Frimley Health
NHS Foundation Trust

Antepartum Haemorrhage

Key Points

- **Regardless of gestation, the mother's life should take priority**
- **Call for senior help early**
- **Consider consequential risks such as postpartum haemorrhage and venous thromboembolism**
- **Prevent future haemolytic disease of the newborn by administering Anti-D according to Trust guidance.**

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Abbreviations

APH	Antepartum Haemorrhage
PPH	Postpartum Haemorrhage
IUD	Intrauterine death
USS	Ultrasound Scan
FBC	Full Blood Count
PTL	Preterm Labour
VE	Vaginal Examination
SROM	Spontaneous Rupture of Membranes
G&S	Group and Save
CTG	Cardiotocography
FMH	Fetal maternal haemorrhage
MEOWS	Modified Early Obstetric Warning System
U&Es	Urea and Electrolytes

Contents

1. Introduction

Vaginal bleeding after 24 weeks occurs in 3-5% of pregnancies. The major causes are placenta praevia (30%), placental abruption (20%) but the majority are of unknown aetiology (40%). Five per cent of women have a low-lying placenta at 20 weeks but only 0.5% persist past 37 weeks gestation[1]. Placental abruption occurs in 0.65% of pregnancies[2].

All women ≥16 weeks with significant revealed vaginal bleeding or suspicion of concealed bleeding should be reviewed on triage/Labour Ward. All women with APH heavier than spotting and women with on-going bleeding should remain in hospital until bleeding has stopped [3].

Women <16 weeks should be referred to gynaecology via the on-call gynaecology team.

It is important to remember that the amount of blood loss is often underestimated; and that haemorrhage can be concealed within abdominal cavity. It is therefore important to look for signs of clinical shock – tachycardia, tachypnoea, hypotension and low 0_2 saturation. [3,7]

Any woman who has had an antepartum haemorrhage must be transferred to consultant led care.

2. Initial assessment

Regardless of gestation, the mother's life should take priority. She should be resuscitated and stabilised before any decision is made regarding the delivery of the baby[3]. During a major or massive haemorrhage an acute assessment of maternal wellbeing should be performed, and resuscitation started immediately[3]. If there is no maternal compromise a full initial assessment should be undertaken.

2.1 Maternal assessment

- Observations: blood pressure, pulse, respiration rate, 0_2 saturations, temperature (document observations on a MEOWS chart via EPIC flowsheet if the woman is not in labour).
- Abdominal palpation, uterine activity, vaginal loss, awareness of fetal movements, pain.
- Ascertain if patient is on any antenatal anticoagulation therapy[3], history of coagulopathy and cervical smear history
- USS by an obstetrician to confirm or exclude placenta praevia if placental site is not known *(digital vaginal examination should not be performed until placenta praevia has been excluded* [3]).
- Speculum to identify cervical dilation or a lower genital tract cause for the APH[3]. If placenta praevia has been excluded, a digital VE can provide information on cervical dilation if APH is associated with pain or uterine activity[3]. If under 37 weeks gestation, this should be performed by/or under the supervision of the registrar or above.
- Document measured blood loss weighing all pads and sheets

2.2 Fetal

- If 26 weeks or more, commence EFM (computerised CTG if not contracting) once the mother is stable or resuscitation has commenced[3].
- If less than 26 weeks auscultate as appropriate.
- If no fetal heart is heard, an ultrasound should be performed to exclude or confirm intrauterine death (IUD)[3].
- If preterm delivery is being considered, please see "Preterm Labour" guideline.

3. Anti-D

Anti-D should be given according to local guidelines. See "Blood Transfusion Policy for Adult Patients with related guidelines", an appendix covers "Anti-D prophylaxis, Fetal RhD testing & management of maternal red cell antibodies".

Definitions

Spotting – staining, streaking or blood spotting noted on underwear or sanitary protection[3]
Minor APH - blood loss less than 50 ml that has settled[3]
Major APH - blood loss of 50–1000 ml, with no signs of clinical shock[3]
Massive - blood loss greater than 1000 ml and/or signs of clinical shock.[3]

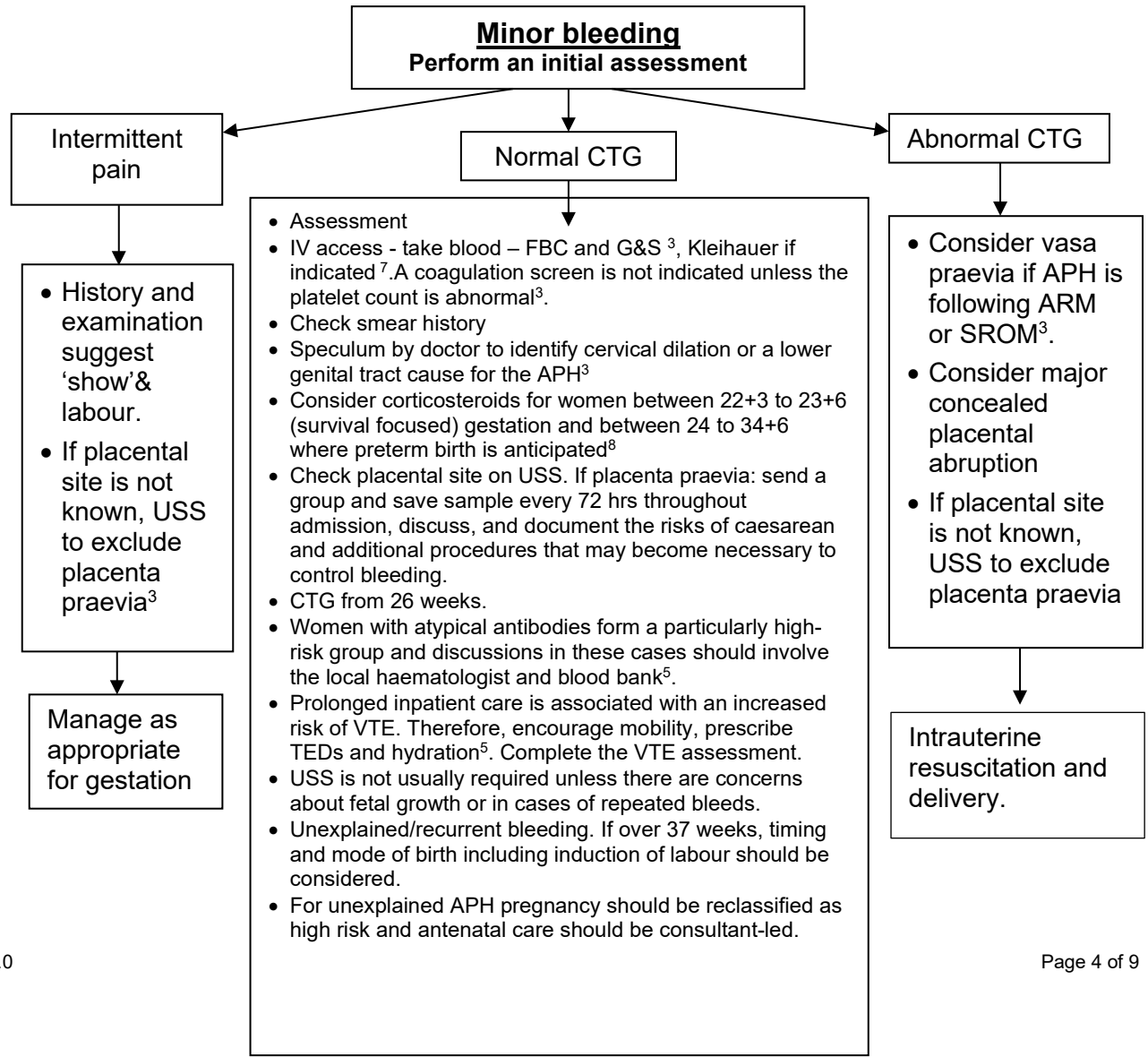
4. Spotting

Women who present with a history of spotting but who are no longer bleeding may go home after a reassuring initial assessment if placenta praevia has been ruled out[3].

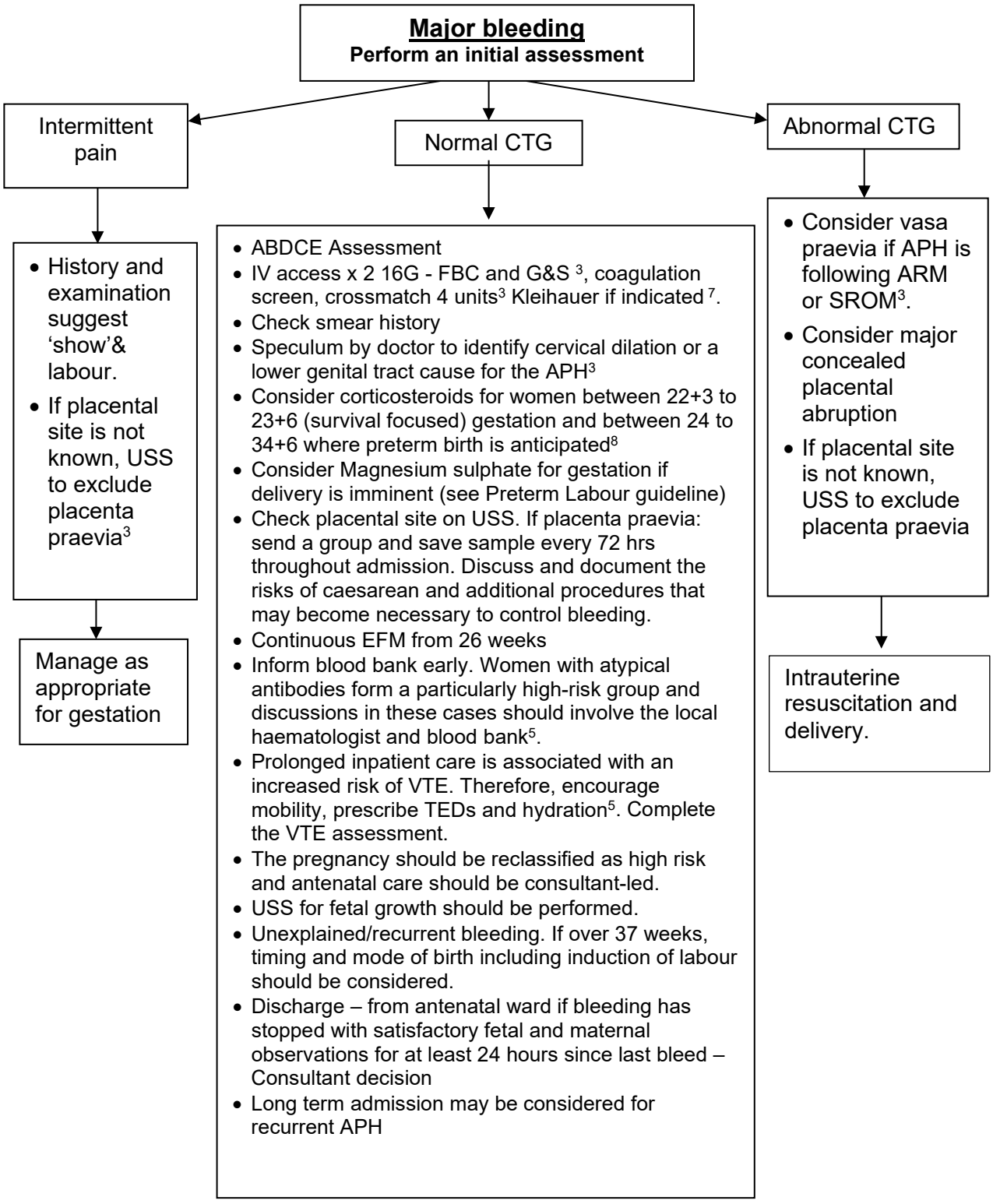
Corticosteroids are unlikely to be of benefit to women presenting with spotting where the most likely cause is lower genital tract bleeding but could still be considered[3] (See Preterm Labour guideline).

A "show" or blood streaked through mucus is unlikely to require active intervention[3].

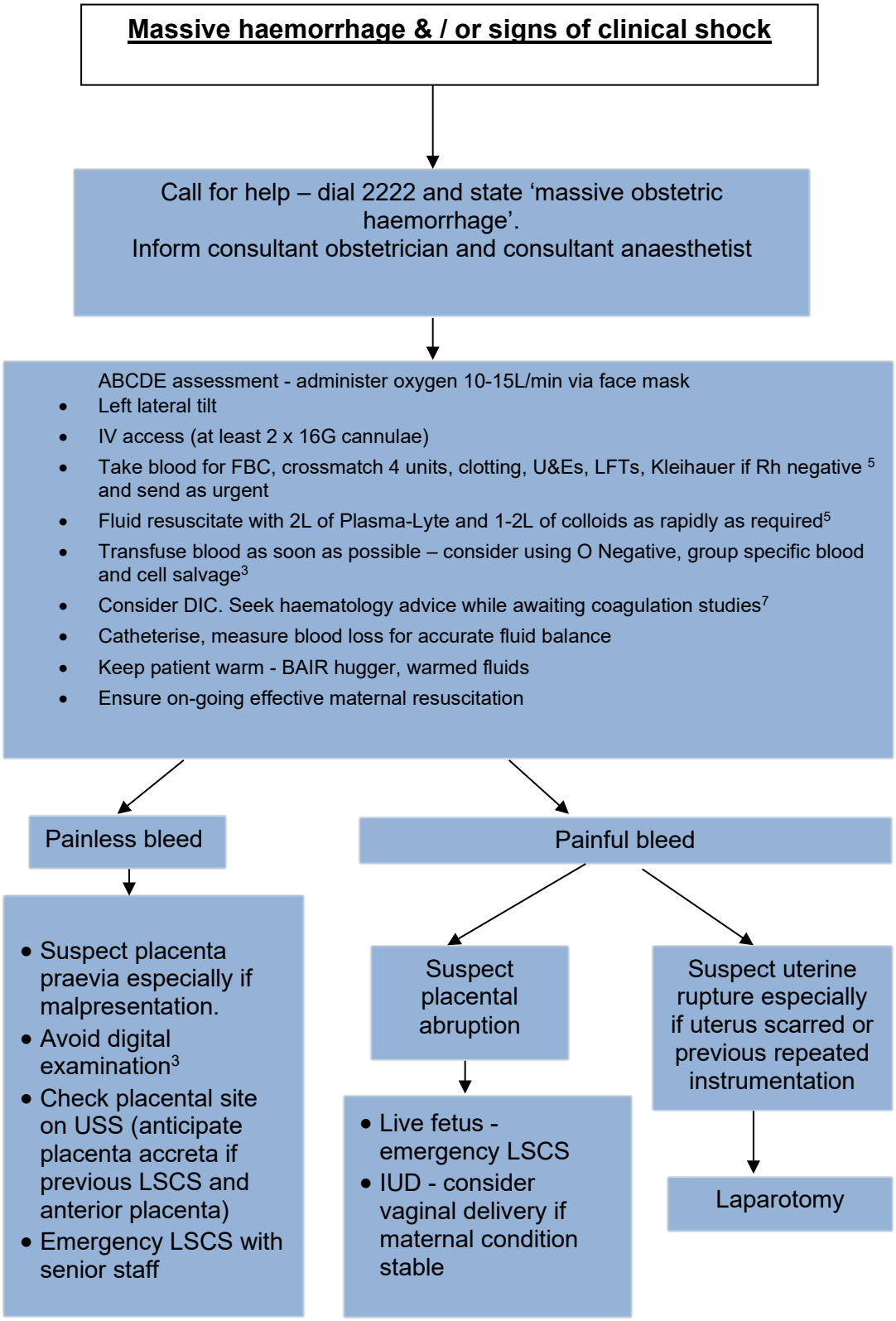
5. Minor Bleeding



6. Major bleeding



7. Massive Haemorrhage and / or Signs of Clinical Shock



8. Post Delivery

Postpartum haemorrhage (PPH) should be anticipated (see PPH guideline). Active management of the third stage should be strongly recommended to women with an APH due to placental abruption or placenta praevia, preferably Syntometrine® (oxytocin with ergometrine) if there is no hypertension[3].

9. Venous Thromboembolism

Haemorrhage is a risk factor for VTE. As soon as the immediate risk of haemorrhage is reduced, thromboprophylaxis should be commenced according to the VTE guideline.

10. Patient Debrief

A full debrief should take place prior to discharge for any woman with a massive haemorrhage and consider a follow up appointment in 4-6 weeks[3].

11. Incident Reporting

A large APH may need to be incident-reported if any triggers are met.

12. Auditable standards

Appropriate administration of Anti-D to women presenting with APH.

Percentage of women with APH (recurrent episodes of minor APH, a major APH that has resolved or unexplained APH) referred for serial growth scans.

Management of the third stage of labour in women who had a major APH.

Appropriate training of the multidisciplinary team.

13. Monitoring

This guideline will be subject to 3 yearly audits. The audit midwife is responsible for coordinating the audit. Results will be reported to the departmental clinical audit meeting. Action plans will be monitored at the departmental clinical governance meeting.

14. References

1. Neilson JP, Interventions for suspected placenta praevia. *Cochrane review* 2003 Issue 4.
2. Neilson JP, Interventions for placental abruption. *Cochrane review* 2001 Issue 4.
3. RCOG Antepartum Haemorrhage Green-top Guideline No. 63 1st Edition, November 2011
4. RCOG Placenta praevia, placenta praevia accreta and vasa praevia: diagnosis and management Green-top Guideline No.27, January 2011.
5. Qureshi, H., et al. (2014), BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. Transfusion Medicine, 24: 8–20. doi: 10.1111/tme.12091
6. https://www.nice.org.uk/guidance/ng25
7. RCOG Prevention and Management of Postpartum Haemorrhage Green-top Guideline No. 52 December 2016
8. RCOG Antenatal corticosteroids to reduce neonatal morbidity and mortality Green-top Guideline No 74 July 2022

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Guidelines Lead(s):	Dr Nana Yaa Seiwaa Opare, Miss Zoe Vaid, Consultant Obstetrician Mr Francisco Garcia, Consultant Obstetrician
Contributors:	
Lead Director/ Chief of Service:	Miss Anne Deans, Chief of Service
Professional midwifery advocate:	Kate Sheehan
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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Dec 2016	Karen Phillips, Frank Garcia – Consultant Obstetricians	Final	Cross-site guideline developed
2.0	June 2019	Miss Zoe Vaid, Consultant Obstetrician Mr Francisco Garcia, Consultant Obstetrician	Final	Reviewed and updated
2.1	September 2020	Amendment by B. Sagoo	Interim	Gestational age for steroids changed in line with new Preterm labour guidance. See section 5 Minor Bleeding pg5 Approved at OGCGC 30th September 2020
3.0	July 2023	Nana Seiwaa Opare ST6 Registrar	Final	Amended to include RCOG classifications and management of minor, major and massive APH with flowchart and use of EPIC

Related Documents

Document Type	Document Name
Trust Guideline	Maternal collapse in pregnancy and the puerperium
Trust Guideline	Post partum Haemorrhage (PPH)
Trust Guideline	Pre-term labour
Trust Guideline	Intrauterine death (from 24 weeks of gestation)
Trust Guideline	Fetal monitoring including fetal blood sampling
Trust Guideline	Care for women who refuse blood products in pregnancy and the postnatal period
Trust Guideline	Blood Transfusion Policy for Adult Patients with related guidelines