

## **ANTEPARTUM HAEMORRHAGE (APH)**

*This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.*

### **1. AIM**

- 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

### **3. STAFF**

- Medical and midwifery staff

### **4. EQUIPMENT**

- Cardiotocography (CTG) machine
- Fetal Heart Monitor
- Speculum
- Light source
- Lubricant
- 16 gauge intravenous cannula
- FBC (purple top tube), Group and Hold (pink top tube),  $\pm$  Clotting factors (blue top tube).

### **5. CLINICAL PRACTICE**

- Obtain history
- Assess maternal condition including baseline observations
- Resuscitate woman immediately if required:
  - Secure airway, breathing, circulation
  - Call for a Clinical Review or Rapid Response System as appropriate.
- Assess blood loss and measure appropriately
- Perform abdominal examination
- Assess fetal condition by:
  - auscultating fetal heart at < 24 weeks gestation
  - applying CTG at  $\geq$  24 weeks
- Notify appropriate obstetric team member
- Insert a 16 gauge intravenous cannula and collect full blood count, Kleihauer, group and hold or cross match, and coagulation screen according to blood loss
- Check previous ultrasound reports for placental position. If unknown and woman is stable, request ultrasound to determine placental position (as well as fetal growth and wellbeing)
- Examine vulva and vagina and perform speculum examination to determine source of bleeding and to determine cervical dilatation. Do not perform a digital vaginal examination until placenta praevia is excluded
- Insert indwelling urinary catheter if there is substantial blood loss
- Consider intravenous fluid replacement
- Perform half hourly maternal observations and measurement of blood loss until stable
- Consider administration of steroids if 34 weeks or less gestation
- Consider immediate delivery if fetal distress or compromising maternal blood loss
- Notify paediatric team if delivery is imminent

## CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Safety Committee  
16 April 2015

### ANTEPARTUM HAEMORRHAGE (APH) cont'd

- Administer Anti D to Rh negative women – 625 IU (or more depending on Kleihauer result)
- Recommend admission for women if blood loss is heavier than spotting or bleeding is ongoing
- Consider admission for all women under 37 weeks gestation
- Recommend discharge home for women > 37 weeks gestation, who have presented with spotting if:
  - a reassuring clinical assessment
  - they are no longer bleeding
  - significant cause (e.g. placenta praevia, abruption) has been excluded
- Advise to book follow up care with usual care provider within a week of discharge
- Advise to contact hospital immediately if bleeding reoccurs

#### 6. DOCUMENTATION

- Integrated clinical notes
- Standard Maternal Observation Chart
- Fluid balance chart
- Partogram if in labour
- Medication chart
- ObstetriX

#### 7. EDUCATIONAL NOTES

- Causes of APH include; sexual intercourse, constipation, placenta praevia, placental abruption, infection, vulval or vaginal varices, cervical or uterine polyps, cervical ectropion, trauma, carcinoma of the cervix, vasa praevia, uterine rupture, and a 'show'
- There are no consistent definitions of severity of an APH, however RCOG defines blood loss by a combination of volume and signs of clinical shock to guide management:
  - Spotting: staining, streaking or blood spotting noted on underwear or sanitary protection
  - Minor Haemorrhage: blood loss less than 50ml that has settled
  - Major Haemorrhage: blood loss of 50-1000ml, with NO signs of clinical shock
  - Massive Haemorrhage: blood loss greater than 1000ml and/or signs of clinical shock
- 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 nulliparous women
- ≤ 20% of very preterm infants are born in association with APH
- 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 postpartum haemorrhage (PPH)
- Ultrasound can be used to diagnose placenta praevia but does not exclude abruption.
- Placental abruption is a clinical diagnosis and there are no sensitive or reliable diagnostic tests available. Ultrasound has limited sensitivity in the identification of retroplacental haemorrhage
- The value of an Apt-Downey (APTS) test is negligible in current practice <sup>4</sup>

## **ANTEPARTUM HAEMORRHAGE (APH) cont'd**

### **8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP**

- Cardiotocograph (CTG) - antenatal
- Threatened premature labour suppression
- Rhesus D Immunoglobulin in Obstetrics
- Postpartum haemorrhage – prevention and management
- Vaginal Examination
- Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT & MATERNITY Inpatient

### **9. RISK RATING**

- Medium

### **10. REFERENCES**

1. Antepartum Haemorrhage – Patient UK. <http://www.patient.co.uk/showdoc/40000210>  
Hall, J. (2005). Midwifery Basics: complications in pregnancy. The Practising Midwife 8(9) 29-32
2. Ngeh, N. & Bhide, A. (2006). Antepartum Haemorrhage. Current Obstetrics & Gynaecology, 16, 79-83.
3. Antepartum Haemorrhage, RCOG, Greentop Guideline # 63, 1<sup>st</sup> Edition, Nov. 2011
4. Placenta Praevia, Placenta Praevia Accreta and Vasa Praevia: Diagnosis and Management RCOG, Greentop Guideline # 27, 3<sup>rd</sup> Edition Jan 2011
5. Complications of Pregnancy: Antepartum Haemorrhage (APH), KEMH O&G Clinical Guidelines Section B. April 2012

### **REVISION & APPROVAL HISTORY**

Amended August 2019 – change to PACE  
Reviewed and endorsed Maternity Services LOPs 31/3/15  
Approved Patient Care Committee 8/5/08  
Obstetrics Clinical Guidelines Group March 2008

**FOR REVIEW : MARCH 2018**