

- Degree of **resuscitation** and urgency will **depend upon the clinical findings**.
- Commence **CTG** if:
  - ø active bleeding continues and /or
  - ø any uterine activity/tenderness and / or
  - ø concern about fetal heart on auscultation.

  Note: Consult obstetric registrar before commencing CTG if the woman is ≤ 24 weeks gestation.
- Site at least one **large bore intravenous access** if:
  - ø known placenta praevia
  - ø active fresh bleeding
  - ø uterine activity / tone present.
- **Blood taken** for full blood picture, group and hold / cross match. If the estimated blood loss is greater than 200ml or there is suspicion of placental abruption consider a coagulation screen.
- **Anti-D immunoglobulin administration** if the woman is Rhesus (D) negative.

  A dose of 625 units should be given as soon as possible, or at least within 72 hours if possible. Anti-D given within 9-10 days may offer some protection if earlier administration is not possible. [4]

  If the woman is Rhesus negative a **Kleihauer test** should be performed to quantify the magnitude of the feto-maternal haemorrhage and ensure an adequate dose has be given. See Clinical Guidelines, Section B, 2.4 Blood grouping, antibody screening and anti-D.
- **Avoid vaginal examination until the location of the placenta is known**. Information regarding placental location will usually be available from previous ultrasound scan reports, otherwise a realtime ultrasound scan should be performed.
- Arrange review with obstetric registrar.

Refer to Clinical Guidelines, Section B, 2.3.2 'Maternal Fetal Assessment Unit quick reference guide for APH' and 'Flow chart of initial assessment of the woman presenting with APH'.

SUMMARY OF MANAGEMENT OPTIONS

Following initial assessment of severity:

- If severe and continuing to bleed.
  - Resuscitate
  - Deliver / empty the uterus
- If mild / moderate and settling or stopped.
  - Establish cause with examination and investigation
  - Specific management of the cause

REFERENCE:

1. Konje JC, Taylor DJ. Bleeding in late pregnancy. In: James DK, Steer PJ, Weiner CP, Gonik B, editors. **High Risk Pregnancy**. Sydney: WB Saunders; 1999. p. 111-128.
2. Department of Health. **Report on confidential enquiries into maternal deaths in the United Kingdom 200-2002**. London: HMSO; 2003.
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4. National Health and Medical Research Council. In: **Guidelines on the prophylactic use of Rh (D) immunoglobulin (anti-D) in obstetrics**. Canberra: Australian Government Printing Service; 2003.