Approved by Quality & Patient Safety Committee
16 April 2015

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:
    - Secure airway, breathing, circulation
    - 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

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- 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
- $\leq$ 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 [4]

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, 1st Edition, Nov. 2011
4. Placenta Praevia, Placenta Praevia Accreta and Vasa Praevia: Diagnosis and Management RCOG, Greentop Guideline # 27, 3rd Edition Jan 2011
5. Complications of Pregnancy: Antepartum Haemorrhage (APH), KEMH O&G Clinical Guidelines Section B. April 2012

REVISION & APPROVAL HISTORY

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