

STANDARD OPERATING PROCEDURE

Antepartum Haemorrhage

Special Region (1)

Union of Myanmar

Version: (1)

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Antepartum Haemorrhage

Bleeding from the genital tract in pregnancy at ≥ 24 wks gestation before onset of labour. Causes

- Unexplained (80%) – marginal placental bleeds (minor placental abruptions)
- Placenta previa
- Placental abruption
- Others
- Maternal:
 - incidental (cervical erosion / ectropion)
 - Local infection of cervix/ vagina
 - ‘show’ usually light & pink or brown
 - Genital tract tumors, particularly ca cervix
 - Varicosities
 - Trauma
- Fetal: vasa previa

Initial assessment of APH Assessment Management A (Airway) Check patency B (Breathing) Respiratory rate Oxygen saturations 10-15 L via non-rebreathing mask C (Circulation) Heart rate Capillary refill time Blood pressure IV access consider x 2 (16G cannulas) IV fluid resuscitation crystalloid/collide/blood Assess blood loss Consider catheterization (input/output monitoring) D (Disability) Glasgow coma score E (Exposure) Abdominal examination Speculum examination Vaginal examination F (Fetus) CTG Auscultation FHR Ultrasound History taking

- Gestational age
- Amount of bleeding
- Associated or indicating factor (coitus / trauma)
- Abdominal pain
- Fetal movement
- Date of last smear
- Previous episodes of PV bleeding in this pregnancy
- Leakage of fluid PV
- Previous uterine surgery (including CD)
- Smoking and use of illegal drugs (esp. cocaine)

- Blood GP & Rh status
- Previous obstetric H/O (placental abruption, FGR, placenta previa)
- Position of placenta if known from previous scan

Maternal assessment

- BP
- Pulse rate
- Other signs of hemodynamic compromise (e.g., peripheral vasoconstriction or central

cyanosis)

- Uterine palpation for size, hardness / contraction, tenderness, fetal lie, presenting part

➤ Remember, never performed a vaginal examination (VE) in presence of PV bleeding without 1st excluding a placenta previa. Fetal assessment

- Establish whether a FH can be heard.
- Ensure that it is fetal and not maternal (remember, the mother may be very

tachycardic).

- If the FH is heard and gestation is estimated to be 26wks or more, FHR monitoring

should be commenced. Bleeding is minor or settling and neither mother nor fetus compromised is called limited APH. Limited antepartum haemorrhage Maternal management

- FBC
- Keilhauer testing, if woman known to be RhD -ve and fetal blood group unknown or

RhD+ve, to determine extent of fetomaternal haemorrhage and if more anti -D is required.

- Group and save (at least 4 units)
- Coagulation screen and renal function if suspected abruption

Fetal management

• USS to establish fetal well- being (growth/ volume of amniotic fluid) and to confirm placenta location.

• Fetal doppler measurement (the function of the placenta may be compromised even by small abruptions). Ongoing antenatal management

- Admit women who had an APH for 24h, as the risk of further bleeding is estimated to

be greatest during that time.

- Offer steroids if <35wks
- If the bleeding settles and mother is discharged, a clear plan for the remaining pregnancy should be made including extra surveillance of growth and well-being.
- Management must be individualized according to suspected cause of bleeding, gestation, fetal assessment, and continuing maternal risk factors. If bleeding is heavy and continuing, this is called massive obstetric haemorrhage (>2000ml) Placenta previa
- Placenta previa: the placenta is over the internal cervical os
- Low lying placenta: the placenta is within 2 cm of the internal os

Diagnosis Transvaginal USS is safe and is more accurate than transabdominal USS in locating the placenta, particularly if posterior. Management

- Consider admission in women with major placenta praevia who have bled
- Offer steroids if <35wks
- Women with asymptomatic major placenta praevia may remain at home if they
- Are close to the hospital
- Are fully aware of risks to themselves and their baby
- have a constant companion
- CS delivery if the placental edge <2cm from the internal os
- If recurrent PV bleeding: deliver immediately if massive, otherwise electively at 34-

36 wks

- If asymptomatic, consider delivery by 37 wks
- Crossmatch blood (at least 4 units) and ensure senior surgeon

Placenta abruption

- Placenta separates partly or completely from uterus before delivery of fetus.
- Blood accumulates behind placenta in uterine cavity or loss through cervix.

Diagnosis

- Made clinically
- USS – only to exclude PP

Management

- IV access and save blood for Grouping and matching

- Establish immediate fetal well-being with CTG
- Admit all with vaginal bleeding or unexplained abdominal pain
- Arrange USS
- Give steroids if < 35 wks
- If fetal distress or maternal compromise, resuscitate, consider magnesium sulfate

(MgSO₄) if < 30 – 32 wks and deliver

- If the fetus is alive, expedite the delivery by the most expedient route. If fully dilated, instrumental delivery may be possible. If not, to do emergency CS.

- If the fetus has died, vaginal delivery is the preferable mode (ARM, syntocinon)
- If no fetal distress, and bleeding & pain cease, consider delivery by term

Documentation

- Time of bleeding started
- Amount of blood loss
- Maternal vital signs
- Fetal heart rate
- Intervention given

References

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3. RCOG (2011). Antepartum haemorrhage; Green top Guideline No. 63; Royal College of Obstetricians and Gynaecologists, London, UK
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