HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Antepartum Haemorrhage Policy

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:

- Establish a local approach to care, that is evidence based and consistent
- Inform good decision making
- Provide safe and effective care for women and their babies experiencing this condition

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff
- Neonatal staff

Definitions

APH	Antepartum Haemorrhage
CBC	Complete Blood Count

Introduction

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.

Causes:

Placenta praevia	Bleeding from separation of an abnormally situated placenta. (The placenta lies partly or completely in the lower uterine segment) Tend to have smaller 'warning bleed' prior to labour
Abruptio placenta	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 erosion, cervical polyps etc.

If a local cause can be seen an ultra sound can be arranged on a non-urgent basis.

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 women be advised to report all vaginal bleeding to their LMC. Women known to be at high risk of haemorrhage should be managed in centres with facilities for blood transfusions and intensive care.

Referral Guidelines
See the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) MOH, 2012.

Women need to be admitted to Delivery Suite and be seen as a priority. An identity bracelet should be applied and admission documentation completed.

Assessment
First establish whether urgent intervention is required to manage maternal or foetal compromise.

- An approximate assessment of the blood lost: women should be asked to bring in towels and pads.
- Was the bleeding associated with pain prior or during the bleed?
- Any foetal movements since bleed?
- Is the mother in hypovolaemic shock?
- Any previous bleeding during the pregnancy?
- Any contractions?
- Any recent history of sexual intercourse?
- 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:

- Foetal viability/heart rate.
- Degree of anaemia in woman.
- Degree of shock in woman.
- 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

    - High blood pressure (pre eclampsia/PIH/essential hypertension)
- Rigid board-like abdomen
- Early scan in Delivery Suite if possible.
- A **digital** vaginal examination of cervical status is not carried out as part of the initial assessment. It may be performed at the discretion of the consultant, and this may be in theatre with preparation for immediate caesarean section.
- A gentle speculum examination should be carried out by the obstetric team as part of the initial assessment of the woman.
- The consultant will formulate plan of care.

Moderate bleeding

- Call for help, ring emergency bell, ring 777 and state **This is a <u>CODE 2 EMERGENCY</u>, venue and room number**
- CBC and cross-match if bleeding continues. Transfusion should start as quickly as possible.
- Clotting studies and Kleihauer should be obtained.
- Cannulate size 16g x2
- Commence CTG if appropriate
- Maternal pulse, BP every 15 minutes if active bleeding
- Maternal O2 via non-rebreather mask
- Vaginal blood loss (weigh if necessary 1ml = 1g)
- Contractions
- Rigid abdomen
- Pain
- Inform Special Care Staff.
- **Early** ultrasonic evaluation of placental site.
- Insert 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 obs on call.
  (BMJ, 2009)

If woman 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/foetal compromise.
- Active Management of third stage required
- Record blood loss at delivery.
- Keep whānau/family informed

IF MAJOR BLEED – refer Major Obstetric Haemorrhage Policy

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.
REFERENCES
(*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

Associated policies and guidelines

EFM Guidelines
Management of Massive Obstetric haemorrhage policy
Transfer of women from Hutt Valley DHB to Capital and Coast DHB policy
Management of PPH policy
Management Placenta praevia protocol

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 woman 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).

Appendix 1

Management of antepartum haemorrhage flowchart

On admission
- Assess degree of bleeding (Weighing 1ml=1g)
- Consider cause
- Check maternal obs
- Check foetal heart (CTG)

CAUSES
- Placenta praevia
- Abruption – concealed or revealed
- Marginal bleed
- Local causes
- Vasa praevia (rare)
- Heavy 'show'

DEFER VAGINAL EXAMINATION UNTIL PLACENT PRAEVIA EXCLUDED

MINOR APH
- Mild pain/tenderness
- Maternal obs and FHR normal

MODERATE
- Pain (if present) moderate
- Maternal obs and FHR normal

MAJOR
- Marked abdominal pain or tenderness
- FHR abnormalities

- IV Cannula **NOT** required
- Take CBC
- Group & Hold
- Kleihauer

- IV Cannula 16G
- Take CBC and Clotting Studies
- APTT, INR
- Kleihauer
- Group & Hold

Refer to Massive Haemorrhage

Ultrasound Scan
- Exclude placenta praevia
- Exclude retroplacental clot
- (establish baseline growth)

- If praevia IV 16 G access x2
- Cross match 2 Units

- Speculum examination to rule out local causes

- Give Anti -D If Rh NEG