CLINICAL PRACTICE GUIDELINE

Antepartum Haemorrhage (APH)

This document should be read in conjunction with the Disclaimer

Background

APH complicates 2-5% of pregnancies and is defined as bleeding into or from the genital tract after the 20th week of pregnancy. [1]

Identifiable causes of APH are recognised in 50% of cases, and in the other 50% of cases the cause for the APH is indeterminate or unknown. [3] Blood loss is often underestimated and the amount visible may only be a portion of the total volume of the haemorrhage (e.g. with a concealed placental abruption).

Women with a history of APH are at increased risk for adverse perinatal outcomes including small for gestational age and growth restricted fetuses, therefore initiation of serial ultrasounds is recommended. Other risk factors include increased risk for oligohydramnios, premature rupture of membranes, preterm labour and increased rates of caesarean section. Women diagnosed with placenta abruption, [2, 3] or placenta praevia[3] are at increased risk for postpartum haemorrhage

Possible causes include:

Local genital tract and other causes

- blood stained show
- cervical ectropian or erosions
- trauma (post coital), vaginal lesions or grazes
- vulvovaginal varicosities
- haemorrhoids

Placental site causes

- marginal sinus rupture
- placental abruption
- retro-placental haemorrhage
- placenta praevia
- vasa praevia

Unknown causes

Definitions of APH

- Spotting – staining, streaking or blood spotting noted on underwear or sanitary wear
- Minor Haemorrhage – blood loss of 50-1000mL with **no** signs of clinical shock
- Massive Haemorrhage – blood loss greater than 1000 mL **and/or** signs of clinical shock

Clinical assessment:

1. Take a comprehensive history (via phone if not in attendance) noting:

- The onset, amount, colour, consistency, and pattern of the bleeding.
- Any precipitating events (e.g. post coital), including evidence of pain, trauma and any concerns of maternal compromise.
- Whether the membranes have ruptured.
- Uterine tone and activity noting frequency, intensity and duration.
- If the client is aware that she has a low lying placenta
- Fetal movements.
- Document findings.
- If not in attendance (and consulting via phone), recommend immediate referral to the client's support hospital if clinically indicated (see management below).

2. If in attendance – perform an assessment to include:

- Take a comprehensive history as outlined above.
- Review blood loss on clothing, pad or linen.
- Perform baseline maternal observations (BP, pulse, respirations, temperature, conscious state).
- Pain score
- Observe pallor/restlessness
- Review any pathology and USS reports noting the placental location.
- Perform gentle abdominal palpation noting:
  - fundal height
  - fetal lie
  - presentation
  - uterine tone
  - maternal guarding
  - presence of uterine contractions, noting intensity, frequency & duration.
- Fetal activity and fetal heart rate (with a doptone), noting FH range and the presence of accelerations and/or decelerations.
- DO NOT PERFORM a digital vaginal examination.
- Document all findings in the Pregnancy Health Record or Birth book (CMP MR 08).

Management:

The initial assessment will indicate if urgent intervention is required (refer to 'management for moderate/severe haemorrhage/collapse' below).

If the woman is asymptomatic of haemorrhage and vaginal blood loss is minimal:

1. Continue to manage as for normal labour if the pregnancy is at term and determined to be a show.
2. In all other cases consult, refer and transfer to support hospital for obstetric review.
3. Arrange for appropriate transfer to hospital according to severity of maternal condition (refer to CMP guideline 'Transfer from home to hospital').
4. Ensure the woman remains fasted until a formal assessment of maternal and fetal wellbeing has been made.
5. Ensure that all antenatal notes and all blood test results accompany the woman.
6. Document all management and findings.
7. Consider accompanying the woman to hospital with relevant support person, for obstetric assessment.

Management for moderate or severe haemorrhage/ collapse:

1. Ask support person to call for an ambulance immediately.
2. Take a quick history from the woman or the significant other person present to determine the nature of the incident and the duration of time since the onset of the bleed. Concealed placental abruption will present with severe abdominal pain and no visible bleeding.
3. Lay the woman on her left side.
4. Monitor maternal vital signs (respiratory rate, BP, pulse, conscious state, colour) frequently.
5. Commence maternal resuscitation as required.
6. Ensure airway is patent and administer oxygen therapy for maternal resuscitation.
7. Gain IV access, take bloods for FBC and Group and Hold and commence IV fluid resuscitation immediately using Hartmann's solution 1000 mL (following verbal order).
8. Monitor the fetal heart rate using a doptone once woman's condition is stable/ if possible
9. Keep the woman fully informed of all findings and remain calm and supportive.
10. Prepare for immediate hospital transfer.

11. Inform the receiving hospital of imminent emergency admission.
12. Estimate the total blood loss on all clothing, pads and linen.
13. Document all findings and emergency management.
14. Accompany the woman and support person to hospital and give a formal handover to the obstetric team. Ensure that the pregnancy health records and all test results accompany woman.
15. Continue to provide continuity of care as either the primary or support midwife where possible.

Reference

1. Thorogood C, Donaldson C. Challenges in pregnancy. **Midwifery preparation for practice**.2nd ed. Sydney: Churchill Livingstone; 2010. p. 754-817.
2. Royal College of Obstetricians and Gynaecologists. **Antepartum Haemorrhage. Green-top Guideline No 63.** 2011.
3. Krishna A, Chandraharan E. Management of Massive Obstetric Haemorrhage. **Current Women's Health Review.** 2011(7):136-42.

Related policies

1. CMP Transfer from Home to Hospital
2. Midwifery care when a Client Makes a Decision that Is Incompatible with the CMP Midwifery Standard of Practice

Related WNHS policies, procedures and guidelines

KEMH Clinical Guidelines: APH

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