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), ± Clotting factors (blue top tube).

5. CLINICAL PRACTICE
   • Obtain history
   • Assess maternal condition including baseline observations
   • Resuscitate woman immediately if required:
      o Secure airway, breathing, circulation
      o Call for a Pace 1 or Pace 2 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 ≥ 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
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

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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
   5. Complications of Pregnancy: Antepartum Haemorrhage (APH), KEMH O&G Clinical Guidelines Section B. April 2012

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