HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Placenta Praevia 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

- Establish a local approach to care, that is evidenced based and consistent
- Inform good decision making
- Provide safe and effective care for women and their babies who are effected by this condition

Scope

To all medical, midwifery and nursing staff employed by the Surgical, women's and children's directorate, and other practitioners holding an access agreement.

Definitions

Placenta praevia - the placenta is inserted wholly or in part into the lower segment of the uterus. It is classified by ultrasound imaging - if the placenta lies over the internal cervical os, it is a major praevia; if the leading edge of the placenta is in the lower uterine segment but not covering the cervical os, minor or partial praevia exists.
A morbidly adherent placenta includes **placenta accreta**, increta and percreta as it penetrates through the decidua basalis into and then through the myometrium, but for ease of description the term accreta will be used in this guideline as a general term for all of these conditions.

Vasa praevia describes fetal vessels coursing through the membranes over the internal cervical os and below the fetal presenting part, unprotected by placental tissue or the umbilical cord. This can be secondary to a velamentous cord insertion in a single or bilobed placenta (vasa praevia type 1), or from fetal vessels running between lobes of a placenta with one or more accessory lobes (vasa praevia type 2). Unlike placenta praevia, vasa praevia carries no major maternal risk, but is associated with significant risk to the fetus. When the fetal membranes are ruptured, either spontaneously or artificially, the unprotected fetal vessels are at risk of disruption with consequent fetal haemorrhage. Vasa praevia therefore often presents with fresh vaginal bleeding at the time of membrane rupture and fetal heart rate abnormalities such as decelerations, bradycardia, a sinusoidal trace or fetal demise (RCOG Green-top Guideline No. 27).

Clinical suspicion

For women who have previously had a caesarean section, it is important to rule out placenta accreta using antenatal imaging by colour flow Doppler ultrasonography, or MRI and Doppler ultrasound. Especially when there is an anterior placenta praevia.
Clinical suspicion of placenta praevia should be raised in the event of any woman experiencing vaginal bleeding after 20 weeks gestation. A high presenting part or abnormal lie, painless and unprovoked bleeding should raise the suspicion of placenta praevia irrespective of previous imaging results (Health Pathways CDHB).

Antenatal care plan At or >32 weeks, transfer of clinical responsibility (unless diagnosed earlier from an Antepartum haemorrhage) (Referral guidelines 4020).
A plan of care is documented in the clinical notes and identified on the yellow '*at risk*' chart at the front of the notes. This includes informed consent for an emergency caesarean section and blood transfusion, and discussion around the chance of hysterectomy
Home-based care requires close proximity to the hospital, the constant presence of a companion and full informed consent by the woman. It should be made clear to any woman being managed at home that she should attend immediately if she experiences any bleeding, contractions or pain (including vague suprapubic period-like aches).
Prevention and treatment of anaemia.
The goals of care are to monitor the well-being of both the mother and her baby.
Women who have had a previous caesarean section who also have either placenta praevia or an anterior placenta underlying the old caesarean section scar at 32 weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations for surgery made (RCOG Green-top Guideline No. 27).

On admission to delivery suite (if the woman is clinically shocked)
Dial 777
Consult with on-call obstetric team
Assess amount of blood loss
Observations – Blood pressure, Pulse, Resps
Continuous CTG monitoring
IV access x 2 with 16 gauge cannula
IV fluid therapy
Indwelling catheter
Do not perform VE
Blood urgently to lab for Cross match
Consider corticosteroids
Any sign of maternal or fetal compromise, prepare for emergency caesarean section
Follow protocol for massive obstetric haemorrhage

For women stabilised on delivery suite and for admission to postnatal ward for conservative management
Ensure ongoing careplan is current

- Nature, type and amount of bleeding that has occurred
- Condition of the mother: maternal observations (BP, P, T, R)
- Electronic fetal monitoring (this will depend on the clinical picture)
- Consider use of corticosteroids prior to elective caesarean section

- Assessment of vaginal blood loss
- IV fluid therapy as prescribed
- Patent IV access, documented when inserted, time last flushed – Phlebitis score undertaken each shift, as per IV protocol

Bloods taken for cross match and complete blood count and when this should be repeated. Decisions regarding blood availability during inpatient antenatal care should be based on clinical factors relating to individual cases as well as on local blood bank services. Women with atypical antibodies form a particularly high-risk group and discussions in these cases should involve the local haematologist and blood bank.

- Consider use of thromboembolic stockings to prevent thrombosis:
- Consider referral to social worker
- Update LMC if still involved

Birth

Blood should be readily available for the peripartum period; whether ready cross-matched blood is required and in what amount will depend on the clinical features of each individual case. When women have atypical antibodies, direct communication with the local blood bank should enable specific plans to be made to match the individual circumstance.

Documentation

All care is clearly documented in the body of the notes and the antegram/ MEOW chart.
An accurate plan is kept updated.

Associated documents/guidelines

Management of Massive Obstetric Haemorrhage policy
Postpartum haemorrhage policy
Acute management APH
Active Management Third stage of labour
IV therapy policy

References

Christchurch Womens Hospital (CDHB). Placenta praevia and placenta accreta. Health Pathways. Canterbury, 2016.

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.

Royal College of Obstetricians and Gynecologists (RCOG). Placenta praevia, placenta praevia accreta and vasa praevia:diagnosis and management. Green-top Guideline No 27; London RCOG 2011.

Categories of referral

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

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).