Bleeding in Pregnancy

Pre-eclampsia

Pathology

Pregnancy induced HT with proteinuria +/- oedema
Affects hepatic, renal and coagulation systems
Develops after 20 weeks, usually resolving within 10 days of delivery
Major cause of maternal death and fetal mortality/morbidity
May be asymptomatic so frequent screening is vital
Maternal: past or FHL <155cm tall, large weight, age <20 or >35, Hx of migraine, HT
Fetal: multiple pregnancy, placental hydrops (e.g. thalas disease)
Lower plasma volume
Increased peripheral resistance
Placental ischaemia
If BP very high microaneurysms develop in arteries
Fetal asphyxia, abruptio - small babies
Late effects: HT and renal failure (consider screening)
Antenatal BP checks / urinalysis
Use of magnesium sulphate
Aspirin at low dose for high risk women
Flu-like symptoms
Headache, chest or epigastric pain
Vomiting
Tachycardia
Visual disturbances, shaking, hyperreflexia, irritability
Risk of generalised seizures
Do not ignore proteinuria - death may result from stroke, hepatic, cardiac or renal failure
Anti hypertensives do not stop pre-eclampsia, only delivery does
Loss greater than 500ml in first 24hrs after delivery
Occurs in 6% of deliveries
Causes: poor uterine contractions, genital tract trauma, clotting disorders
Mgt: usual measures + oxytocin slowly IV
Excessive blood loss > 24hrs after delivery
Usually occurs between 5 and 12 days and is due to retained placental tissue or clot
Secondary infection is common

Complications in Pregnancy & Labour 3

Threatened miscarriage
Bleeding in presence of intra-uterine pregnancy with a closed cervical os
Diagnosis until proven otherwise
Expulsion of products of conception before viability (<24 weeks)
Causes: commonly no cause found, chromosomal anomalies, disappearing twin, thrombophilia, infection
Surgical (vacuum / scrape out products)
Implantation outside uterine cavity
Sites: tubal (95%), cervical, ovarian, abdominal
Risk factors: Hx of infertility, PID, pelvic surgery, IVF, IUCD
Symptoms and signs: lower abdo pain, slight vaginal bleeding, shoulder tip pain, cervical excitation and tenderness on bimanual, supoptimal rise in 48hr serum bHCG
Management: medical (methotrexate), surgical (remove ectopic)

Ectopic pregnancy
Implantation outside uterine cavity
Incidence of 1%
Sites: tubal (95%), cervical, ovarian, abdominal
Risk factors: Hx of infertility, PID, pelvic surgery, IVF, IUCD
Symptoms and signs: lower abdo pain, slight vaginal bleeding, shoulder tip pain, cervical excitation and tenderness on bimanual, supoptimal rise in 48hr serum bHCG
Management: medical (methotrexate), surgical (remove ectopic)

APH
40% no cause found
Local causes: intra / vaginal infection, trauma, cervical ectropion, tumours
Insertion of the placenta in the lower segment of the uterus
Painless bleeding and recurrent bleeds (small before large)
Source of bleed is maternal (fetal rarely distressed)
Management: usual measures + oxytocin slowly IV

Placenta praevia
Uterus not tender
Placenta praevia + C section scar = increased risk of placenta accreta (abnormal adherence attachment of placenta to abdo wall)
Source of bleed is maternal (fetal rarely distressed)
Management: usual measures + oxytocin slowly IV

Pre-eclampsia
Hypertension
Pathology
Lower plasma volume
Increased peripheral resistance
Placental ischaemia
No rapid response to treatment
Causes: low birth weight, stroke, HT, renal failure, HELLP
Risk factors: pregnancy induced HT, past or FHx, <155cm tall, obesity, age >35
Management: supportive measures

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Postpartum Haemorrhage

Abruption
Shock in proportion to blood loss
Foetus often distressed
Late effects: HT and renal failure (consider screening)

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