ANTEPARTUM HAEMORRHAGE

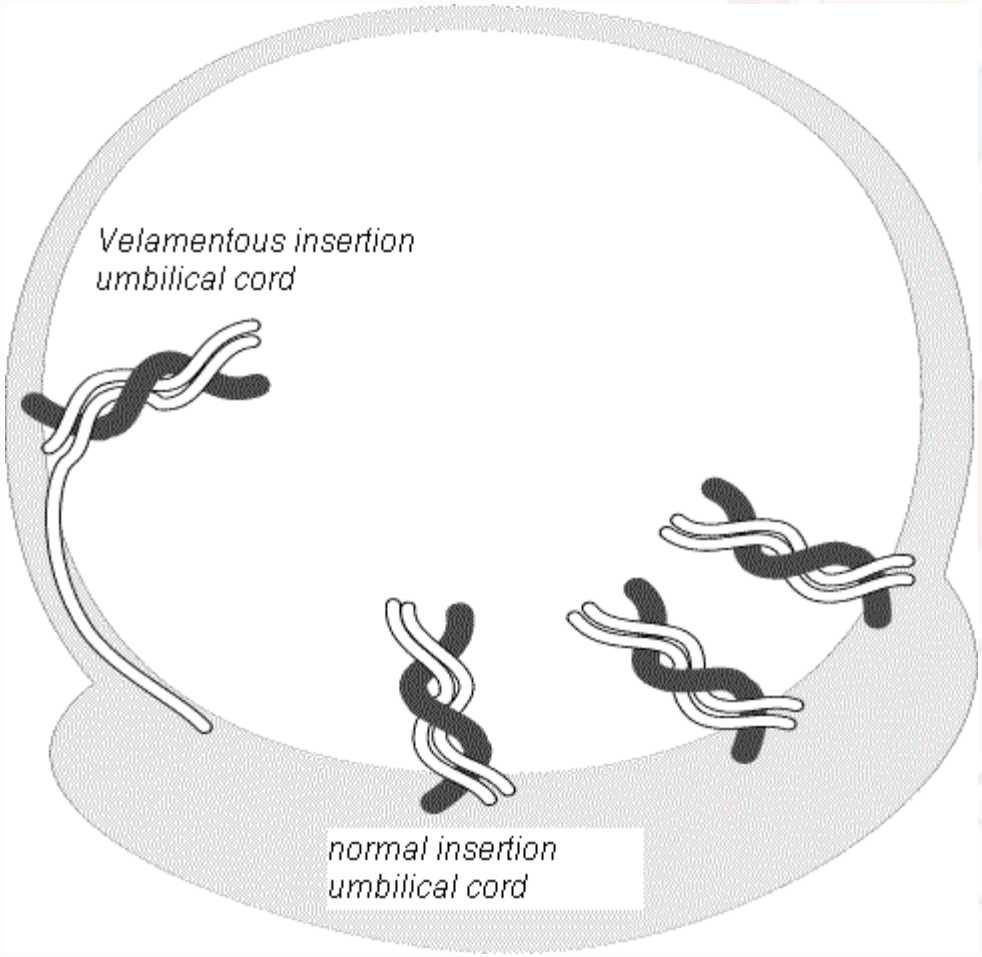
LECTURE 2

Vasa Praevia (VP)

- Rupture of fetal vessels that run in membrane below fetal presenting part which is unsupported by placenta/ umbilical cord.

- **Predisposing Factors:**

- -Velamentous insertion of the umbilical cord
- -Accesory placental lobes
- -Multiple gestations



The term velamentous insertion is used to describe the condition in which the umbilical cord inserts on the chorioamniotic membranes rather than on the placental mass.

Diagnosis of VP

- Antenatal diagnosis –reduced perinatal mortality and morbidity.
- Painless vaginal bleeding at the time of spontaneous
- rupture of membrane or post amniotomy
- Fetal bradycardia Fetal shock or death can occur rapidly at the time of diagnosis due to blood loss constitutes a major bulk of blood volume is fetus (3kg fetus-300ml)
- Hence, ALWAYS check the fetal heart after rupture of membrane or amniotomy.
- Definitive diagnosis by inspecting the placenta and fetal membrane after delivery.

Complications of APH

- Maternal complications
  - Anemia
  - Infection
  - Obstetrical shock
  - PPH
  - Prolonged hospital stay
- Fetal complication
  - Fetal hypoxia
  - small for gestational age and fetal growth restriction
  - Fetal death

Clinical assessment in APH

- First and foremost →**Mother and fetal well being** (mother is the priority)
- establish whether urgent intervention is required to manage maternal or fetal compromise.
- Assess the extent of vaginal bleeding, cardiovascular condition of the mother
- Assess fetal wellbeing.

Full History

Should be taken after the mother is stable.

- associated pain with the haemorrhage?

Continuous pain : Placental abruption.

Intermittent pain : Labour.

- Risk factors for abruption and placenta praevia should be identified.
- reduced fetal movements?
- If the APH is associated with spontaneous or iatrogenic rupture of the fetal membranes : ruptured vasa praevia
- Previous cervical smear history possibility of Ca cervix. Symptomatic pregnant women usually present with APH (mostly postcoital) or vaginal discharge.

Examination

- **General**: PULSE & BP (a MUST!)
- **Abdomen**:

- The tense, tender or 'woody' feel to the uterus indicates a significant abruption.
- Painless bleeding, high fetal presenting part – Placenta praevia
- soft, non-tender uterus may suggest a lower genital tract cause or bleeding from placenta or vasa praevia.

Examination

- **Speculum** :

-identify cervical dilatation or visualise a lower genital tract cause.

- **Digital vaginal examination**

- Should NOT be done until Placenta Praevia has been excluded by USG.

Investigations

- FBC
- Coagulation profile
- Blood Grouping
- Ultrasound
- D-dimer : AP
- colour doppler TVS

Fetal monitoring:

- CTG monitoring

Management

- WHEN to admit?
- Based on individual assessment

-Discharge after reassurance and counselling

Women presenting with spotting who are no longer bleeding and where placenta praevia has been Excluded.

However, a woman with spotting + previous IUD due to placenta abruption, an admission would be appropriate.

- All women with APH heavier than spotting and women with **ongoing bleeding** should remain in hospital at least until the bleeding has stopped.

Management

- If preterm delivery is anticipated, a single course of antenatal corticosteroids (dexamethasone 12mg 12 hourly ,2 doses) to women between 24 and 34 weeks 6 days of gestation.
- Tocolytics should NOT be given unless for VERY preterm women who need time to transfer to hospital with NICU.

- **For very preterm (24-26 weeks)** ,

-conservative management if mother is stable .

-Delivery of fetus – life threatening

At these gestations, experienced neonatologists should be involved in the counselling of the woman and her partner

Management

For Placenta Praevia

- Conservative – MaCafee's regime

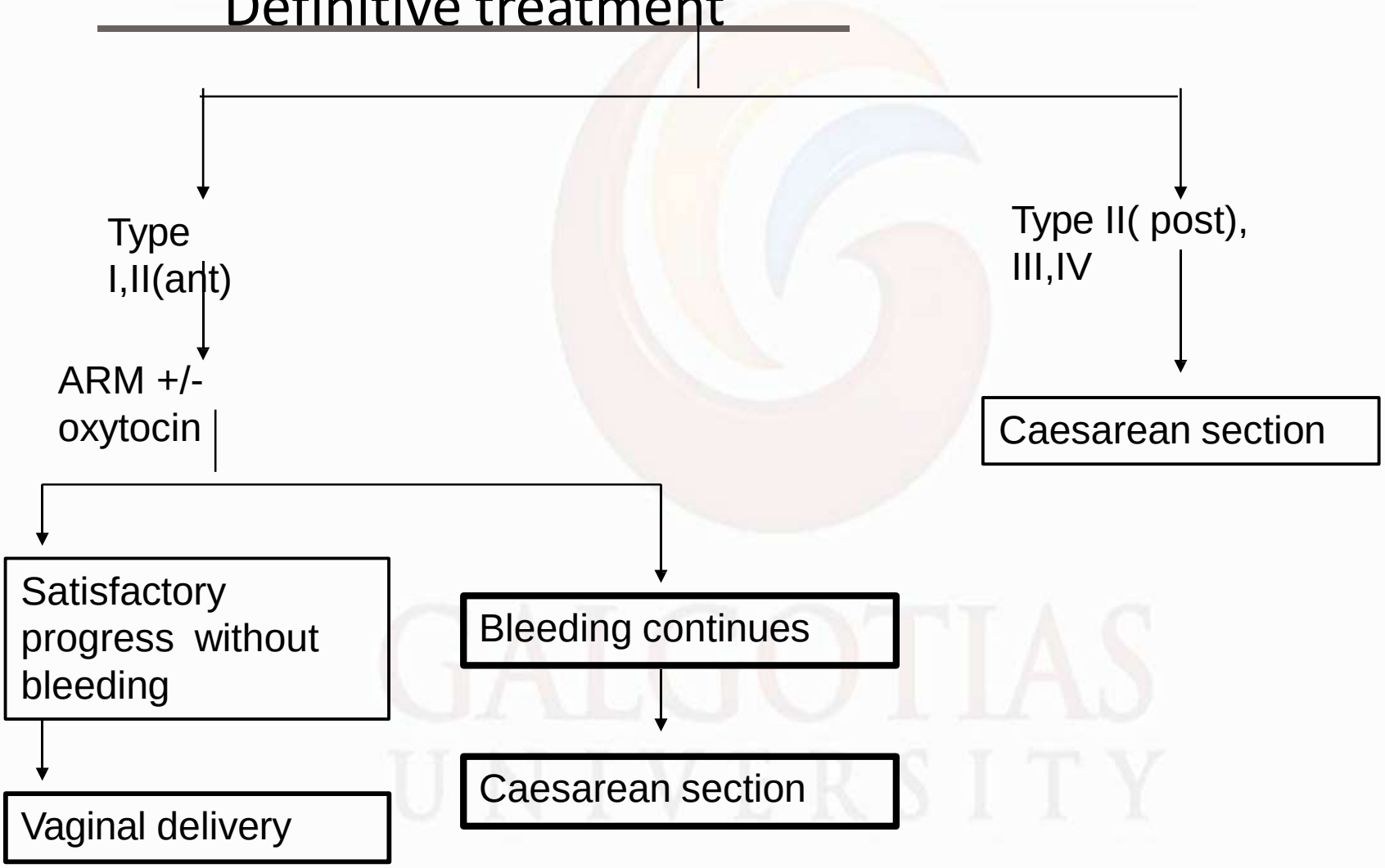
(premature < 37 weeks;mother haemodynamically stable,no active bleeding, fetus stable)

-advise bed rest, keep pad chart, vital signs monitoring , Ultrasound, steroids, GSH, Daily CTG and biophysical profile, fetal movement count.

- Plan for delivery (>37 weeks)

Crossmatch 4 units of blood.

Definitive treatment



For Abruptio placenta,(obs emergency)

- ICU admission : Close monitoring and resuscitation!
- ABC (high flow O2, aggressive fluid resuscitation)
- Continuous Vital signs monitoring and urine output
- Monitor vaginal bleeding – strict pad chart
- Continuous CTG for fetal heart rate
- Crossmatch 4 units of blood
- FFP – Fresh frozen plasma ,coagulopathy
- Dexamethasone – preterm

Abruptio Placenta

Decide Mode of delivery

- Vaginal delivery – when fetal death
- Caesarean section –if maternal/ fetal health compromised
- Consent should be taken for hysterectomy in case bleeding could not be controlled.

QUIZ

1. Common causes of antepartum haemorrhage (APH, bleeding from the genital tract from 24 weeks' gestation) include which of the following?

A Vasa praevia

B Undetermined origin

C Placenta praevia

D Uterine rupture

E Placental abruption

F None of the above

2. Regarding placenta praevia, which of the following are true?

A Placenta praevia complicates about 0.4% of pregnancies at term.

B Placenta praevia cannot be diagnosed with ultrasound.

C The majority of 'low-lying' placentas diagnosed at 20 weeks will remain so at term.

D The patient should be routinely managed under inpatient care with delay of delivery until the patient labours, at which time caesarean section will be performed.

E Complications of placenta praevia include need for caesarean section, haemorrhage, placenta accreta, placenta percreta and hysterectomy.

F Placenta praevia is typically more painful than an abruption.

3. Placental abruption: which of the following are true?

A Many antepartum haemorrhages of 'undetermined origin' are probably small placental abruptions.

B Most of the blood loss is fetal.

C Visible haemorrhage is absent in 20%.

D Risk factors for abruption include pre-eclampsia, autoimmune disease, maternal smoking, cocaine use and a previous history.

E Abruption is best diagnosed by ultrasound.

F Abruption is usually painless.

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