Assessment

- Vital signs / Pain assessment
- Estimate blood loss
- History
- Abdominal palpation (gentle)

The serious causes of APH are:

- Placenta Praevia (US dx)
- Placenta Abruption (clinical dx)
- Vasa Praevia (rare)

Consider

- IV Access (16g)
- Collect blood for: Hb, Group & X Match,

NO

*FMH test (Rh neg)

Is the CTG non-reassuring or any maternal compromise?

Summon help

YES

- Obstetric Medical Officer
- Anaesthetist
- Haematologist
- Paediatrician

Management - according to gestation and diagnosis

- Clinical history and examination
- Consider analgesia
- Ultrasound to confirm placental site
- Speculum
- If RH negative: *FMH test / Anti D if required Rh D Immunoglobulin in Obstetrics

Differential diagnosis:

- Placenta praevia
- Placental abruption

Resuscitation (Concurrent management)

- IV access 16g and
- Collect blood:
 - o FBC
 - Group & Cross-match 0
 - Coagulation profile
 - *FMH test (Feto-maternal haemorrhage) for Rh negative women
- If significant blood loss → Volume/Blood replacement. Blood administration
- Oxygen
- Indwelling urinary catheter
- FHR auscultation/ continuous CTG
- Maternal monitoring: ongoing, vital signs, blood loss

Ongoing management is individualised according to gestation, diagnosis and patient condition.

Principles may include:

20-24 weeks

- Admission
- Bed rest
- Maternal monitoring
- Paediatric consultation

24-36 weeks

- Consider corticosteroids (usually 24-34 weeks)
- Continued fetal surveillance
- Anti D if RH negative

Rh D Immunoglobulin in Obstetrics

Paediatric consultation

36 weeks

Praevia

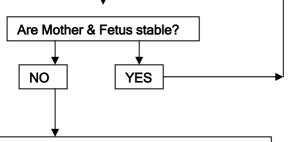
- Expectant management
- Elective C/S Booking

Abruption

- **Expectant management**
- Consider induction 37 weeks+. earlier if fetal or maternal compromise

Confirm diagnosis / gestation

- Ultrasound
- Speculum examination



Timing and mode of delivery determined by gestation and maternal / fetal status