Antepartum Haemorrhage Management Guideline (MATY007)	
Type: Guideline	HDSS Certification Standard:
Issued by: Maternity PPG Group	**Version:** 1.3
Applicable to: HVDHB Maternity	**Contact person:** O&G SMO
Lead DHB: HVDHB	**Level:**

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose:

The purpose of this guideline is to: provide evidence based care to women and their babies, and establish a consistent local approach to care.

Scope:

For the purposes of this document, staff will refer to:

All staff within Hutt Valley DHB. This includes staff not working in direct contact with patients/consumers. Staff are taken to include anyone engaged in working to the Hutt Valley DHB. This may include but is not limited to:

- Employees irrespective of their length of service
- Agency workers
- Self-employed workers
- Consultants
- Third party service providers, and any other individual or suppliers working for [organisation], including personnel affiliated with third parties, contractors, temporary workers and volunteers
- Students

Definitions:

Antepartum haemorrhage is defined as bleeding into and from the genital tract after 24 weeks of pregnancy until the birth of the baby (NICE, 2011). In practice, all women beyond 20 weeks should be assessed along the lines suggested.

APH	Antepartum Haemorrhage
FBC	Full Blood Count
FHR	Fetal Heart Rate
STI	Sexually Transmitted Infections
Hb	Haemoglobin
CTG	Cardiotocograph

Referrals

Obstetric Referral Guidelines ('Section 88') considerations:

Code	*Condition*	*Description*	*Referral category*
4004	Antepartum haemorrhage	-	Consultation

Causes

Placenta praevia Bleeding from separation of an abnormally situated placenta. (The placenta lies partly or completely in the lower uterine segment)

Placental abruption Bleeding from separation of a normally situated placenta.
Bleed can be concealed.

Incidental causes Bleeding can arise from some other part of the birth canal e.g. cervical ectropion or polyps etc.

There are no consistent definitions of the severity of APH.

Blood loss is known to be underestimated and APH may often be concealed. It is therefore important to assess for signs of clinical shock.

It is recommended that pregnant people be advised to report all vaginal bleeding to their LMC. Pregnant people known to be at high risk of haemorrhage should be managed in centres with facilities for blood transfusions and intensive care.

Assessment

⚠ **Admit to Birthing Suite and be seen as a priority**

⚠ **First establish whether urgent intervention is required to manage maternal or fetal compromise**

Consider supports and chaperones when asking sensitive questions such as:

- Is the pregnant person in hypovolaemic shock?
- An approximate assessment of the blood lost: people should be asked to bring in towels and pads.
- Was the bleeding associated with pain prior or during the bleed?
- Any fetal movements since bleed?
- Any previous bleeding during the pregnancy?
- Any contractions?
- Any recent history of sexual intercourse (consensual or non-consensual)?
- Any history of STI?
- Any recent history of physical trauma?
- Any history of domestic violence?
- Any symptoms of pre-eclampsia?
- What was the last Hb?

Important points in the examination are:

- Signs of hypovolemic shock
- Fetal viability/CTG
- Signs of membrane rupture
- Signs suggestive of placenta praevia:
    - Malpresentation
    - Minimal tenderness
    - Unengaged head
- Signs suggestive of abruption:
    - Pain and tenderness
    - Co-existing pre-eclampsia / pregnancy induced hypertension / chronic (essential) hypertension
    - Rigid board-like / "woody" abdomen
- Avoid vaginal examination in known placenta praevia / low lying placenta. If placental position is unknown ie has not yet had second trimester scan for placental location
- A gentle speculum examination should be carried out by the obstetric team as part of the initial assessment of the pregnant person

If pregnant person and baby able to tolerate labour:

- Consider the need for Paediatric SMO and Obstetric SMO for the birth
- Continuous CTG in labour
- Consideration of caesarean section if bleeding heavy, or if maternal/fetal compromise
- Active management of third stage required and anticipate PPH
- Record blood loss at delivery
- Keep pregnant person/whānau/family informed
- If fetal death is confirmed, vaginal birth is the recommended mode for most, provided maternal condition is stable. But Caesarean Section may need to be considered in some.
- Anti-D prophylaxis for rhesus negative women (refer to guideline)

Moderate/Severe bleeding (principles of management)

⚠ **IF MAJOR BLEED – refer Massive Obstetric Haemorrhage (MATY037) Policy**

1. Call for help, ring emergency bell, ring 777 and state **OBSTETRIC EMERGENCY (AND NEONATAL EMERGENCY if birth imminent), venue and room number**
2. Start with an ABC approach
    - Secure airway
    - Maternal O_2 via non-rebreather mask
    - Initial circulation assessment, then maternal pulse, BP, RR and O_2 sats every 15 minutes if active bleeding and document on a MEWS chart

3. Cannulate size two 16g IV cannulae, take 20mL blood
    - FBC, cross-match. If bleeding continues, transfusion should start as quickly as possible.
    - Renal function, LFTs, Clotting studies and Kleihauer should be obtained.
4. Commence clinical assessment
    - Vaginal assessment and blood loss (weigh if necessary 1ml = 1g)
    - Assess for Contractions / ROM / Abdominal or back pain / Rigid abdomen
5. Inform Special Care Baby Unit (SCBU) staff
6. Early ultrasonic evaluation of placental site (if not previously documented)
7. Consider inserting an indwelling catheter into the bladder, measure urine hourly which is maintained at 0.5 mls/kg/hour. If it is less than 0.25 mls/kg/hour for more than 2 hours notify the obstetrician on call. (BMJ, 2009)
8. Consider steroids if preterm gestation (refer to steroid guideline)
9. If APH is associated with ROM consider vasa praevia
10. Tocolysis should not be used in major APH

References

ALSO, (2000). *Advanced Life Support in Obstetrics.* USA: AAFP

Konje, J. C., Taylor, D.J. Bleeding in late pregnancy. In James, D.K., Steer, P.J., Weiner, C.P. & Gonik, B. (2000). *High risk pregnancy: Management options 2nd ed*. London: W.B Saunders.

Lindsay, P. Bleeding in Pregnancy. In Henderson, C. & McDonald, S. eds. (2004). *Mayes Midwifery A textbook for midwives 13th ed*. London: Balliere Tindall.

British Journal of Midwifery, February 2009, vol 17, no 2

Ministry of Health. (2012) Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington: Ministry of Health

RCOG APH (Green-top Guideline No.63). November 2011.

Related Documents:

- Fetal heart rate monitoring in the antenatal and intrapartum period MATY022
- Massive Obstetric Haemorrhage policy MATY037
- Transfer of women from Hutt Valley DHB to Capital and Coast DHB MATF068
- Postpartum Haemorrhage policy MATY058
- Placenta praevia policy MATY049

Keywords for searching:

1. Antepartum haemorrhage

2. Haemorrhage

3. Pregnancy

4. Bleeding

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a pregnant person can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Tangata Whenua Statement

The Women's Health Service recognises the rights and responsibilities of Māori as tangata whenua and Treaty Partners. This allows and acknowledges the importance of cultural diversity in all aspects of our care and practice in Aotearoa New Zealand.

As stated in Te Pae Amorangi (Hutt Valley DHB Māori Health Strategy) 2018-2027, Hutt DHB as a Crown agency is committed to our role in maintaining active relationships with iwi, under Te Tiriti o Waitangi. This strategy recognises the established principles of Partnership, Participation and Protection and recognises steps towards the reviewed interpretation of Te Tiriti principles to date (from the Wai 2575 claim into health). These are tino rangatiratanga, equity, active protection, partnership and options.

Attention in particular is drawn to:

- **Article one – Kāwanatanga**: actively engaging and working alongside with local iwi through the Hutt Valley Māori Health Unit
- **Article two – Tino Rangatiratanga**: Self-autonomy, self-determination; the responsibility to enable Māori to exercise their authority over their own health, determinants and definition of health
- **Article three – Ōritetanga**: equal health outcomes of peoples; ensuring that policy, guidelines or programmes do not further perpetuate any inequity
- **Article four (the 'oral clause') – Wairuatanga**: spirituality; thriving as Māori and the importance of health providers understanding health in te ao Māori (the Māori world), acknowledging the interconnectedness and inter-relationship of all living and non-living things.

Management of antepartum haemorrhage (flowchart)

On admission

- Assess degree of bleeding (weighing 1ml=1g)
- Consider cause
- Check maternal observations (Maternity Early Warning)

Causes

- Placenta praevia
- Abruption – concealed or revealed
- Marginal bleed
- Local causes