PIPADOR REVISION

MRCOG Part 1 Revision Notes

Antepartum Haemorrhage

CLINICAL MANAGEMENT • LECTURE 466

VISUAL EXAMINATION REVISION NOTES

2026 Edition

466

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Antepartum Haemorrhage

Definitions, causes, assessment and management of APH, placenta praevia, accreta and vasa praevia

≥ 24 weeks	Praevia	Abruption	No VE
APH definition	Painless bleeding	Painful bleeding	Until praevia excluded

■ KEY FACTS: Learning objectives

- Define antepartum haemorrhage (APH), its severity grades and the definitions of placenta praevia, low-lying placenta and vasa praevia.
- Describe the causes, assessment and initial management of APH (RCOG GTG 63).
- Describe management of placenta praevia, placenta accreta spectrum and vasa praevia (RCOG GTG 27a/27b).

466.1 Key definitions

Term	Definition
Antepartum haemorrhage (APH)	Bleeding from or into the genital tract from 24+0 weeks of pregnancy until the birth of the baby
Spotting	Staining, streaking or blood spotting on underwear or sanitary protection
Minor APH	Blood loss < 50 mL that has settled
Major APH	Blood loss 50–1,000 mL with no signs of clinical shock
Massive APH	Blood loss > 1,000 mL and/or signs of clinical shock
Recurrent APH	More than one episode of APH
Low-lying placenta	Placental edge < 20 mm from the internal os (TVS) after 16 weeks
Placenta praevia	Placenta lying directly over the internal os
Placenta accreta spectrum (PAS)	Abnormally invasive placenta (accreta, increta, percreta) — risk ↑ with previous CS + praevia
Vasa praevia	Fetal vessels running in membranes over or near the internal os — unprotected by placenta or cord

■ IN PLAIN ENGLISH: APH

Bleeding in later pregnancy can come from the **placenta** (praevia, abruption), the **fetus** (vasa praevia) or the **lower genital tract**. Visible blood loss often **underestimates** the true loss — especially in abruption.

466.2 Causes

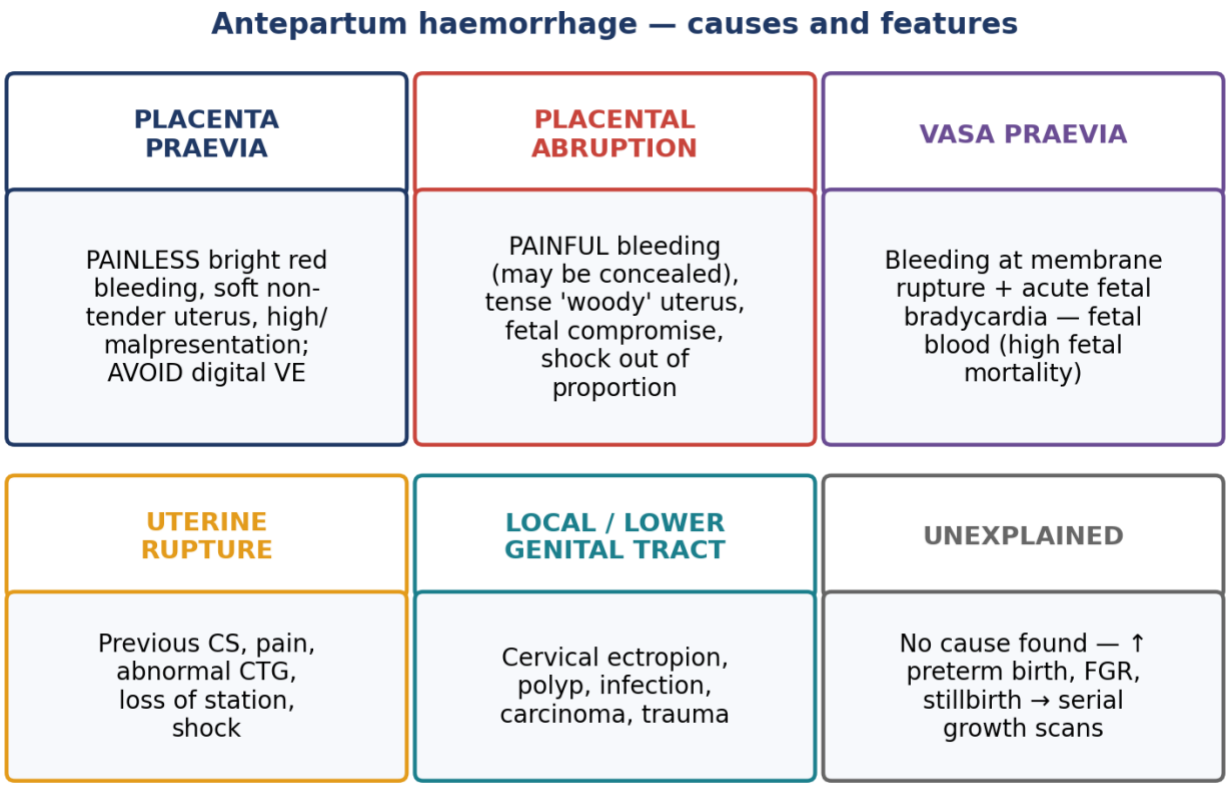


Figure 466.1 — Causes of APH

466.3 Assessment and initial management

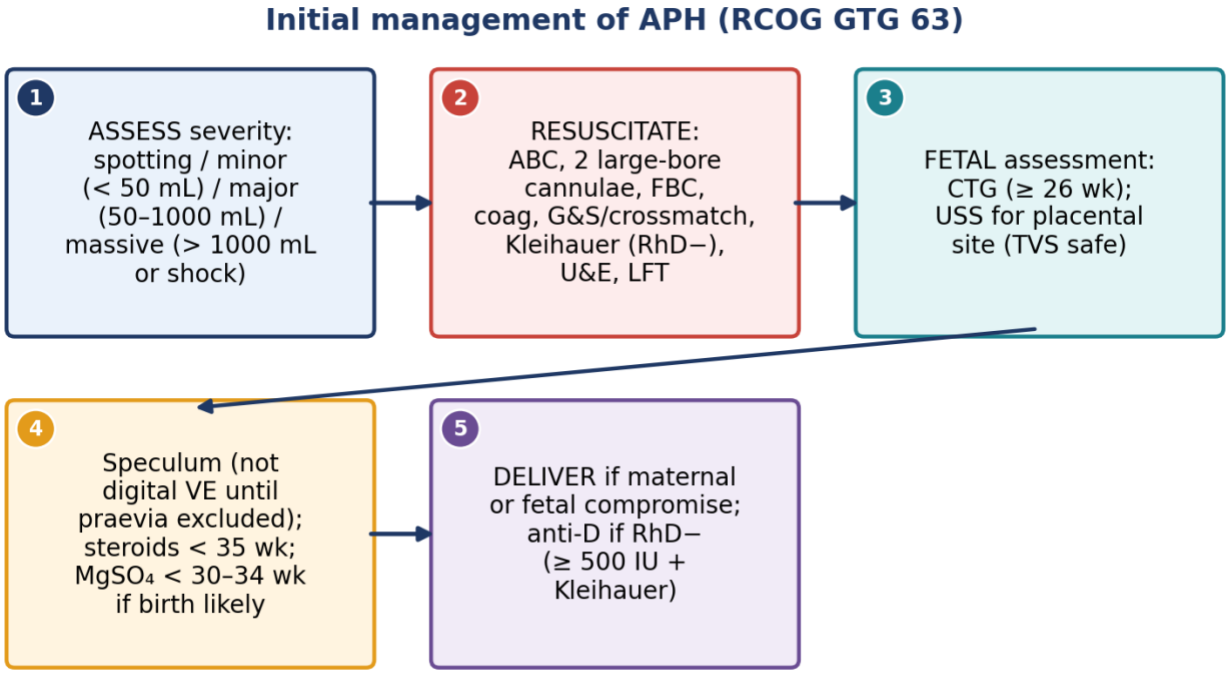


Figure 466.2 — Initial management of APH

Element	Details (RCOG GTG 63)
History	Amount, colour, pain, trigger (intercourse, trauma), fetal movements, previous scans (placental site), risk factors
Examination	• Pulse, BP (tachycardia may precede hypotension), abdominal tenderness/tone, fetal lie/presentation • Speculum to assess bleeding and cervix • NO digital examination until placenta praevia excluded
Investigations	• FBC, coagulation (massive APH/abruption), group & save or crossmatch (4–6 units if massive), U&E, LFT • Kleihauer in RhD-negative women
Fetal	• CTG once maternal condition stable (from 26 weeks) • USS for placental location, fetal wellbeing
Steroids	Antenatal corticosteroids if 24+0–34+6 wk and birth likely
$MgSO_4$	Neuroprotection if birth anticipated < 30 wk (consider to 33+6)
Anti-D	RhD-negative: ≥ 500 IU and Kleihauer (repeat every 6 weeks if recurrent bleeding)
Tocolysis	Not recommended in APH (may mask abruption)

466.4 Placenta praevia and accreta (RCOG GTG 27a)

Topic	Recommendation
Diagnosis	• Low-lying/praevia suspected at 20-week scan → TVS at 32 weeks • If still present → further scan at 36 weeks
Previous CS + low/anterior placenta	• Specialist ultrasound for PAS (± MRI) • Birth in a PAS centre with MDT, cell salvage, interventional radiology
Antenatal care	• Advise to attend immediately with bleeding/pain/contractions • Anaemia optimisation • Individualised inpatient vs outpatient care • Steroids before birth
Timing of birth	• Uncomplicated praevia/low-lying: 36+0–37+0 weeks • PAS: 35+0–36+6 weeks • Earlier if bleeding
Mode	• CS if placental edge < 20 mm from os in 3rd trimester (consider vaginal birth if > 20 mm) • Senior obstetrician and anaesthetist present
PAS surgery	Planned CS-hysterectomy (placenta left in situ) or conservative management in selected cases

466.5 Vasa praevia (RCOG GTG 27b)

- Risk factors: low-lying placenta, velamentous cord insertion, bilobed/succenturiate placenta, IVF, multiple pregnancy.
- Diagnosis: TVS with colour Doppler (not universal screening) — confirm at 32 weeks.
- Management: consider admission from 30–32 weeks (individualised); steroids; **elective CS at 34+0–36+0 weeks** before labour.

- Acute: bleeding at rupture of membranes with fetal bradycardia → **category 1 CS**; neonatal team for transfusion.

466.6 Unexplained APH

- No cause after assessment — associated with ↑ preterm birth, FGR and stillbirth → **serial growth scans**
  - Consider induction around 39–40 weeks with recurrent/unexplained bleeding (individualise).

■ RED FLAGS

Massive APH: call for help, major obstetric haemorrhage protocol, consider immediate birth regardless of gestation if maternal life at risk.

Shock out of proportion to visible loss → concealed abruption.

■ COMMON PITFALLS

Digital vaginal examination before excluding praevia.

Forgetting anti-D/Kleihauer in RhD-negative women.

Discharging unexplained APH without growth surveillance.

466.7 Must-know summary

■ EXAM TIP

- APH = bleeding ≥ 24+0 wk; grades: spotting, minor (< 50 mL), major (50–1,000), massive (> 1,000 or shock).
- Praevia painless; abruption painful (may be concealed); vasa praevia = fetal bleeding with bradycardia.
- Resuscitate, bloods, Kleihauer + anti-D, CTG, USS; steroids/$MgSO_4$; no VE until praevia excluded; no tocolysis.
- Praevia birth 36+0–37+0; PAS 35+0–36+6; vasa praevia CS 34–36 wk; unexplained APH → serial growth.

■ MNEMONIC / MEMORY AID

APH grades — 'Spot, Fifty, Thousand, Shock'.