

Antepartum Haemorrhage (including placenta praevia, abruption and MOH)

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline covers the diagnosis and management of Antepartum Haemorrhage (APH) and associated conditions.

This Guidance should be used in conjunction with the trust guideline [Major Haemorrhage Protocol](#).

This guideline is for use by the following staff groups:

Midwives and Doctors

Lead Clinician(s)

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Approved by *Maternity Governance Meeting* on: 17th October 2025

Approved by Medicines Safety Committee on: 13th January 2026

Review Date: 17th October 2028

This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
Oct 25	Combined Guidelines, no clinical practice updates.	MGM

Inclusion statement

We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

Ockenden Maternity Guidelines Assessment

Is there National Guidance Available for this guideline?	Yes
National Guidance used to inform guideline <i>e.g. NICE/RCOG</i>	RCOG Green-top guideline no. 63 Antepartum Haemorrhage (Green-top Guideline No. 63) RCOG
Does the guideline follow National Guidance if available? <i>If no, what rationale has been used.</i>	Yes
If no national guidance available or national guidance not followed, what evidence has been used to inform guideline.	
Ratified at Maternity Guidelines Forum:	17/10/2025

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Definitions

Antepartum haemorrhage (APH) is bleeding from the genital tract after 24 weeks of gestation up to and including delivery of the fetus. Volume lost is often difficult to quantify, therefore it is paramount to be guided by clinical signs and that fetal compromise or demise serves as an important indicator of volume loss.

- Spotting – streaking/staining or blood spotting on underwear or pad
- Minor haemorrhage - <50ml that has settled
- Major haemorrhage – 50-1000ml w/o signs of shock
- Massive haemorrhage - >1000ml or any volume with evidence of shock

Introduction

Obstetric Haemorrhage remains one of the most important causes of maternal mortality. One of the common causes for concern was poor management of placenta praevia.

The recumbent pregnant women can maintain a normal pulse and blood pressure until she has lost one third of her blood volume and therefore in obstetric haemorrhage hemodynamic status may not correspond to apparent blood loss.

Women who decline blood products

Women who decline blood products should be reviewed by an obstetrician and an anaesthetist antenatally. A clear management plan should be documented in the medical records. (Refer to the guidelines Treatment of obstetric haemorrhage in women who refuse blood transfusion and Management of Jehovah's witness patient and others who refuse blood transfusion).

Causes of APH

Main causes are:

- Placenta praevia
- Placental abruption
- Unclassified APH
- Vasa praevia – see guideline
- Local causes e.g. bleeding from cervix / vagina
- Bleeding from previous caesarean scar/ uterine rupture – see [Ruptured Uterus](#) & [Vaginal birth after caesarean section \(VBAC\)](#)

Risk Factors

APH has heterogeneous pathology and cannot be predicted, however modifiable risk-factors include.

- Smoking (encourage cessation)
- Cocaine and amphetamine misuse (encourage cessation)
- Use of artificial reproductive techniques

Clinicians should note that APH (regardless of the cause) is associated with increased perinatal morbidity and mortality and as such those presenting with APH should be considered a high-risk pregnancy and transferred to consultant-led care.

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Management

- History - including any risk factors and smear history
- Maternal observations
- Abdominal palpation
- Speculum examination
- Digital examination – only perform if certain there is no placenta praevia
- Consider – USS for placental localisation (if not known or evidence to suggest it may be low lying)
- Consider Kleihauer if RhD –ve
- Assess fetal wellbeing – CTG/USS

Women presenting with spotting, who are no longer bleeding and where placenta praevia has been excluded may go home, following a reassuring initial clinical assessment, in the absence of additional risk factors.

All women with an initial APH, heavier than spotting or with ongoing bleeding should remain in hospital until the bleeding has stopped (usually 24hours after the bleeding has stopped).

Paired steroids, for fetal lung maturation should be considered from 24+0-34+6 if preterm delivery is likely. For women presenting with spotting, where lower genital tract bleeding is the likely source and imminent delivery is unlikely, steroids are unlikely to be of benefit, but should still be considered.

Tocolysis should only be used to allow for steroid administration if the woman is stable and there is no fetal compromise. This decision should be made by the senior decision maker.

Following a single episode of spotting from a cervical ectropion antenatal care need not be altered, however following an APH from any other source, the pregnancy should be reclassified as 'high risk', the women booked under consultant led care with serial growth scans performed.

RhD –ve women should be given anti D Ig following an APH regardless of whether prophylaxis has been given or not. In those with recurrent APH, anti D Ig should be given every 6 weeks as a minimum.

Timing of Delivery

Women with an APH and evidence of maternal/fetal compromise require immediate delivery.

Optimum timing of delivery for women presenting with an unexplained APH without evidence of maternal/fetal compromise is not known. Therefore, timing of delivery in such cases should be individualised and made by a senior obstetrician.

Fetal monitoring in labour

Women with a history of APH require continuous, external fetal monitoring in labour. For those with a single minor APH/episode of spotting and no subsequent concerns or risk factors, intermittent auscultation is appropriate.

Management of Major APH

1. Prompt recognition
2. Summon help - Consultant obstetrician / anaesthetist
Registrar obstetrician / anaesthetist
Midwives and delivery suite coordinator
Porters should be informed to be on standby for urgent blood collection from the lab
Haematologist and blood transfusion technicians
HCAs

Identify an individual to scribe.

3. Activate 2222 call and say 'Major Haemorrhage' and give location. Switchboard will contact the lab, the anaesthetist on call, the porters and consultant haematologist. The major haemorrhage pack will be initiated as per [Major Haemorrhage Protocol](#).

Follow ABCD rule

A - Airway

- Assess and maintain patency.
- O2 via face mask (Hudson).
- Attach pulse oximeter to patient.

B - Breathing

- Assess
- Protect airway
- Monitor respiratory rate

C - Circulation

Restoration of circulating volume should be the first priority and labour ward anaesthetist should take charge of this.

- Insert 2 large bore IV cannulae.
 - Send bloods for FBC, clotting studies, PET bloods and X-match 4 units blood. If the baby is dead the abruption is major by definition and a coagulopathy is possible. There is likely to have been up to 1500ml of haemorrhage. It is important to give up to 2 units of blood as soon as possible. Do not be fooled by haemoglobin estimation on admission as it may well be falsely elevated.
 - Clinical vigilance & ongoing assessment of patient. Continuous pulse/BP/ECG/Oximeter monitoring
 - Regularly assess volume loss
 - Consider CVP/arterial line.
 - Catheterise and monitor urine output hourly.

Replace volume loss and Urgent access to blood

- Warm IV fluids and infuse with a pressure bag. Initially infuse up to 2 litres of Hartmann's solution followed by colloid e.g. Volplex 500millilitres. Administer blood as soon as it is possible.

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- If blood loss appears life threatening, consider giving O Rh negative red cells. Preferably however please use group specific fully X matched blood.
- When requesting blood be clear in your request to the haematologist and porters about the urgency and state what you need, when you need it and enquire when it will be ready for collection alert.
- If transferring to theatre for caesarean consideraiton should be given to the use of cell salvage

D - **Diagnose** the cause of APH and manage accordingly as above with regards to fetal monitoring and delivery.

Inform paediatricians and request attendance of experienced paediatrician for delivery.

NB: APH predisposes to PPH (PPH guideline)

After Care

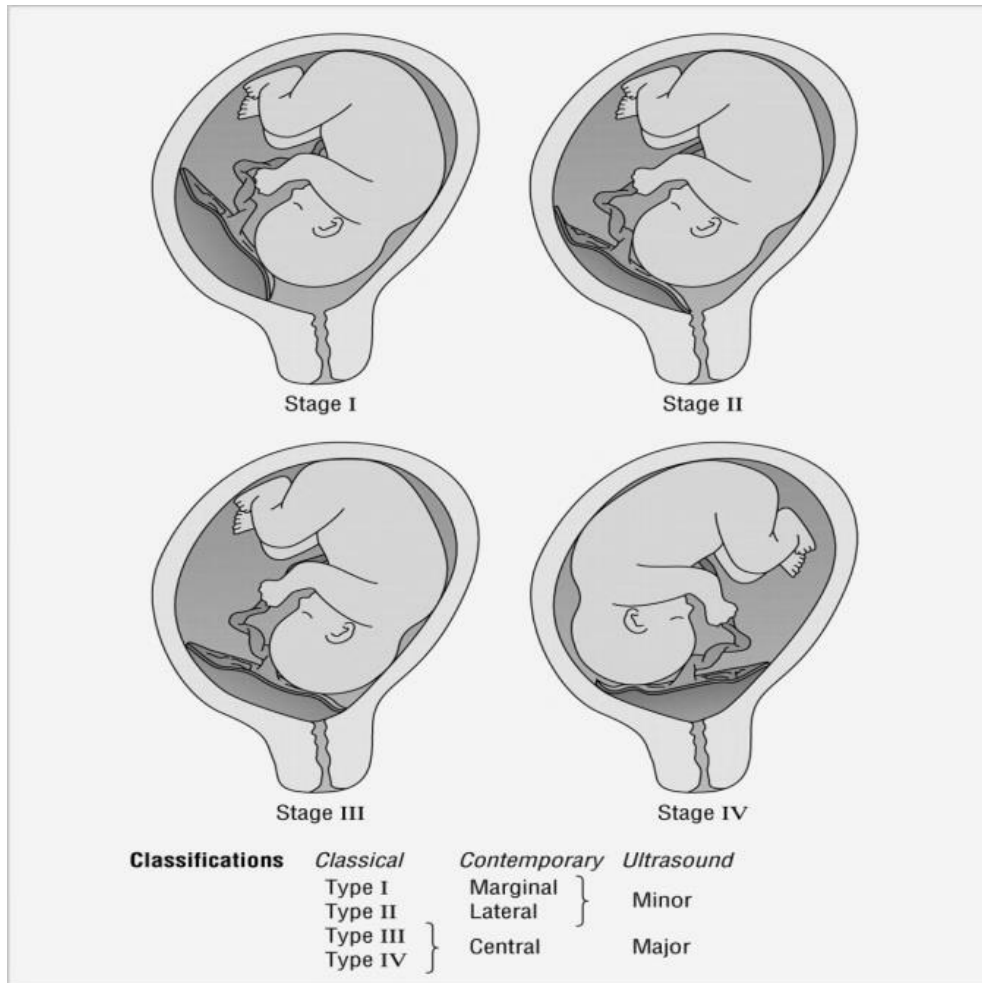
- All women following major APH require intensive monitoring for at least first 24 hours.
- In some cases, transfer to high dependency unit or ITU may be required.
- Remember accurate documentation at all times.
- Debrief/discuss with patients & colleagues following delivery.
- Datix should be completed for all major APH cases.
- It is important to remember that thrombo-embolic disease (TED) is still one of the leading causes of maternal death. TED stockings should be the bare minimum in these cases. Consider pneumatic calf compression devices and continue them post-operatively until it is safe to give heparin (e.g. Inhixa)

Likely Causes

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Placenta Praevia

When the placenta is implanted in part or in whole on the lower uterine segment (LUS)



Signs & Symptoms

- It usually presents as painless and bright red bleeding PV and often with no precipitating factors.
- Uterus is usually soft and non-tender
- In certain cases of preterm labour with placenta praevia there may be associated abdominal pain.
- There is malpresentation and/or high presenting part
- Patient's hemodynamic status usually corresponds to apparent blood loss
- Fetal heart is usually normal. If there is difficulty in picking up fetal heart ultrasound scan should be performed.

Diagnosis

- Placenta localisation should be performed routinely at the mid trimester scan. If placenta is low lying on the mid trimester scan it should be repeated at 32weeks of gestation to confirm the diagnosis (See [Placenta Accrete \(Management of\)](#) for scan timings of women with a low lying placenta and a previous Caesarean Section)

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- Occasionally, however, this is not the case e.g. if the woman declines antenatal scans and therefore placenta praevia should be suspected if a woman presents with the above symptoms and signs.
- Transvaginal ultrasound scan does not increase the risk of PV bleeding and is more accurate in diagnosing placenta praevia especially in cases of posterior placenta.
- See [Placenta Accrete \(Management of\)](#) for scan timings of women with placenta praevia at 20 weeks and a previous caesarean section

Management of placenta praevia

Massive haemorrhage should be dealt with in accordance with the protocol for major APH (see below):

- All women with placenta praevia must be seen by a consultant obstetrician antenatally and counselled regarding risk of major haemorrhage, transfusion and hysterectomy, and any objections or queries dealt with effectively.
- Aim to prevent and actively treat anaemia in the antenatal period.

Asymptomatic placenta praevia (when reviewed at 32-34 weeks)

- Woman should be advised to avoid intercourse, limit travel and attend hospital immediately if bleeding starts.
- If no bleeding she may be managed as an outpatient after careful counselling.
- A woman with an asymptomatic major praevia at 34 weeks should be very carefully counselled by the consultant before contemplating outpatient care. Any home-based care requires close proximity with the hospital, the constant presence of a companion and full informed consent from the woman.
- It should be made clear to any woman being managed at home that she should attend hospital immediately if she experiences any bleeding, any contractions or any pain (including vague suprapubic period-like aches).

Placenta Praevia and antepartum haemorrhage (APH)

- Management will depend upon gestation, amount of bleeding, site/ type of placenta and haemodynamic status of the woman.
- Vaginal examination should be avoided in all known cases of placenta praevia and in cases where placenta praevia has not been excluded.
- Massive haemorrhage should be dealt with in accordance with the protocol for massive obstetric haemorrhage.
- Women with minor placenta praevia who present with APH should be admitted and monitored. If bleeding settles and there are no further episodes of bleeding PV over 48 hours they may be managed as an outpatient with careful counselling. It should be made clear to any woman being managed at home that she should attend hospital immediately if she experiences any bleeding, any contractions or any pain (including vague suprapubic period-like aches).
- **Women less than 34 weeks with major praevia who have previously bled should initially be managed as an inpatient for at least 48 hours after the bleeding settles. They may then be managed as an outpatient after careful counselling and review by a consultant.**
- **Women from 34 weeks of gestation with major placenta praevia who have previously bled should be reviewed and counselled on an individual basis. There should be a low threshold for offering admission from 34/40 and if being managed**

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as an outpatient they must be advised to attend hospital immediately if she experiences any bleeding, contractions or pain (including vague suprapubic period-like aches). She should be advised to remain close to the hospital and to have the constant presence of a companion.

- Decisions regarding blood availability during inpatient antenatal care should be based on clinical factors relating to individual cases, as well as local blood bank services. Women with atypical antibodies form a particular high-risk group and discussions in these cases should involve the local haematologist and blood bank.

Mode of delivery

Should be based on clinical judgement supplemented by sonographic information. Based on the RCOG Green Top Guideline No 27 2011

- A woman with a placental edge less than or equal to 2cm from the internal os should be delivered by caesarean section.
- If placental edge is >2 cms from the internal os women are suitable for vaginal delivery.

Timing of delivery

Late preterm (34+0 to 36+6 weeks of gestation) delivery should be considered for women presenting with placenta praevia or a low-lying placenta and a history of vaginal bleeding or other associated risk factors for preterm delivery.

Delivery timing should be tailored according to antenatal symptoms and, for women presenting with uncomplicated placenta praevia, delivery should be considered between 36+0 and 37+0 weeks of gestation.

Emergency caesarean section will be influenced by individual circumstances.

Personnel at delivery

Any woman going to theatre with known placenta praevia should be delivered by the most experienced obstetrician and anaesthetist on duty. As a minimum requirement during a planned procedure, a consultant obstetrician and anaesthetist should be present within the delivery suite. A junior doctor should not be left unsupervised when caring for these women.

When an emergency arises, consultant staff should be alerted and should attend as soon as possible.

CEMACH recommends that all caesarean sections performed in women with placenta praevia who have had a previous caesarean section should be conducted by a consultant obstetrician, because of the high risk of major morbidity.

Anaesthesia

The choice of anaesthetic technique for caesarean section for placenta praevia must be made by the anaesthetist, in consultation with the obstetrician and mother, but there is increasing evidence to support the safety of regional blockade.

Technical aspects of caesarean section for placenta praevia

- Placenta praevia with or without previous caesarean section carries a risk of massive obstetric haemorrhage and hysterectomy.
- Consent should include risk of hysterectomy, massive blood loss and need for blood products.
- In most cases the lower uterine segment (LUS) is sufficiently developed to allow low transverse uterine incision.

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- If LUS is marginally developed and there are large vessels over the LUS then classical caesarean section may be a safer option
- Its best to leave membranes intact go to the edge of the placenta, rupture the membranes and bring the presenting part out through the incision, this is much better than cutting through the placenta, which increases the risk of fetal exsanguination
- The surgical manoeuvres required in the face of massive haemorrhage associated with placenta praevia caesarean section should be performed by appropriately experienced surgeons.
- See the guidelines on management of PPH for the management of bleeding from placental bed including use of Balloon Tamponade. - PPH & Balloon tamponade guideline)
- Blood should be readily available for the peripartum period: whether ready cross matched blood is required and in what amount will depend on the clinical features of each individual case. When women have atypical antibodies, direct communication with the blood bank should enable specific plans to be made to match the individual circumstance.
- Cell salvage should be considered in women at high risk of massive haemorrhage and especially in women who refuse donor blood.

Placental Abruption

Partial or complete premature separation of a normally situated placenta before the delivery of the baby.

Risk factors include: previous abruption, pre-eclampsia, IUGR, non-vertex presentation, polyhydramnios, advanced maternal age, multiparity, low BMI, IVF, intrauterine infection, PROM, trauma, smoking and drug use (cocaine and amphetamines) and maternal thrombophilias.

- The bleeding may be concealed, revealed or both.
- Patient's hemodynamic status does not always correspond to apparent blood loss. Be aware of large concealed abruption where revealed APH may be minimal.
- All women presenting with APH should have their pulse and blood pressure checked.
- Be Alert! Pre-eclampsia and abruption commonly co-exist.
- There is tendency to under transfuse in cases of massive APH, and CVP should be considered.
- Sudden onset of severe abdominal pain, shock, and tenderness over a hard woody feeling uterus are the characteristic signs and symptoms.
- However where there an abruption in a posteriorly sited placenta the uterus may be soft.
- The fetal heart sounds may be muffled or absent. If unsure perform ultrasound scan to confirm fetal heart either present or absent.
- Fetomaternal haemorrhage during abruption can be significant. Kleihauer test should be performed on all Rh negative women with abruption and appropriate dose of anti-D should be given. Anti D Guideline

Placental Abruption & Intrauterine Fetal Death

- If an IUD has been identified the abruption is major by definition and a coagulopathy is possible. There is likely to have been up to 1500ml of haemorrhage (always implement

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the massive haemorrhage protocol see page 3). Consider early and appropriate blood transfusion

NB: Haemoglobin estimation on admission may be falsely elevated.

- On-call consultant obstetrician and anaesthetist should be informed a.s.a.p.
- ARM should be performed if cervix is favourable as this will reduce intra-uterine pressure.
- If maternal condition is stable and cervix is not favourable induction of labour should be considered using Propess 10milligrams vaginally (see guideline Induction of labour)
- Urine output should be monitored hourly.
- Labour usually progresses quickly to vaginal delivery in this situation.
- If labour progress is inadequate labour should be augmented with oxytocin
- Try and avoid a caesarean section in these cases where the fetus is dead.

Mild revealed abruption & live fetus and no uterine tenderness

- Expectant management may be followed.
- Timing and mode of delivery depends upon amount of bleeding, maternal status and presence or absence of fetal heart and gestation.

Major Placental Abruption & Live Fetus

- In all cases of significant revealed APH / concealed abruption management depends on maternal condition and should be dealt with in accordance with the protocol for major APH (see below).
- In suspected cases of placental abruption where the fetus is alive the decision regarding delivery will be determined by a number of factors e.g. CTG, maternal condition, degree of bleeding (if revealed haemorrhage) and gestation.
- The decision re delivery should be made by an experienced obstetrician.
- If caesarean section is to be performed for major abruption Consultant Obstetrician and Consultant Anaesthetist should ideally be present and haematology must be involved. There may be cases of major abruption where urgent caesarean section may be required and senior most obstetrician available should proceed with the delivery while awaiting arrival of on-call consultant.

Unclassified APH

- In almost 50% of cases cause of APH cannot be established. Some of these are minor degrees of placenta praevia and placental abruption and others may be disruption of sinuses or small vessels.
- Usually associated with mild APH and in some cases recurrent episodes of minimal bleeding PV.
- These cases may be managed as an outpatient after initial assessment for 24 hours.
- Fetal growth should be monitored by serial growth scans as there is a higher risk of IUGR and perinatal loss.
- In cases of recurrent unclassified APH induction of labour should be considered at or near term even if fetal growth is satisfactory.
- Kleihauer test should be performed on all Rh negative women with abruption and appropriate dose of anti-D should be given. Anti D Guideline

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Local Causes

- Bleeding can occasionally occur from the cervix either due to cervical ectopy or polyps (very rarely cervical carcinoma).
- The bleeding however is not usually massive.
- Bleeding from the vagina is not common and usually follows on from trauma.
- Vulval bleeding can result from the rupture of vulval varicosities. Immediate treatment is by applying pressure to the vulva and resuscitation. Surgery may well be necessary to stop the bleeding.
- Bleeding may occur from perineal laceration caused by descending fetal parts during active second stage. If there is significant bleeding while awaiting delivery of the baby it should be expedited e.g. by giving episiotomy or instrumental delivery as maternal shock can occur from significant APH whatever the cause.

References

Royal College of Obstetricians and Gynaecologists (RCOG). (2011). *Antepartum Haemorrhage (Green-top Guideline No. 63)*. London: RCOG. Available at: <https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/antepartum-haemorrhage-green-top-guideline-no-63/>

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Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: <i>(Responsible for also ensuring actions are developed to address any areas of non-compliance)</i>	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	Datix Reporting of APH occurrence	DATIX	AdHoc	Governance Team	QSRM	AdHoc

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Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Maternity Governance Meeting
Maternity Guidelines Committee

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting