Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

Health
South Eastern Sydney
Local Health District

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SUMMARY	Identification and management of a woman with placenta praevia or low-lying placenta
Key Words	Placenta Praevia, Low-lying Placenta

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Placenta Praevia and Low-lying Placenta — RHW CLIN182

Contents

This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is to provide evidence-based information for the identification, escalation, and management of women with placenta praevia (PP) or low-lying placenta (LLP)

Definitions:

- Placenta praevia = Placenta covering or encroaching upon the internal cervical os[4]
- Low-lying placenta = Placenta within 20mm but not covering the cervical os[4]

2 RESPONSIBILITIES

2.1 Staff (medical, midwifery, nursing & allied health)

Identify, escalate, and manage cases of PP and LLP during pregnancy to ensure evidence-informed care for surveillance, counselling and birth planning (see appendix.1)

3 PROCEDURE

3.1 Screening

- Recommend a morphology ultrasound at 18-20 weeks gestation to ascertain placental location
- Include on the ultrasound form, any history of uterine surgery (e.g. previous caesarean section (CS), myomectomy) to ensure that features of placenta accreta are examined
- Identify woman with a:
  - LLP (≤ 20mm of, but not covering the internal cervical os)
  - PP (Partially or completely covering the internal cervical os)

3.2 Antenatal care LLP

- Reassure woman that 9 out of 10 LLP identified at 18–20-week morphology ultrasound resolves by term[1]
- Reassure woman with a LLP that if she remains asymptomatic, there is no increased risk of adverse outcomes in the mid-trimester and she may continue normal activities such as travel, intercourse and exercise[2]
- Advise woman with an LLP from 36 weeks' gestation that this is not a contraindication to a trial of labour. Mode of birth should be determined through individualised counselling and shared decision-making, considering clinical circumstances and the woman's preferences[10]
- Repeat ultrasound for asymptomatic woman with LLP at 35-36 weeks gestation if she has not had any other incidental ultrasounds in the interim which have already demonstrated

the placenta is no longer low-lying[5]. **Do not order ultrasound earlier as it will frequently need to be repeated**
- Refer to obstetric antenatal clinic (ANC) of usual model of care (MOC) at 36-37 weeks gestation if LLP persists

3.3 Antenatal care PP

- Arrange consultation with obstetric team for discussion of PP after 20 weeks gestation
- Advise woman with PP found at morphology ultrasound, chance of vaginal birth approximately[3]:
  - 79% if placenta reaches internal cervical os
  - 43% if placenta overlaps internal cervical os 0-25mm
  - 0% if placenta overlaps internal os >25mm
- Advise woman with known PP to contact Birth Unit (BU) or immediately present to her nearest BU for assessment if antepartum haemorrhage (APH) or any signs of labour occur[4]. Admission will usually be required and managed as per antepartum haemorrhage (APH) Clinical Business Rule
- Use tocolysis with caution following discussion with obstetric consultant
- Prescribe appropriate prophylaxis for venous thromboembolism for a woman with prolonged inpatient stay
- Individualise advice regarding normal activities based on each woman's clinical circumstances
- Repeat ultrasound at 34 weeks for asymptomatic women with PP[5], unless a prior incidental scan has already shown resolution. **Do not order ultrasound earlier as it will frequently need to be repeated**
- Refer to obstetric ANC of usual MOC at 34-35 weeks gestation if PP persists
- Refer to Antenatal Obstetric Anaesthesia Clinic (AOAC) following third trimester scan if PP still present and planning surgical birth

3.4 Obstetric ANC (34-37 weeks gestation)

- Counsel woman following the third trimester ultrasound, where LLP/PP remains, about the following:
  - The importance of optimising maternal haemoglobin (Hb) and iron stores. Order full blood count (FBC) and iron studies, if > 4 weeks since previous tests, and manage appropriately
  - Increased risk of bleeding/haemorrhage/blood transfusion and admission to hospital
  - Increased risk of preterm labour with APH and subsequent birth, and management options
  - Mode of birth options appropriate to her circumstances
  - Potential for major surgical interventions including hysterectomy
- Document plan and mode of birth after discussion with consultant obstetrician. This may involve a repeat ultrasound and further obstetric ANC visits before deciding mode of birth, particularly with LLP which may continue to resolve as gestation advances[1,6,10]
- Plan caesarean section at:
  - 37 weeks gestation for PP, in the absence of the indication for earlier birth. Consider corticosteroid administration
  - 39 weeks gestation for persistent LLP if woman chooses this option
- Complete Recommendation for Admission (RFA) form and consent at this consultation

- Order a further ultrasound if a change in diagnosis would affect mode of birth or timing of elective CS

3.5 Caesarean Section Pre-anaesthesia clinic (CS PAC)

Anaesthetic Medical Officer

- Confirm woman with PP has attended AOAC
- Ensure anaesthetic consultant who will be present at elective CS is aware of LLP/PP
- Discuss with anaesthetic consultant option of regional versus general anaesthesia and document plan/advice
- Give woman instructions to have blood collected at NSW Health Pathology the day prior to surgery (Ideally). If elective CS is booked for a Monday, blood collection to occur on Saturday morning prior (NSW Health Pathology: Saturday 0800-1200 hours)
- Send blood forms to NSW Health pathology:
  - FBC and group and hold if posterior/lateral LLP
  - FBC and crossmatch 2 units packed cells if PP or anterior LLP and have blood available in theatre

PAC Obstetric Medical Officer

- Ensure most recent ultrasound for LLP/PP is within 2-3 weeks of planned surgery, especially for LLP as these may continue to resolve as gestation advances.
- Ensure the obstetric consultant who will be present at elective CS is aware of LLP/PP. This may involve contacting booking office to ascertain which obstetric consultant to contact.

3.6 Birth

- Ensure pre-operative bloods have been taken and results are available prior to commencement of surgery
- Ensure cross-matched packed cells (if been ordered) are available in theatre prior to commencement of surgery
- Ensure obstetric consultant is present for all births when an anterior LLP/PP is present or any suggestion of an accreta, including previous CS
- Ensure obstetric consultant is present for all births with an obstetric registrar who has NOT yet completed their FRANZCOG written and oral examination when a posterior LLP/PP is present

4 DOCUMENTATION

- Antenatal yellow card
- Medical Records

5 EDUCATION NOTES

- If the placental edge is 20 mm or more on transvaginal ultrasound (TVS), location is normal and managed routinely, with no increased caesarean risk due to haemorrhage[4]
- Diagnosis: TVS for the diagnosis of PP or LLP is superior to transabdominal and transperineal approaches and is safe[4]
- Incidence:
  - LLP seen in 5% of women at morphology ultrasound[4]

- 96% LLP diagnosed in second trimester resolve before 36 weeks; another 2.5% 'clear' the cervix between 36-41 weeks[1]
- PP persisting to term is rare (0.5%)[1]

- Risk factors for PP:[4]
  - Previous PP (recurrence 4-8%)[6]
  - Prior caesarean section or uterine surgery (risk increases with number)
  - Multiple pregnancy
  - Advanced maternal age
  - Multiparity
  - IVF
  - Maternal smoking, cocaine use
- Persistence more likely with:
  - Placenta overlapping the os ≥ 25 mm at 20-23 weeks[3]
  - Posterior placenta[15]
- Risks associated with LLP/PP
  - There is an association between PP and intrauterine growth restriction among multiparous, but not nulliparous, women[7,8]
  - Increased risk of preterm birth with LLP/PP [10,11,12]
  - Postpartum haemorrhage higher (7.6 vs 4.7 %) [2,13,14]
- Corticosteroids recommended for women < 34+6 weeks' gestation if birth likely within seven days as reduces the risk of neonatal respiratory distress syndrome from 26% to 17%[16,17,18]

Birth planning LLP:

- For asymptomatic LLP in the third trimester, mode of birth should be guided by the clinical background and the woman's preferences, supported by ultrasound findings such as the distance between the placental edge and the fetal head position in relation to the leading placental edge on TV ultrasound[4]
- 0-20 mm away from cervical os is associated with a higher CS rate, although vaginal birth is still possible depending on the clinical circumstances[6]
- Mode of birth - if aiming for vaginal birth[10]:
  - LLP 11-20mm from os: 83% success, 15% risk emergency CS
  - LLP 0-10mm from os: 43% success, 45% risk emergency CS

Birth planning PP:

- Symptomatic woman with recurrent APH: manage individually as outlined in antepartum haemorrhage (APH) Clinical Business Rule. Consider admission depending on woman's needs and social circumstances such as distance from hospital, previous bleeding, haematology laboratory results, and transfusion preferences[4]
- Asymptomatic woman in the third trimester: Counsel about the risk of preterm birth and obstetric haemorrhage - care should be tailored to individual needs[4]

6 RELATED POLICIES/PROCEDURES

- Iron Deficiency, Anaemia and Haemoglobinopathies in Pregnancy
- Antepartum Haemorrhage (APH)
- Caesarean Birth - Maternal preparation and receiving the neonate(s)
- Corticosteroids - for women at risk of preterm birth or with a fetus at risk of respiratory distress- antenatal- MoHGL2022_006

- Next Birth after Caesarean Section (NBAC)
- Venous Thromboembolism Prevention (VTE) https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety/vte-prevention
- Specialist Obstetrician – Ward Rounds, Handover, Conditions and Procedures Requiring Attendance
- RHW Close Observation Unit: Admission, Escalation, Transfer and Discharge
- Postpartum Haemorrhage (PPH) - Prevention and Management
- Blood Products - Management of pregnant woman unable to use blood products
- Critical Bleeding Protocol - POWH/RHW

7 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers, or other culturally specific services

8 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters

9 NATIONAL STANDARDS

- Standard 5 - Comprehensive Care

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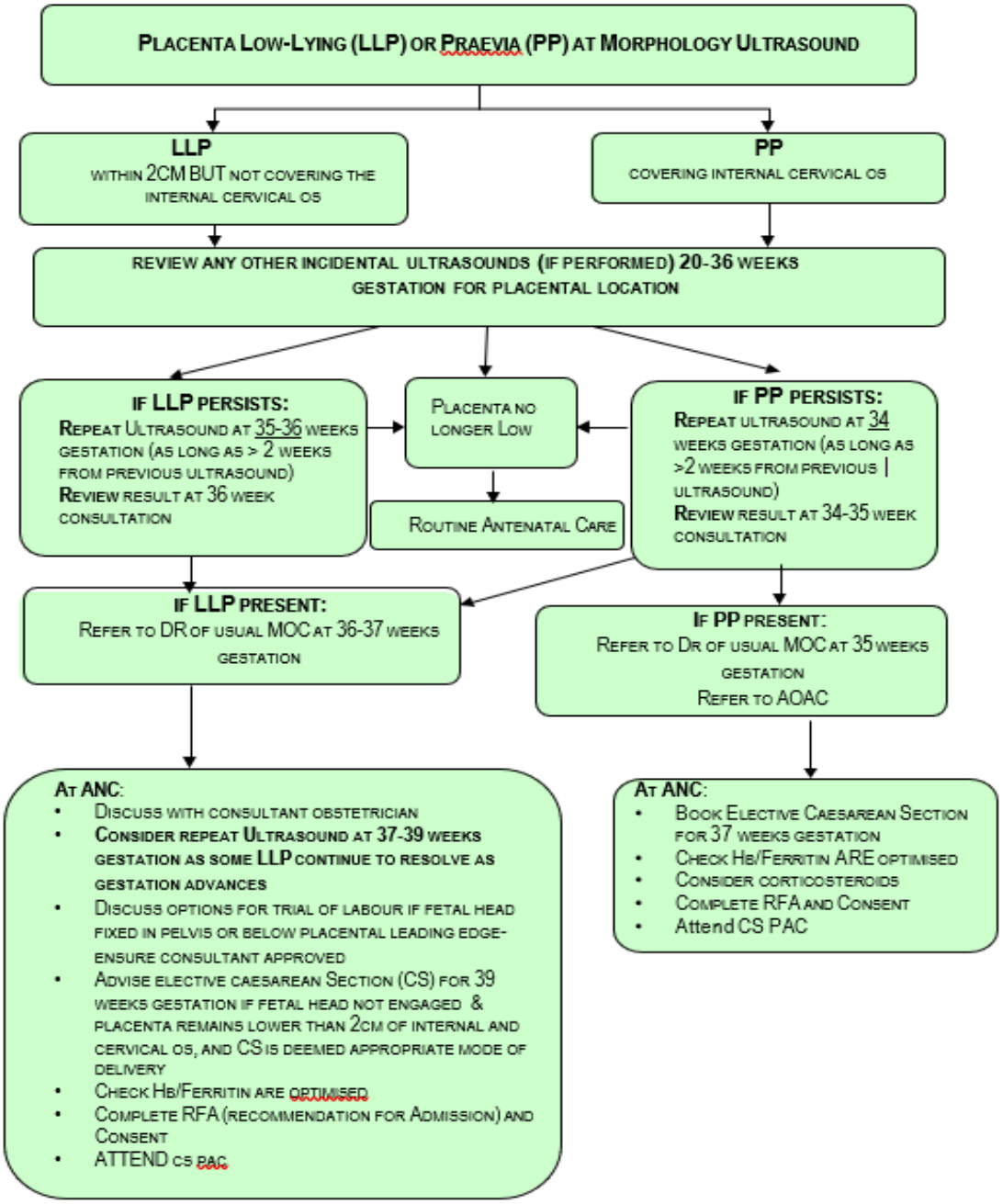
11 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Oct 2025	V1	Draft
Nov 2025	V1	Final
Nov 2025	V1	RHW BRGC

Appendix A


PLACENTA LOW-LYING (LLP) OR PRAEVIA (PP) AT MORPHOLOGY ULTRASOUND
LLP
WITHIN 2CM BUT NOT COVERING THE INTERNAL CERVICAL OS
PP
COVERING INTERNAL CERVICAL OS
REVIEW ANY OTHER INCIDENTAL ULTRASOUNDS (IF PERFORMED) 20-36 WEEKS GESTATION FOR PLACENTAL LOCATION
IF LLP PERSISTS:
REPEAT ULTRASOUND AT 35-36 WEEKS GESTATION (AS LONG AS > 2 WEEKS FROM PREVIOUS ULTRASOUND)
REVIEW RESULT AT 36 WEEK CONSULTATION
PLACENTA NO LONGER LOW
ROUTINE ANTENATAL CARE
IF PP PERSISTS:
REPEAT ULTRASOUND AT 34 WEEKS GESTATION (AS LONG AS >2 WEEKS FROM PREVIOUS ULTRASOUND)
REVIEW RESULT AT 34-35 WEEK CONSULTATION
IF LLP PRESENT:
REFER TO DR OF USUAL MOC AT 36-37 WEEKS GESTATION
IF PP PRESENT:
REFER TO DR OF USUAL MOC AT 35 WEEKS GESTATION
REFER TO AOAC
AT ANC:
DISCUSS WITH CONSULTANT OBSTETRICIAN
CONSIDER REPEAT ULTRASOUND AT 37-39 WEEKS GESTATION AS SOME LLP CONTINUE TO RESOLVE AS GESTATION ADVANCES
DISCUSS OPTIONS FOR TRIAL OF LABOUR IF FETAL HEAD FIXED IN PELVIS OR BELOW PLACENTAL LEADING EDGE- ENSURE CONSULTANT APPROVED
ADVISE ELECTIVE CAESAREAN SECTION (CS) FOR 39 WEEKS GESTATION IF FETAL HEAD NOT ENGAGED & PLACENTA REMAINS LOWER THAN 2CM OF INTERNAL AND CERVICAL OS, AND CS IS DEEMED APPROPRIATE MODE OF DELIVERY
CHECK HB/FERRITIN ARE OPTIMISED
COMPLETE RFA (RECOMMENDATION FOR ADMISSION) AND CONSENT
ATTEND CS PAC
AT ANC:
BOOK ELECTIVE CAESAREAN SECTION FOR 37 WEEKS GESTATION
CHECK HB/FERRITIN ARE OPTIMISED
CONSIDER CORTICOSTEROIDS
COMPLETE RFA AND CONSENT
Attend CS PAC