

## Antepartum Haemorrhage Placenta Praevia

Leonie Semmens

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### Definition

The placenta lies low in the lower uterine segment and can cover the internal os, and lies in front of the presenting part of the fetus.

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## CHẨY MÁU TRƯỚC SANH NHAU TIỀN ĐẠO

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### ĐỊNH NGHĨA

Bánh nhau nằm thấp ở đoạn dưới tử cung, có thể che kín lỗ trong và nằm ngay trước ngôi thai.

## Definition

- Placental plantation that overlies or is within 2 cm (0.8 in) of the internal cervical os
- Classification
  - ♦ Complete: Placenta completely covers the os
  - ♦ Partial: Placenta partially covers the os
  - ♦ Marginal: Placenta edge lies within 2 cm of the os
  - ♦ Low lying: Placenta edge lies 2 to 3.5 cm from the os
- Normal – positioned away from cervix (posterior position)

## ĐỊNH NGHĨA

- Bánh nhau tràn qua hoặc cách lỗ trong cổ tử cung 2cm (0.8 in)
- Phân loại :
  - ♦ Toàn phần: bánh nhau che kín hoàn toàn lỗ trong CTC
  - ♦ Bán phần: bánh nhau che lấp 1 phần lỗ trong CTC
  - ♦ Bám mép: mép nhau cách lỗ trong CTC 2cm
  - ♦ Bám thấp: mép nhau cách lỗ trong CTC 2 đến 3.5cm
- Vị trí bình thường nhau bám cách xa CTC (bám mặt sau)

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## Classification

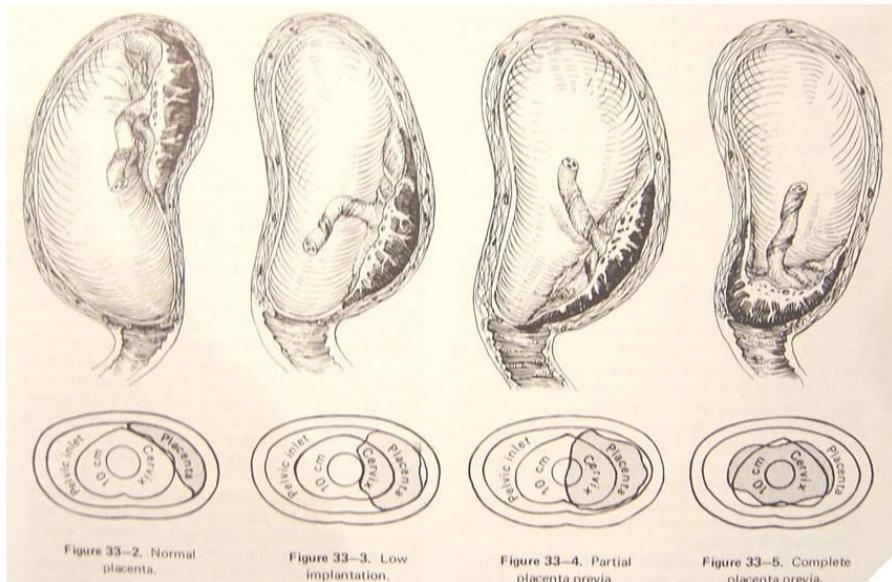


Figure 33-2. Normal placenta.

Figure 33-3. Low implantation.

Figure 33-4. Partial placenta previa.

Figure 33-5. Complete placenta previa.

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## PHÂN LOẠI

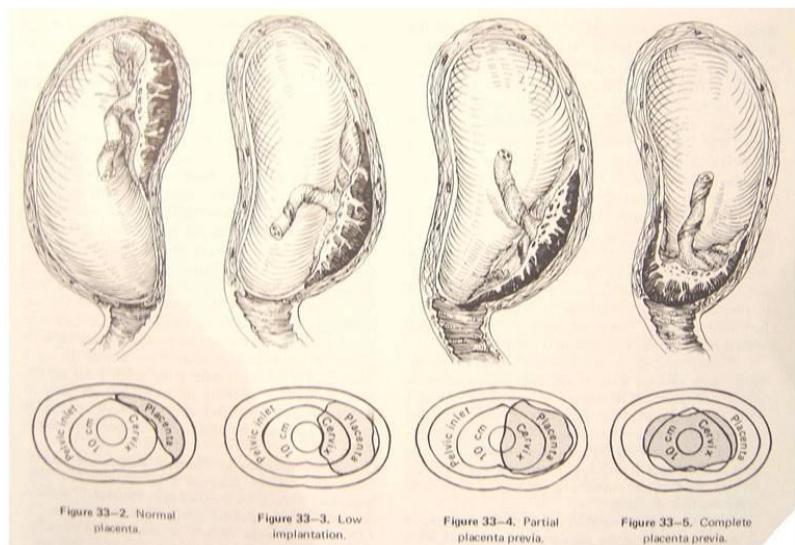


Figure 33-2. Normal placenta.

Figure 33-3. Low implantation.

Figure 33-4. Partial placenta previa.

Figure 33-5. Complete placenta previa.

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- Detected on ultrasound scans in about 25% of all pregnancies
- As the pregnancy progresses the lower uterine segment stretches and placental site moves up the uterine wall – in placenta praevia – the placenta does not move up

- Phát hiện qua siêu âm khoảng 25% trong tất cả các thai kỳ
- Khi thai kỳ tiến triển, đoạn dưới tử cung bị kéo giãn ra và bánh nhau bị kéo lên cao – trong nhau tiền đạo –bánh nhau không di chuyển lên

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## Causes of Placenta Praevia

- Multiparity
- Multiple pregnancy
- Age
- Previous scarring
- Smoking
- Placental abnormality
- Fetal sex
- Number of prior curettes or terminations
- Asian mothers

## NGUYÊN NHÂN

- Đa sản
- Đa thai
- Lớn tuổi
- Sẹo cũ
- Hút thuốc
- Bất thường bánh nhau
- Giới tính thai
- Số lần nạo phá thai hoặc sẩy thai
- Nhóm bà mẹ Châu Á

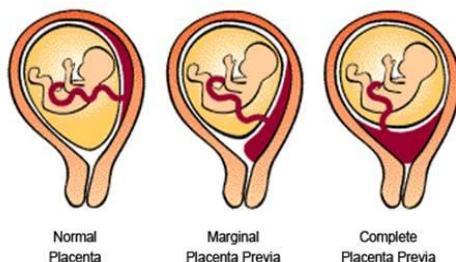
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- PAINLESS vaginal bleeding after 20 weeks
- Malpresentation of fetus – often breech
- Non-engagement of presenting part
- Post-coital bleeding



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## Diagnosis

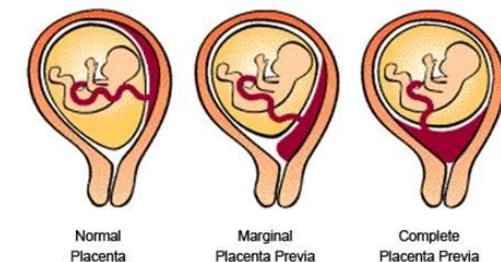
- Detected on ultrasound scan
- Post-coital bleeding
- High presenting part and malpresentation of the fetus
- Vaginal haemorrhage – anaemia and shock
- Sterile speculum examination as vaginal examination can cause life-threatening haemorrhage

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## TRIỆU CHỨNG

- Chảy máu âm đạo không gây đau sau 20 tuần
- Ngôi thai bất thường – thường là ngôi mông
- Ngôi thai cao
- Chảy máu sau giao hợp



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## CHẨN ĐOÁN

- Phát hiện qua siêu âm
- Chảy máu sau giao hợp
- Ngôi thai cao và bất thường
- Xuất huyết âm đạo – thiếu máu và sốc
- Khám bằng mỏ vịt vì khám âm đạo có thể gây chảy máu nhiều nguy hiểm tính mạng

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# Diagnosis

Can you see the placenta previa?



Figure 1. Ultrasound (sagittal view) shows placenta previa

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Bạn có thể nhìn thấy nhau tiền đạo?



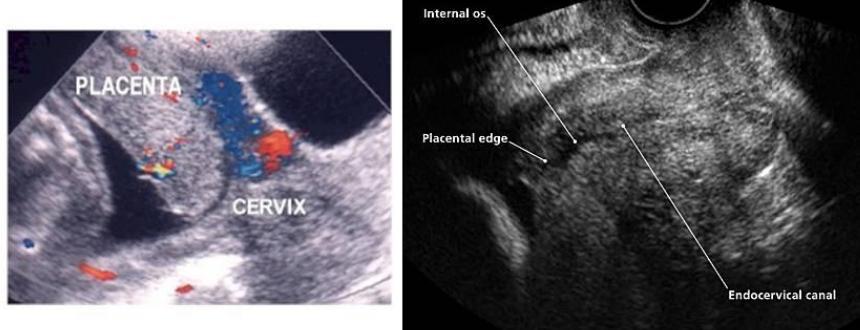
Figure 1. Ultrasound (sagittal view) shows placenta previa

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# Diagnosis

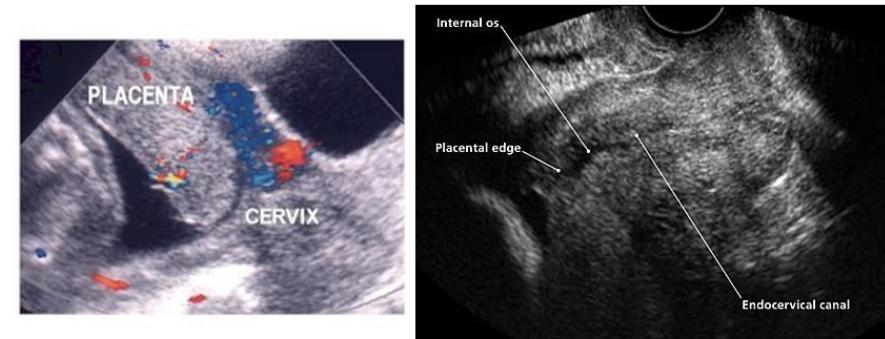
More examples...



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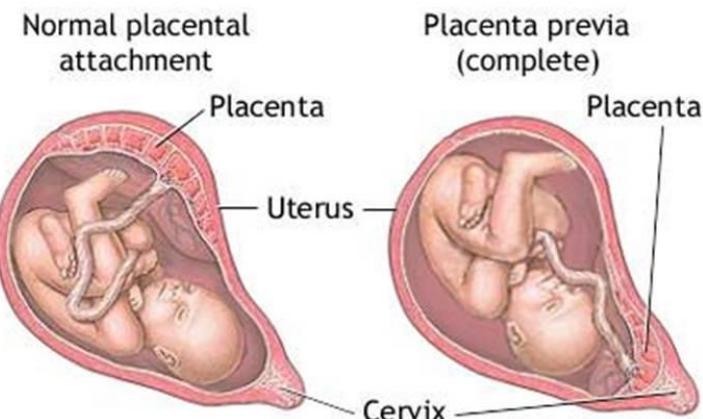
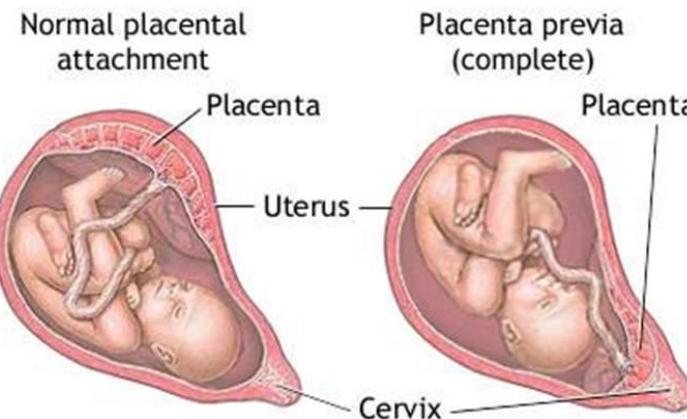
Những ví dụ khác...



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# CHẨN ĐOÁN



ADAM.

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ADAM.

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## Placenta Praevia

Is a major life-threatening complication of pregnancy

## NHAU TIỀN ĐẠO

Là một biến chứng quan trọng đe dọa tính mạng trong thai kỳ

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## Management

- Maternal pulse and BP 4/24 when actively bleeding
- Administer oxygen if signs of shock
- Pad check 4/24 when bleeding, otherwise daily
- Fetal heart twice daily – more frequent if PV loss significant, perform CTG
- Rhesus status – anti D if needed
- If vasa praevia and fresh PV bleeding – code pink
- Blood tests – FBC, Rhesus factor, group and X match + ? coagulation studies

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## Management

- Decision for caesarean section is not made until after 36 weeks, as the placenta will often migrate
- Expectant management if fetus is immature and no active bleeding – bed rest
- Urgent/emergent cesarean delivery for active or persistent bleeding or fetal distress
- Documentation in mothers' chart

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## ĐIỀU TRỊ

- Đếm mạch, đo huyết áp ngày 4 lần khi đang ra huyết
- Cho thở thêm oxy nếu có dấu hiệu của sốc
- Kiểm tra băng lót ngày 4 lần khi có ra huyết, nếu không ra huyết thì kiểm tra 1 lần mỗi ngày
- Theo dõi tim thai ngày 2 lần – thường xuyên hơn nếu có mất máu nghiêm trọng, có thể đo CTG
- Tình trạng Rhesus – tiêm anti D nếu cần thiết
- Nếu sa dây rốn và mất máu âm đạo đỏ tươi – mã hóa hồng
- XN máu: Huyết đồ, yếu tố Rhesus, nhóm máu và phản ứng chéo, XN đông máu

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## ĐIỀU TRỊ

- Quyết định cho mổ lấy thai được thực hiện sau 36 tuần, vì bánh nhau thường sẽ di chuyển
- Điều trị bảo tồn nếu thai nhi còn non và không có ra huyết nhiều – nghỉ ngơi tại giường
- Mổ cấp cứu khi có mất máu nhiều hoặc kéo dài dai dẳng hoặc tim thai suy
- Ghi nhận biểu đồ của mẹ

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# Care Plan

Mercy Public Hospitals Inc.			
<b>CLINICAL PATHWAY ANTENATAL</b>			
		Attach Patient Label	
<b>HOSPITAL ADMISSION CURRENT PREGNANCY</b>		Q.	P.
1. Date	/ /	Gestation	Reason for Admission
3. Date	/ /	Gestation	
Ante-Group	Rutisha Status	Maternal GBS Status	Delivery
Ante-D. Date 1	Immune / Non-immune	Negative / Positive / Unknown	Date 1
Date 2			Date 2
			Date 3
<b>ALLERGIES:</b>			
<b>FAMILY AND SOCIAL HISTORY:</b>			
Partner / Need of Kid			
Cultural / Religious Requirements			
Interpreter			
Dietary Requirement			
<b>MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:</b>			
<b>ISSUES / CONCERNs</b>			
<b>SMOKING: Y/N</b>		PER DAY:	
CESSATION DATE:		ADVICE / INFORMATION GIVEN:	
<b>ALLIED HEALTH/SPECIALIST REFERRAL (please circle)</b>			
MBU _____ Yes / No / Not Applicable			
Diabetes / Diabetes Educator _____ Yes / No / Not Applicable			
Psychiatrist _____ Yes / No / Not Applicable			
Pain Doctor _____ Yes / No / Not Applicable			
Parent Education _____ Yes / No / Not Applicable			
Revised Care _____ Yes / No / Not Applicable			
Physiotherapist _____ Yes / No / Not Applicable			
Social Worker _____ Yes / No / Not Applicable			
Tour of SCN _____ Yes / No / Not Applicable			
Want orientation on admission:	Y/N	Booking Ref#	Booking Ref#
		Anasthetic Referral #	Y/N
<b>INSTRUCTIONS FOR USE</b>			
<p>This pathway is intended as a guide only. The woman must continue to be assessed individually as to the needs of her pregnancy and the outcome must be achieved.</p> <ul style="list-style-type: none"> <li>● This is a legal document and as such must be completed correctly. Use black pen.</li> <li>● This chart is designed for a multiparous woman.</li> <li>● The midwife or doctor responsible for individual aspects of care or assessing individual outcomes, are to initial in the appropriate area and sign at the bottom of the chart.</li> <li>● This document is to keep at the woman's bedside with the medication and observation charts.</li> <li>● You may enter H/A, only if a procedure or intervention is not appropriate.</li> </ul>			
Admission completed by:		Print Name / Signature / Description	
		Date / /	

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## KẾ HOẠCH CHĂM SÓC

Mercy Public Hospital Inc.			
<b>CLINICAL PATHWAY ANTENATAL</b>		Attach Patient Label	
<b>HOSPITAL ADMISSION CURRENT PREGNANCY:</b>		<b>G</b> <b>R</b> <b>EDC</b>	
<b>1. Date</b> / / <b>2. Date</b> / / <b>3. Date</b> / /	<b>Gestation</b>	<b>Reason for Admission</b>	
Blood Group	Rubella Status	Maternal GBS Status	Streptols
Anti D Date 1 Date 2	Immune / Non-Immune	Negative / Positive / Unknown	Date 1 Date 2 Date 3
<b>ALLERGIES:</b>			
<b>FAMILY AND SOCIAL HISTORY:</b>			
Patient's Name _____ Cultural / Religious Requirements Interpreter Dietary Requirements			
<b>RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:</b>			
<b>ISSUES / CONCERNs:</b>			
<b>SMOKING: Y / N</b>		<b>PER DAY:</b>	
<b>ADVICE / INFORMATION GIVEN:</b>			
<b>CESSATION DATE:</b>			
<b>ALIED HEALTH/SPECIALIST REFERRAL (please circle)</b>			
MBB Yes / No / Not Applicable			
District / Diabetes Educator Yes / No / Not Applicable			
Paediatrician Yes / No / Not Applicable			
Physiotherapist Yes / No / Not Applicable			
Festive Care Yes / No / Not Applicable			
Psychotherapy Yes / No / Not Applicable			
Social Worker Yes / No / Not Applicable			
Tear of SCN Yes / No / Not Applicable			
<b>Want orientation on admission</b>		<b>Height</b>	<b>Booking Bill</b>
			Anesthetic referral if > 35
<b>INSTRUCTIONS FOR USE</b>			
<p>This pathway is intended as a general one. The woman's individual needs to be assessed individually as to the appropriateness of each component and each section reviewed.</p> <ul style="list-style-type: none"> <li>● This is a legal document and any section must be completed correctly. Use black pen.</li> <li>● This chart is designed for a multidisciplinary team.</li> <li>● All staff involved in the care of the woman must contribute for individual aspects of care or assessing individual components, to be initial in the appropriate area and sign at the bottom of the chart.</li> <li>● This document is to be kept at the woman's bedside with the medication and observation charts.</li> <li>● You may enter N/A, only if a procedure or intervention is not appropriate.</li> </ul>			
Admission completed by:		Date	/ /
Print Name / Signature / Despatchation			

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## Care Plan

ANTENATAL ASSESSMENT STANDARDS	
1. Antenatal assessments are to take place at the antenatal visit or on a daily basis during the hospital stay	
1. <u>Antenatal Assessments</u>	
a. Medical Officer admission – documented in progress notes of patient record file	
b. Midwife admission	
i. Electronic Antenatal Clinical Pathway and Clinical Observation chart	
ii. Refer to Medical Officer admission	
2. <u>Daily Antenatal Assessment</u>	
a. Midwife admission – documented as outlined below, and:	
i. Refer to progress notes in patient record file	
DAILY ANTEPARTUM ASSESSMENT – CORE CARE	
<u>Material</u>	<u>Patient</u>
Vital Observations - Pulse, Temp, BP	Pulse, Blood Movements list
Abdominal Palpation (include APNTPL) i.e., presentation	Pulse, Heart rate, blood pressure (within 2 hours +/-)
Other PV (loss, bowel, oedema)	
<b>DVT assessment</b>	<b>Obstetric Health Assessment</b>
Examine lower legs and confirm with the woman the presence of any pain, heat, redness, tenderness, swelling and/or changes in skin colour. Risk factors and clinical reassessments indicated if there is swelling.	Discussion of services available & / or required and clinical requirements. Consider specific pregnancy specific risk factors. Pathology and other requirements – consider use of results
<b>NOTE:</b> The above are minimum observation requirements. More frequent antenatal observations are required if: a) clinical judgement suggests more frequent observations are indicated OR b) as part of medical management or if the following risk factors are present in the following categories	
<b>SPECIFIC OBSERVATION REQUIREMENTS FOR THE FOLLOWING CONDITIONS</b>	
<b>Premature Rupture of Membranes</b>	<b>Hypertension/Preeclampsia</b>
- No contractions, Prevalence labour, Cord prolapse, Oedema	- Hypertension pre E, Eclampsia M / HELLP syndrome
( CTO as indicated )	- Hypertension post E
( No signs right to check less than 12 weeks gestation )	( CTO as indicated )
( CTO as indicated )	- Gestational diabetes
( CTO as indicated )	( CTO as indicated )
<b>APH / Placenta Previa</b>	- Thrombocytopenia/Premature Labour
- No contractions, material / maternal complications	( CTO as indicated )
- Observations:	- Hypotension, uterine contractions, delivery
( maternal pulse & BP at least twice weekly when bleeding present, once weekly when bleeding subsides, otherwise daily )	( CTO as indicated )
( Fetal heart rate (FHR) or more frequently FVU (if less than 36 weeks gestation) or FHR (if greater than 36 weeks gestation) )	( CTO as indicated )
( If status = ARI + CTG if needed )	( CTO as indicated )
( Maternal pulse and free PB bleeding – CTG and code pink )	( CTO as indicated )
( Specific pathology attended to )	( CTO as indicated )
	- Observations:
	( Heavy bleeding, intact membranes, first assessment, medical assessment if ROM )
<b>Breastfed Cervix</b>	<b>Pathophysiology</b>
Risks: Preterm birth	Risks: Cord prolapse
Observations:	Observations:
- Rest in bed	- Intact membranes
( CTO as indicated )	( First assessment )
( Tenderness/bruising position )	( Medical assessment if ROM )
<b>INUR</b>	
Risks: False cord prolapse	
Observations:	
- Monitor fetal movements	
( Encourage maternal rest and adequate diet )	
( CTO as indicated as indicated )	

ANTENATAL RECORD OF CLINICAL OBSERVATION									
Date									
Gravidae									
Time									
BP	100	105	110	115	120	125	130	135	140
	95	100	105	110	115	120	125	130	135
	90	95	100	105	110	115	120	125	130
	85	90	95	100	105	110	115	120	125
	80	85	90	95	100	105	110	115	120
	75	80	85	90	95	100	105	110	115
	70	75	80	85	90	95	100	105	110
	65	70	75	80	85	90	95	100	105
	60	65	70	75	80	85	90	95	100
	55	60	65	70	75	80	85	90	95
	50	55	60	65	70	75	80	85	90
	45	50	55	60	65	70	75	80	85
	40	45	50	55	60	65	70	75	80
	35	40	45	50	55	60	65	70	75
	30	35	40	45	50	55	60	65	70
	25	30	35	40	45	50	55	60	65
	20	25	30	35	40	45	50	55	60
	15	20	25	30	35	40	45	50	55
	10	15	20	25	30	35	40	45	50
	5	10	15	20	25	30	35	40	45
	0	5	10	15	20	25	30	35	40
Temperature	36	36.5	37	37.5	38	38.5	39	39.5	40
Diastolic	60	65	70	75	80	85	90	95	100
Pulse	60	65	70	75	80	85	90	95	100
Height									
LM									
Presentation									
FHR (FM)									
CTG									
Patient Activity									
Assessment									
PV Loss									
Edema									
Contraceptives									
Breast									
Pathology									
New Organ	0	1	2	3	4	5	6	7	8

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## KẾ HOẠCH CHĂM SÓC

ANTENATAL ASSESSMENT STANDARDS									
1. <b>On Admission:</b> Antenatal Assessment	<ul style="list-style-type: none"> <li>a. Medical Office admission - documented in progress notes of patient record file</li> <li>b. Maternity admission           <ul style="list-style-type: none"> <li>- completed Antenatal Clinical Pathway and Clinical Observation chart.</li> <li>- refer to Medical Office admission</li> </ul> </li> </ul>								
2. <b>Daily Antenatal Assessment</b>	<ul style="list-style-type: none"> <li>a. Minimum observations as outlined below, and</li> <li>b. These observations must be entered in patient chart file</li> </ul>								
<b>DAILY ANTENATAL ASSESSMENT - CORE CARE</b>									
<b>Maternal</b>	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"><b>Pulse</b></td><td style="width: 15%;"><b>Fetal</b></td> </tr> <tr> <td>Vital Observations-Pulse, Temp, BP</td><td>Fetal Movements/MFT</td> </tr> <tr> <td>Abdominal Palpation (include APNTPL) L/R; presentation</td><td>Fetal Heart Rate (24 weeks+)</td> </tr> <tr> <td>Other FV loss, breast, etc.</td><td></td> </tr> </table>	<b>Pulse</b>	<b>Fetal</b>	Vital Observations-Pulse, Temp, BP	Fetal Movements/MFT	Abdominal Palpation (include APNTPL) L/R; presentation	Fetal Heart Rate (24 weeks+)	Other FV loss, breast, etc.	
<b>Pulse</b>	<b>Fetal</b>								
Vital Observations-Pulse, Temp, BP	Fetal Movements/MFT								
Abdominal Palpation (include APNTPL) L/R; presentation	Fetal Heart Rate (24 weeks+)								
Other FV loss, breast, etc.									
<b>GVT assessment:</b>	Examine lower legs and confirm with the woman the presence of any pain, heat, redness, tenderness, and changes in skin texture. If two or more of these 4 C/D measurements are reduced it is swelling								
<b>NOTE:</b>	The above are minimum observation requirements. More frequent early specific observations are required if: <ul style="list-style-type: none"> <li>- clinical judgement suggests more frequent observations are indicated OR</li> <li>- as part of medical management unit, CR</li> <li>- if there is a high risk pregnancy site</li> </ul>								
<b>SPECIFIC OBSERVATION REQUIREMENTS FOR THE FOLLOWING CONDITIONS</b>									
<b>Premature Rupture of Membranes</b>	<b>Hypertension / Pre Eclampsia</b> - Blood Substantiated PE / Eclampsia III / HELLP <b>Observations:</b> - 4 hourly temperature, pulse and check - NB-Must sight pad to check loss - CTG and urinalysis								
<b>Obstetrics:</b>	<b>Threatened Premature Labour</b> - Blood, premature delivery <b>Observations:</b> - Heavy observations if contracting - fetal heart check at 1 pm. - CTG ordered - Documentation of contractions and corresponding fetal heart rate - Medical assessment if contracting								
<b>APM / Patients Present</b>	<b>Polyhydramnios</b> - Rupt. Cord, prepuce <b>Observations:</b> - Impact membranes - FHR assessment - Medical assessment if ROM								
<b>Risk: Hemorrhage, maternal / fetal compromise</b>	<b>Uterus</b> - Risk, fetal compromise <b>Observations:</b> - Monitor fetal movements - Encourage maternal rest and adequate diet - CTG and ultrasound as ordered								
<b>Observations:</b>									
- In bed									
- +-- Trendelenburg position									
<b>Shortened Cervix</b>									
<b>Risk: Premature birth</b>									
<b>Observations:</b>									
- In bed									
- +-- Trendelenburg position									

ANTENATAL RECORD OF CLINICAL OBSERVATION											
Date											
Duration											
Time											
HR	160	150	140	130	120	110	100	90	80	70	60
BP	120/80	110/70	100/60	90/50	80/40	70/30	60/20	50/10	40/0	30/0	20/0
Temperature	37.0	36.5	36.0	35.5	35.0	34.5	34.0	33.5	33.0	32.5	32.0
BABY'S HR	160	150	140	130	120	110	100	90	80	70	60
Pulse											
Weight											
Le											
Presentation											
FHR / FFM											
CTG											
Placenta Activity											
Uterine											
Assessment											
PU Loss											
Defens											
Contract											
Brad											
Pathology											
Score	None	1	2	3	4	5	6	7	8	9	10
Score	None	1	2	3	4	5	6	7	8	9	10
Score	None	1	2	3	4	5	6	7	8	9	10

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- Ailsworth, k, Anderson, J, Atwood, L, Bailey, R & Canavan, T et al. *Advanced Life Support in Obstetrics*. 4<sup>th</sup> ed. 2000. American Academy of Family Physicians: Kansas
- Henderson, C & Macdonald, S. *Mayes' Midwifery: A textbook for midwives*. 2006. Bailliere Tindall: China
- Oxorn, H. *Human Labour & Birth*. 1986. Prentice-Hall:USA

- Ailsworth, k, Anderson, J, Atwood, L, Bailey, R & Canavan, T et al. *Advanced Life Support in Obstetrics*. 4<sup>th</sup> ed. 2000. American Academy of Family Physicians: Kansas
- Henderson, C & Macdonald, S. *Mayes' Midwifery: A textbook for midwives*. 2006. Bailliere Tindall: China
- Oxorn, H. *Human Labour & Birth*. 1986. Prentice-Hall:USA

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# THANK YOU

# CHÂN THÀNH CÁM ƠN

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