Ante partum haemorrhage

Definition:

- Is any bleeding occuring in Preg after 24 weeks gestation and prior to birth of the baby
- 2–6 % of Pregnancies. * Leading cause of Mortality in Developing. ↓C
- D.D:

  Show.

  Abruptio Placentae AP. $\frac{1}{3}$rd

  placenta previa PP. $\frac{1}{3}$rd.

  Vasa previa VP

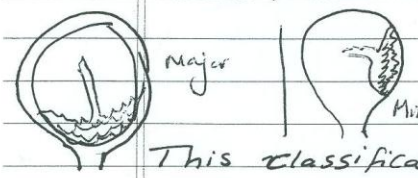
  Local causes: cervicitis, Trauma, carcinoma, uterine rupture.

  Unexplained APH ↑ Risk of PreTerm, IUGR)

1) placenta praevia:

placenta that has implanted into the lower segment of the uterus after 24 weeks

Classification: major → Placent covers the internal cervical os.



minor: placenta is sited within the lower segment of uterus.

This classification Replaces the olde I–IV classification

- complete or Total.
- Partial.
- Marginal.
- Low-lying (within 2cm) From Internal OS.

Incidence:

1: 200 to 1 in 390 Pregnancies Over 20 weeks

↑ with increasing age, Parity and uterine scars.

Smoking, multiple Pregnancies, Previous uterine Curettage. Uterine structural anomaly. Assisted Conception.

- single c/s → 1% placenta previa
- 4 c/s → ↑ 10% " "

Morbidly adherent placenta } 3 Types:

1. Placenta accreta: placenta adherent to uterine wall
   4% → if placenta previa. (No previous scar)
   25% → if Previous Uterine scar.
2. Placenta increta:
   placenta invades myometrium.
3. • Percreta: penetrate the ~~entire~~ entire wall Potentially growing into bladder or bowel.

. PP associated with Double Rate of Fetal
. Congenital malformation CNS. GIT, CVS, Resp.S.
. Fetal malpresentation.
. Pre Term Premature Ro.m.
. IUGR. Velamentous cord insertion. . UP.

Diagnosis:

History: Acute painless vaginal bleeding with brightred.
≈ 34 weeks. (1st attack)
1/3rd develop before 30w
1/3rd = after 36w
. Recurrent . Causless.

Ex: :- vitals . Abd E: Soft abdomen, Presenting Part Free Can't enter pelvis.
xxxx No Vaginal ↓ Ex. or rectal . Speculum Ex To R/o Other Local Causes.

investigations

- Vaginal U/s is gold Standard ~~For~~ Diagnosis
- CBC. Coag. P. Kleihauer.. Betke Test in Rh-ve Mother
- APT Test (Not practical)
- Type and cross Match.
- Keep HCT >30%.
- Tocolytics can be Considered Mgso4 For Steroids administration
- outpt: If No bleeding
  . An adult with her To Assist her.

Managment:

Delivery c/s. if severe bleeding, mature fetus, or distressed.

- Minor bleeding:
  - Observe ~~24h~~ for maternal & Fetal Monitoring.
  - Lab studies.
  - steroids 24 — 34w.
  - Rh DIg To Rh -ve mother.
- Severe bleeding - ABC
  - c/s by senior obst. senior Anasthitist
- Risk of Massive PPH.
- minor placenta previa within 2cm can deliver vaginaly

- There is No place To insert CX cercalge or use of Prophylactic Tocolytics in PL with previa To prevent bleeding or prolonged pregnan

Risk during operation:-

- Anasthesia.
- Difficult delivery if Anterior placenta.
- Morbidly adherent placenta.
- PPH.
- hysterectomy.

Placental abruption. (PA)

Definition:

Is the Premature separation of the normally implanted Placenta From the Uterine wall due to Maternal /Uterine bleeding into Decidua basalis

A) Revealed B) Concealed.

Epidemiology

- 1 in 75 to 1 in 225 births
- previous history $\xrightarrow{\text{Risk}}$ 5% → 17%
- Two c = → ↑ 25%.
- Incidence of Stillbirth 7% in future pregnancy due P.A

~~Etiology~~ history:

- Vaginal bleeding, ~~Painful~~. Vary in amount.
- Forceful, Tetanic uterine contraction → Ischemic abdominal pain (Continuous pain)

Etiology

- ↑ age, ↑ Parity, ↑ B.P. Cocaine use, Tobacco (↑ 2.5 Fold)
  Chorioamnionitis and Trauma.
  idiopathic, placenta implants with submucous fibroid.
  Rapid changes in intra-uterine volume → Ro.m or amnioreduction with Polyhydramnios or during Labor of Multiple Pregnancy.
- Thrombophilias → ↑ risk of abruptio. P.

O/E

↑ B.P. Tender uterus, hard (± woody feel. ↑ in Size (blood), CTG non reassuring or Fetal Death

Assess Vaginal bleeding (by Speculum Ex)

- Defere Digital Exam unhill P.P + VP R/o.

Dx: Examination: is

U/S ~~IN~~sensitive To diagnose P. A.

U/S To R/o placentaprevia.

Complications:

- hemorrhagic Shock → Renal tubular necrosis
- DIC (10-30% IUFD)
- Couvelaire's uterus → Extravasation of blood directly into the uterine muscle → Massive PPH.
- Fetal hypoxia or Death

investigation:

CBC. Plat < 100,000/ml → Severe.
CXM blood
PT, APTT.
Fibrinogen < 200mg/d → Severe.

Managment

- ABC.
- Aim HCT > 25% Plat > 60,000 Fibrinogen > 150
- Dead fetus → aim vaginal Delivery.
- Aline → CVS.

bleeding grading:-

1. Spotting: Staining, smearing or blood spotting noted
2. Minor hemorrhage < 50 ml
3. Major = 50 - 1000 ml. No sign of Shock.
4. Massive >1000 ml and or signs of Clinical Shock: ↑ Pulse ↓ B.P

CAN APH prevented:

- Smoking and, Cocaine, amphetamine Cessation.
- Folic acid supplementation
- ASpirin ± LMWH heparin in Thrombophilia
- There is Limited evidence to support intervention to Prevent APH.
- Domestic Violence in pregnancy may result in APH.

Unexplained APH: Risk of PreTerm L, Smaller

Managment of pt known to be at high risk of haemorrhage should be in centres with Facilities of blood Transfusion intesive care.

Senior obstetrican
Senior Anasthetist
Senior Neonatologist
→ Needed in APH.

Vasa praevia: 1:1000 and 1:5000 pregnancies. Rare. Catastrophic for fetus.
- Rupture of Fetal Blood vessels running within the membranes, often near to cervical os and damaged when Rupture of membranes.
- Fetal blood lost → high risk of Death 60%.

CTG will show abnormalities Tachycardia Then deep Decelerations or Sinusoidal pattern.

Risk group:
- placenta previa.
- velamentous placenta.
- multiple preg.

Rx: CIS.

- APTS Test not used.

- Dx during pregnancy color doppler U/S → 97% Survival Rate.

APT's Test:
To Evaluate Whether vaginal blood is from mother or Fetus. Collect blood + NaOH → Fetal Hb resistant To base → Remain Pink.
maternal will oxidize → brown.