ANTEPARTUM HAEMORRHAGE
Lecture 1

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TOPICS TO BE COVERED

- ✓Definition
- ✓Etiology
- ✓Types of ante partum hemorrhage
- ✓Placenta previa
- ✓Abruptio placenta
- ✓Vasa previa
- ✓Management

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Definition

- Antepartum haemorrhage (APH) is defined as bleeding from or in to the genital tract, occurring from **22 weeks (>500g)** of pregnancy and prior to the birth of the baby.

- complicates 3–5% of pregnancies
- leading cause of perinatal and maternal mortality worldwide.
- Up to one-fifth of very preterm babies are born in association with APH
- Most of the time unpredictable.

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Severity

NO consistent definitions of the severity of APH.

It is recognised that the amount of blood lost is often underestimated .

The amount of blood coming from the introitus may not represent the total blood lost (for example in a concealed placental abruption).

It is important to assess for signs of clinical shock. The presence of fetal compromise or fetal demise is an important indicator of volume depletion.

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Different terminologies used:

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

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Etiology

- Placenta praevia
- Abruptio placenta
- Vasa praevia
- Excessive show
- Local causes (bleeding from cervix, vagina and vulva)

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Placenta Praevia (PP)

- Implantation of placenta over or near the internal os of cervix.
- Confirm diagnosis of PP can be done at 28 weeks when LUS forming.

Leading cause of vaginal bleeding in the 2nd and 3rd trimester.

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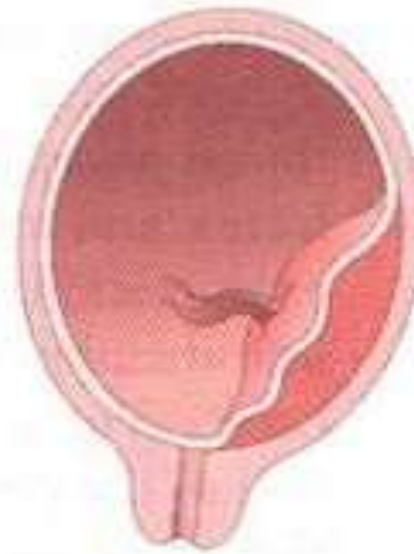
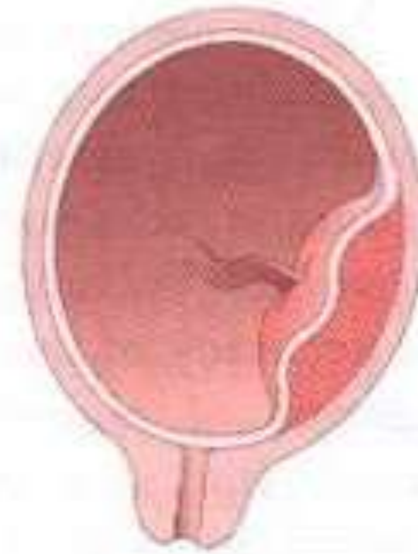
Classification

Complete

Partial


Marginal


Low lying

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Risk Factors of Placenta Praevia

- **Previous placenta praevia (4-8%)**
- **Previous caesarean sections** (risk with numbers of c-section)
- Previous termination of pregnancy
- Multiparity
- Advanced maternal age (>40 years)
- Multiple pregnancy
- Smoking
- Deficient endometrium due to presence or history of:
  - uterine scar
  -endometritis
  -manual removal of placenta
  - curettage
  -submucous fibroid
- Assisted conception

Clinical classification

- **Minor :**
  - Type 1 (anterior/posterior)
  - Type 2 anterior

Deliver vaginally
Type 1 Posterior > likelihood of fetal distress

- **Major:**
  - Type 2 posterior (dangerous type)
  - Type 3
  - Type 4

Caesarean section **Type 2 posterior** > chance of fetal distress
Type 3 & 4 anterior –cut through placenta to deliver. Hence need to be fast and efficient.

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Abruptio Placenta (AP)

Separation of normally located placenta after 22 weeks of gestation (> 500g) and prior to delivery

TYPES:

- ❑Revealed
- ❑Concealed
- ❑Mixed

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Risk factors:

- Previous history of AP
- Maternal hypertension
- Advanced maternal age
- Trauma (domestic violence, accident, fall)
- Smoking/alcohol/cocaine
- Short umbilical cord
- Sudden decompression of uterus (PROM/delivery of 1st twins)
- Retroplacental fibroids
- Idiopathic

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Obstetrics Emergency!!

Diagnosed CLINICALLY :

- Painful vaginal bleeding -80%
- Tense and tender abdomen/back pain (70%)
- Fetal distress(60%)
- Abnormal uterine contractions (hypertonic and high frequency)
- Preterm labour (25%)
- Fetal death (15%)

Ultrasound is NOT USEFUL to diagnose AP.
Retroplacental clots (hyperechoic) easily missed.

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