MANAGEMENT OF ANTEPARTUM HAEMORRHAGE (APH)

SCOPE:
All midwives, nurses and obstetricians working in the maternity unit

AUTHOR:
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PURPOSE:
Provide guidance on the appropriate management of women experiencing antepartum haemorrhage (APH) presenting at the maternity unit. This guideline aims to reduce maternal morbidity and mortality associated with APH, and to ensure the wellbeing and safety of the woman and her unborn baby.

DEFINITIONS:
Antepartum Haemorrhage: Bleeding from the genital tract after 20+0 weeks of pregnancy. APH is unpredictable, and at any time the woman's condition may deteriorate rapidly.

CAUSES:
Potential causes of APH include:
Placenta praevia and placental abruption represent the most common causes of APH and can result in both maternal and fetal death. The absence of pain is often regarded as a significant and distinguishing factor between praevia and abruption, although some of women with placenta praevia will have a co-existing abruption. Any pregnant women who presents with abdominal pain and uterine contractions, even a small amount of vaginal bleeding should prompt close maternal and fetal evaluation for placental abruption
Other common causes:
1. Marginal, Edge Bleeds
2. Show
3. Cervicitis
4. Trauma
5. Other- cervical cancer, vasa praevia and genital infections.

ASSESSMENT:
Initial assessment will determine the severity of APH and therefore the management. As part of the assessment you will take a history from the woman to help make a diagnosis ASAP.

History
This should be taken to try and find 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, watery (which may indicate SROM)
- Has bleeding settled/ continuing?
- Nature of any associated pain: continuous, intermittent or worsening
- Abdominal and/or low back pain (note that if posterior placental abruption back pain more likely)
· Presence of fetal movement: description of fetal activity, normal or reduced
· Ultrasound scan: most recent report, check placental site
· Identify risk factors for placental abruption:
  ➢ hypertension / pre-eclampsia
  ➢ coagulation disorders
  ➢ smoking
  ➢ previous abruption
  ➢ IUGR
  ➢ domestic violence
  ➢ abdominal trauma
· Accurate gestation.

Considerations for Abdominal Examination
· Uterine tone and tenderness: a tense or ‘woody’ feel to the uterus can indicate significant abruption and is known as guarding of the uterus. A soft non-tender uterus may indicate lower genital tract cause or placenta praevia.
· Contractions.
· Fundal height.
· Presenting part.
· Relation of presenting part to pelvic brim: if the presenting part is well engaged then placenta praevia is unlikely.
· Check for bruises and trauma.

DO NOT PERFORM A VAGINAL EXAMINATION UNTIL/UNLESS PLACENTA PRAEVIA IS EXCLUDED

MANAGEMENT OF MINOR / MAJOR HAEMORRHAGE
(Minor =50ml, Major <1000 ml)

1. Admit to Delivery Unit and inform consultant obstetrician. Apply SBARR and document in MCIS. Keep accurate documentation at all times.
2. Communicate with the woman and gain informed consent for any procedures
3. Estimate blood loss. If possible weigh pads, inco sheet for accuracy of blood loss measurements. (1g equates to 1ml)
4. Continuous CTG
5. Record baseline observations: pulse, BP, temperature, respiration and oxygen saturation.
6. Take and record regular ongoing observations as indicated and enter on to MEWS chart on MCIS.
7. Assess uterine tone and pain by gentle palpation.
8. Insert IV leur (16 or 18 gauge) and commence intravenous infusion if indicated.
9. Take bloods for:
   - CBC
   - Group and Hold (pink bottle) NB: Name, NHI number & information to be hand-written
   - Antibody screen & Kleihauer if Rh negative (purple bottle, use sticker).
   - Coagulation screen if indicated (blue bottle, use sticker).
   - Cross match 2 units if indicated, this request will require the Blood Bank Form to be signed by consultant.
   - Therefore take bloods using one purple, one pink and one blue blood bottle

10. Review placental site on scan and confirm presentation of fetus

11. Administer Anti-D if rhesus negative if not received in preceding 6 week period

12. Speculum examination to exclude lower genital cause with caution if known placenta praevia.

13. Review regularly for contractions and any further bleeding.

DO NOT PERFORM A VAGINAL EXAMINATION UNTIL/UNLESS PLACENTA PRAEVIA IS EXCLUDED

MANAGEMENT OF SEVERE ANTEPARTUM HAEMORRHAGE (1000 ml +)

1. Admit to Delivery Unit and inform consultant obstetrician, SBARR and document, call 777 team if immediate resuscitation needed, alert paediatrician, anaesthetist and Theatre if C/S needed.

2. Site 2 large bore IV cannulas, size 16 or 18 G and commence intravenous infusion, Plasmalyte or Volulyte.

3. Consider activating massive blood transfusion policy by calling blood bank on 8174 and stating “I am activating the massive transfusion protocol” then collect blood samples using pre-made numbered packs in the MTP box located in the red obstetric emergency trolley

4. Oxygen via rebreathable mask, oxymeter flow on high = 15 L

5. Take bloods for:
   - CBC
   - Coagulation Screen
   - Kleihauer
   - Group and Hold
   - Cross match 4-6 units fresh whole blood (more may be required)
   - Therefore take bloods using one purple, one pink and one blue blood bottle

6. Continuous CTG.

7. Estimate blood loss (see PPH guideline for pictorial guide)

8. Record observations regularly in MCIS– pulse, BP, respiration rate and oxygen saturation every 10 minutes until stable. Record temperature hourly.

9. Place indwelling catheter and measure hourly urine output and record.

10. Place in Trendelenburg position. The head is low and the body and legs are placed in an inclined plane. If unable to tilt the bed then raise the legs manually.
11. For women with placenta praevia if very heavy bleeding persists and birth is unavoidable, it will be necessary to perform a caesarean section Category 1. Use the RED crash section form.

12. Give Anti-D for all APH in Rh negative mothers within 72 hrs.

13. Nil by mouth

14. Transfuse with blood or blood products as ordered by consultant where necessary.

**On Going Considerations:**

Active management of 3rd stage as PostPartum Haemorrhage (PPH) should be anticipated in all women who have experienced APH. Risk-assess using the “traffic light” PPH risk assessment tool (see PPH guideline).

Following an antenatal admission for APH, the O&G will record a management plan in the woman’s records on MCIS for on-going care. It is reasonable to consider birth by 37 to 38 weeks due to increased risk of stillbirth following an APH.

Tocolysis should be used only with extreme caution to delay birth in APH.

- Communicate the possible diagnosis, sensitively but honestly, to the woman and her whanau /family.
- The Pregnancy is now termed as High Risk and ongoing antenatal specialist care is needed.
- A Consultant Anaesthetist should be involved in the Intrapartum care for complications of APH and associated compromise.
- Babies whose mothers have had an APH need to be seen by Paediatrician, to assess for fetal anaemia and compromise.

**ASSOCIATED DOCUMENTS**

- Maternity guidelines: Administration of Antenatal Corticosteroids
- PPH (Post-Partum Haemorrhage)
- DHB Massive Transfusion Adult Protocol

**REFERENCES**


ALSO; course manual (November 2008) Placental abruption.

vaginal-bleeding-in-pregnant-
women?source=machineLearning&search=antepartum+haemorrhage&selectedTitle=1%7E150&sectionRank=3&anchor=H28#H28 11/12/2014


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Date of Approval: 05.04.2018
Next Review Date: 04.04.2021