Bleeding in Early and Late Pregnancy
DEFINITIONS

• **Miscarriage**: Up to 24 weeks of gestation or less than 500 gms (WHO – 20 weeks)

• **Ante-partum haemorrhage**: From 24 weeks gestation until the onset of labour

• **Intra-partum haemorrhage**: From onset of labour until the end of second stage

• **Post-partum Haemorrhage**: From third stage of labour until the end of the puerperium
MATERNAL MORTALITY

Early pregnancy death was cause of maternal deaths (ectopic, miscarriage and termination)

65% and 71% had substandard care in above groups
EARLY BLEEDING - CAUSES

- Implantation bleed
- Threatened miscarriage
- Inevitable miscarriage
- Incomplete miscarriage
- Complete miscarriage
- Missed miscarriage
- Molar pregnancy
- Ectopic pregnancy
- Local causes
MISCARRIAGE

• Common – 25% of all pregnancies

• Loss to the mother

• Do NOT forget Ectopic Pregnancy (have Ectopic mind, think Ectopic)

• Assess for viability
MISCARRIAGE

- 85% due to chromosomal abnormality
SYMPTOMS

- Bleeding
- Pain
- Passage of tissue (products of conception)
- Haemorrhage / spotting
- No symptoms, diagnosed at booking scan
DIAGNOSIS

- History and examination
- Vaginal or speculum
- Cervix (OS) open, products lying in cervix or vagina
- Ultrasound – very helpful, widely available and used
- Serum Bhcg in doubtful cases
MANAGEMENT

• Depends on diagnosis and patient’s CHOICE
• Threatened: continue, reassure
• Inevitable / incomplete: conservative, medical or surgical evacuation (ERPC)
• Missed: conservative, medical or surgical
• Complete: support, explanation
• Not sure: WAIT and WATCH, follow with scan and Bhcg
• RULE OUT ECTOPIC
• Conservative – leave to nature, do nothing
• Medical – Misoprostal, prostaglandins
• Surgical – evacuation of retained products
  - General Anaesthesia
  - Dilatation of cervix if not open
  - Suction
  - Curettage
ANTI - D

Do not forget
Molar pregnancy

- Bleeding, passage of vesicles
- Large for gestational age
- High Bhcg
- Hyperthyroidism
- Ultrasound – snow storm storm appearance
- Suction Evacuation, rarely hysterectomy
- Persistence, chorio-carcinoma (1%)
- Methotrexate
ECTOPIC PREGNANCY

- Pain, bleeding, fainting
- Examination – abdominal, vaginal
- Tenderness, cervical excitation tenderness
- Ultrasound – TVS
  IU sac seen with Bhcg >1500IU
- Serial Bhcg – doubling up in normal pregnancy
- Laparoscopy
MANAGEMENT OF ECTOPIC PREGNANCY

• Haemo-dynamically unstable: surgery
• Surgical: Laparoscopic salpingotomy
  Laparoscopic salpingectomy
  Open Laparotomy
• Medical: Asymptomatic, small ectopic, low Bhcg levels
  Methotrxate
  Need observation
• Conservative - only if haemodynamicaly stable, asymptomatic, suggestive of tubal miscarriage
LATE BLEEDING IN PREGNANCY- APH

• Placenta previa
• Abruptio placentae
• **Local causes**: Cervical – carcinoma, CIN, polyps, ectropion cervicitis
  Vulval- vaginal – varicose veins, trauma, infection
  Post Coital
• Vasa previa - rare
• Show of labour
ABRUPTION

- Retro-placental haemorrhage and some degree of placental separation
- **Revealed**: visible vaginal bleeding
- **Concealed**: no vaginal bleeding but collection behind placenta
- Marginal bleeding: bleeding from placental edge, can be managed conservatively if fetal wellbeing good
ABRUPTION - CAUSES

- Pre eclampsia
- Hypertension
- Renal diseases
- Diabetes
- Poly-hydramnios, Multiple pregnancy
- Abnormal placenta – IUGR, folic acid def.
- Trauma – blunt, forceful
- Cocaine
ABRUPTION - PRESENTATION

- Painful vaginal bleeding
- Pain, uterine tenderness, shock
- Tense uterus
- Fetal distress or death
- Shock, pallor
- Backache
ABRUPTION - DIAGNOSIS

• History
• Clinical examination – tense, tender uterus, irritable or contractions,
  • – fetal heart rate abnormalities and uterine contractions
• USS – only if large bleed behind placenta
MANAGEMENT

• Fetal problem: CS
• Fetal death: vaginal vs CS, depends on maternal condition and suitability of cervix
• Problems: hypovolemic shock, multisystem failure, DIC
PLACENTA PREVIA

• Placenta encroaching into lower uterine segment
• Major or Minor
  (Grade I to IV)
PLACENTA ACCRETA AND PERCRETA

- inccreta: When placenta invades myometrium
- Percreta: when placenta has reached serosa
- Associated with severe bleeding, PPH and may end up having hysterectomy
PP – PRESENTATION

• Asymptomatic – when picked on routine scanning
• Painless bleeding in late pregnancy
• Clinically – uterus relaxed, non tender, high presenting part, mal-presentation
NO VAGINAL EXAMINATION UNTIL PLACENTA PREVIA IS RULED OUT!
DIAGNOSIS-USS

• Trans-abdominal with full bladder (Anterior)
• Trans-vaginal – IMPORTANT
  To see relation of placental edge to Internal Os
  Especially if posterior placenta
MANAGEMENT

- Asyptomatic or patients with small bleed, living near hospital can be managed as outpatients
- Heavy bleeding, living far away need to be admitted till delivery
- Conservative management if small bleeding and fetal maternal conditions are stable
- Elective CS at 38-39 weeks
MANAGEMENT

• Minor Placenta Previa when presenting part is engaged could be allowed to deliver vaginally
• All major and posteriorly placed minor placenta previa need C.S.
CAESAREAN SECTION FOR PLACENTA PREVIA

• Senior Obstetrician/Consultant
• Consultant anaesthetist
• Haematologist aware
• blood available
• Approach
• PPH – medical and surgical management
MASSIVE HEMORRHAGE

• Get HELP
• Two wide bore IV lines
• Blood for FBC and Group and Crossmatch and Coagulation
• Management depends on cause
• Problems – shock, renal failure, cardiovascular arrest, Sheehan syndrome
**INTRAPARTUM**

- Abruption – can happen
- Uterine rupture - rare
- Vasa praevia – very rare
ANTI-D PROPHYLAXIS

- In Rhesus negative mothers Anti – D is given to prevent Rh-isoimmunization
- Given in all antenatal cases with bleeding