Antepartum Haemorrhage (APH) (excluding Placenta Praevia)

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Document Type	Guideline
Risk of non-compliance	may result in significant harm to the patient/Te Whatu Ora
Function	Clinical Practice, Patient Care
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• Organisation(s)	Te Whatu Ora | Te Toka Tumai Auckland
• Directorate(s)	Women's Health
• Department(s)	Maternity
• Used for which patients?	Maternity patients with potential for (or actual) APH
• Used by which staff?	All maternity practitioners working in or having access to National Women's Health services.
• Excluded	
Keywords	PV bleed, placenta, praevia, abruption
Author	Charge Midwife - Ward 98/96
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• Owner	Service Clinical Director - Secondary Maternity Services
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Contents

1. Purpose of guideline

The purpose of this guideline is to:

- ensure the provision of evidence based care to women/people and their babies.
- reduce or prevent complications associated with antepartum haemorrhage (APH).

2. Definitions

Term	Definition
Antepartum Haemorrhage (APH)	Defined as bleeding from, or into, the genital tract, occurring from 24 weeks of pregnancy and prior to the birth of the baby.
Minor haemorrhage	Blood loss less than 50 mls that has settled
Major haemorrhage	Blood loss of 50-1000 mls, with no signs of clinical shock
Massive haemorrhage	Blood loss greater than 1000 mls and/or signs of clinical shock
Recurrent APH	A term used when there are episodes of APH on more than one occasion.

3. Initial management

Response should be appropriate to the degree of compromise to the mother or fetus.

- Assess pregnant woman/person's general condition using the ABC approach
- Monitor vital signs and document on MEWS chart
- Estimate blood loss
- Commence fetal monitoring (method will depend on gestation)
- Send urgent bloods for FBC, Coagulation, Fibrinogen, group and screen +/- crossmatch. Kleihauer if Rh neg.
- If in AED, follow Acute Obstetric Pathway.
- If pregnant woman/ person is haemodynamically unstable, call 777 Adult Code Red + Obstetric Emergency and:
  - place two 16 gauge IV leurs and commence crystalloid and:
  - follow the Adult Massive Haemorrhage Pathway (Obstetric MHP arm)
- Early involvement of Consultant obstetrician, Anaesthetist and Neonatologist

4. Assessment

4.1 History

- Amount of blood loss.
- Abdominal pain
- Fetal movements.
- Any provoking incident (e.g. trauma, coitus, motor vehicle accident)
- Past history including any bleeding in the current pregnancy, estimated date of delivery, smear history.
- Screen for family violence.

4.2 Examination

- Abdominal examination noting uterine tenderness and tone, fundal height, contractions, fetal lie.

- Speculum examination: amount of bleeding / cervical dilatation / cervical lesion. **Do not** perform a digital examination before excluding.

4.3 Investigations

- Auscultate the fetal heart (FH) / CTG dependent on gestation.
- Ultrasound scan (USS) to confirm FH present and placental site if unsure.
- Review USS report

5. Restoration of circulating blood volume

- Establish IV access with two 16 gauge cannulas. Send bloods as directed above (consider only one cannula for minor APH).
- Commence crystalloid fluid replacement.
- Insert indwelling catheter and record urine output hourly on fluid balance chart. Output should remain ≥ 30 mls per hour.
- Consider need for blood transfusion.

6. Control of bleeding

Consider mode of delivery. If maternal haemodynamic state can only be improved by delivery this should be considered irrespective of gestational age. See section 10 Timing and mode of birth.

7. Ongoing care for minor APH

- Admit for assessment and observation and discharge if no further bleeding for > 24 hours.
- If spotting only, may be discharged same day if settled after assessment (unless praevia).
- Close fetal surveillance is necessary to identify small for gestational age (SGA) – arrange a follow up growth scan in two weeks with follow-up in clinic
- Correct and maintain Haemoglobin levels.
- Consider cervical smear/referral to Colposcopy.

8. Fetal considerations

- Consider corticosteroids if gestation ≤ 34+6 weeks.
- If birth is imminent and the gestation is ≤ 30 weeks consider magnesium sulphate for neuroprotection
- Give patient information leaflet “Your baby’s movements and what they mean”.

9. Maternal considerations

- Consultation for minor APH with clear follow up plan.
- Debrief the pregnant woman/person and her whanau after major APH.
- Rh negative women – take Kleihauer for an estimation of feto-maternal haemorrhage and to confirm the amount of Anti D immunoglobulin required in total.

10. Timing and mode of birth

10.1 Timing of birth

The timing of birth must weigh up the risk of the maternal condition and prematurity against those of continuing the pregnancy.

Consider:

- Gestational age
- Fetal condition
- Severity of abruption – blood loss, clinical signs and symptoms of haemorrhagic shock along with features of concealed blood loss such as abdominal pain and tenderness.
- Co-existent conditions such as pre-eclampsia, placental insufficiency or SGA.
- If abruption is suspected:
    - greater than 36+0 weeks gestation – even if bleeding appears to be minimal, delivery is recommended due to the risk of further, possibly catastrophic abruption.
    - between 32 and 35+6 weeks gestation – conservative management can be considered for mild placental abruptions with no evidence of fetal compromise
    - below 32 weeks gestation – conservative management may be considered, even in the presence of substantive revealed bleeding or significant uterine tenderness unless evidence of maternal or fetal compromise.

If there is evidence of fetal compromise or coagulopathy, birth should be expedited. Fetal death in the presence of APH indicates a significant abruption, birth should be expedited, and maternal compromise anticipated.

10.2 Mode of birth and postpartum management

If the bleeding is significant but the woman is stable, the CTG is normal, and the possibility of placenta praevia has been excluded then vaginal birth can be attempted.

- Continuous electronic fetal heart rate monitoring is indicated.
- Ensure the availability of blood products in the event of catastrophic bleeding.
- Active management of the third stage of labour due to the significant risk of postpartum haemorrhage.
- Refer to Postpartum Haemorrhage (PPH) – Prevention and Management guideline and Massive Haemorrhagic Pathway – Adult guideline.

11. Practical considerations

The initial assessment may occur on either Women's Assessment unit (WAU) or the Labour and Birthing Suite (LBS) depending on gestation and severity of the APH.
The consultant on call for WAU is to be informed of the woman's admission. The WAU consultant will liaise with the LBS consultant as needed.
LMCs are responsible to undertake the initial assessment in WAU or LBS and consult with WAU team when necessary.
There should be a transfer of clinical responsibility to the WAU SMO following the initial assessment of the woman if she is admitted to an inpatient ward.

Handover of care and responsible clinician should be highlighted and authorised on Badgernet. Responsible Clinician should be visible in the top banner.
Iron stores must be optimised with a low threshold for iron infusion.

12. Supporting evidence

- Israelsohn, N. (2015). Antepartum haemorrhage. In M. Permezel, S. Walker, & K. Kyprianou (Eds.) *Beischer & MacKays Obstetrics, gynaecology and the newborn* (4th ed., pp. 85-90). Elsevier.
- Neilson J. P. (2003). Interventions for treating placental abruption. *The Cochrane Database of Systematic Reviews, 2003*(1), CD003247. https://doi.org/10.1002/14651858.CD003247
- Neilson J. P. (2003). Interventions for suspected placenta praevia. *The Cochrane Database of Systematic Reviews, 2003*(2), CD001998. https://doi.org/10.1002/14651858.CD001998
- Royal College of Obstetricians and Gynaecologists. (2011). Antepartum haemorrhage. Green-top Guideline No. 63. https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/antepartum-haemorrhage-green-top-guideline-no-63/

13. Associated documents

- Access Holders in Women's Health
- Acute Caesarean Section – Pre, Peri, and Post-op Care
- Anti-D Administration
- Antenatal Fetal Heart Rate (FHR) Monitoring
- Deceased – Stillbirth Investigation and Follow Up
- Group & Screen Requirements in Maternity
- Hypertension - Antenatal, Intrapartum and Postpartum
- Induction of Labour (IOL) – Clinical Guidance
- Induction of Labour Policy
- Informed Consent
- Intra-Operative Cell Salvage (IOCS) – Obstetrics
- Massive Haemorrhagic Pathway – Adult
- Placenta Praevia and Placenta Accreta Spectrum
- Postpartum Haemorrhage (PPH) – Prevention and Management
- Registrars Guidelines for Support in Obstetrics and Gynaecology
- Small for Gestational Age and Fetal Growth Restriction from 34 weeks – Detection and Management
- Women's Assessment Unit (WAU) – AED Process for Obstetric Patients Over 20 Weeks

Patient information

- Your baby's movements and what they mean https://www.healthnavigator.org.nz/media/7231/your-babys-movements-and-what-they-mean-english.pdf

14. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Te Toka Tumai Auckland guideline to adapt it for safe use

within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

15. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.