ANTEPARTUM HAEMORRHAGE (APH) GUIDELINE

1. OPTIMAL OUTCOMES
   - Investigation and minimisation of fetal and maternal morbidity and mortality secondary to APH

2. PATIENT
   - Pregnant woman presenting with vaginal bleeding after 20 weeks gestation and before labour

3. STAFF
   - Registered Midwives
   - Student Midwives
   - Medical Staff

4. EQUIPMENT
   - Cardio tocography (CTG) machine
   - Speculum
   - Light source
   - KY jelly
   - 16 gauge intravenous cannula
   - EDTA and clotted blood tubes
   - Ultrasound machine

5. CLINICAL PRACTICE
   - Assess maternal condition including baseline observations
   - Obtain history
   - Resuscitate woman immediately if required:
     - Call for assistance Medical Emergency Team (MET) or Code Blue
     - Secure airway, breathing, circulation
   - Assess blood loss and measure appropriately
   - Perform abdominal examination
   - Assess fetal condition by:
     - auscultating fetal heart at < 24 weeks gestation
     - applying CTG at ≥ 24 weeks
     - if any concerns perform ultrasound
   - Notify obstetric registrar/consultant
   - Insert intravenous cannula and collect full blood count, Kleihauer and group and hold or cross match and coagulation screen according to blood loss
   - Consider performing an APTS test to ascertain if fetal or maternal blood
   - Check previous ultrasound reports for placental position, if unknown and woman is stable, request ultrasound to determine placental position, fetal growth and well being
   - Perform speculum examination to determine where bleeding is coming from, do not perform a vaginal examination if known placenta previa
   - Consider administration of steroids if 34 weeks or less gestation
   - Insert indwelling catheter for substantial blood loss
   - Perform half hourly maternal observations and measurement of blood loss until stable
   - Consider intravenous fluid replacement
   - Notify paediatric team if delivery is imminent
   - Consider immediate delivery if fetal distress or compromising maternal blood loss
   - Administer Anti D to Rh negative women – 625 IU or more depending on Kleihauer result

6. HAZARDS/SUB-OPTIMAL OUTCOMES
   - Preterm Labour and birth
   - Fetal morbidity and mortality
   - Maternal morbidity and mortality
   - Failure to administer Anti D

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7. DOCUMENTATION
   - Integrated notes
   - Antenatal observation chart
   - Fluid balance chart
   - Partogram if labouring
   - Medication chart
   - ObstetriX

8. EDUCATIONAL NOTES
   - Bleeding in pregnancy remains an important cause of perinatal mortality
   - APH affects 2-5% of pregnancies and is three times more common in multiparous than primiparous women
   - Causes of APH include; sexual intercourse, constipation, placenta previa, placental abruption, infection, vulval or vaginal varices, cervical or uterine polyps, cervical erosion, trauma, carcinoma of the cervix and rarely vasa previa
   - Approximately 15% of women with unexplained APH will go into spontaneous labour within 2 weeks of the initial haemorrhage
   - Having an APH increases the risk of a PPH

9. RELATED POLICIES/PROCEDURES/GUIDELINES
   - Antenatal CTG Guideline
   - Threatened premature labour suppression guideline
   - Rh D Immunoglobulin in Obstetrics Guideline
   - Post partum haemorrhage – prevention and management guideline
   - Vaginal Examination guideline
   - Procedure for calling the RHW Medical Emergency Team guideline

10. REFERENCES
    - Antepartum Haemorrhage – Patient UK. http://www.patient.co.uk/showdoc/40000210