Antepartum Haemorrhage Placenta Praevia

Leonie Semmens

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HCMC - 2012

AUSTRALIA VIETNAM VOLUNTEERS RESOURCE GROUP

CHẢY MÁU TRƯỚC SANH NHAU TIỀN ĐẠO

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Definition

The placenta lies low in the lower uterine segment and can cover the internal os, and lies in front of the presenting part of the fetus.

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ĐỊNH NGHĨA

Bánh nhau nằm thấp ở đoạn dưới tử cung, có thể che kín lỗ trong và nằm ngay trước ngôi thai.

Definition

- Placental plantation that overlies or is within 2 cm (0.8 in) of the internal cervical os
- Classification
  - **Complete**: Placenta completely covers the os
  - **Partial**: Placenta partially covers the os
  - **Marginal**: Placenta edge lies within 2 cm of the os
  - **Low lying**: Placenta edge lies 2 to 3.5 cm from the os
- Normal – positioned away from cervix (posterior position)

ĐỊNH NGHĨA

- Bánh nhau tràn qua hoặc cách lỗ trong cổ tử cung 2cm (0.8 in)
- Phân loại :
  - **Toàn phần**: bánh nhau che kín hoàn toàn lỗ trong CTC
  - **Bán phần**: bánh nhau che lấp 1 phần lỗ trong CTC
  - **Bám mép**: mép nhau cách lỗ trong CTC 2cm
  - **Bám thấp**: mép nhau cách lỗ trong CTC 2 đến 3.5cm
- Vị trí bình thường nhau bám cách xa CTC (bám mặt sau)

Classification

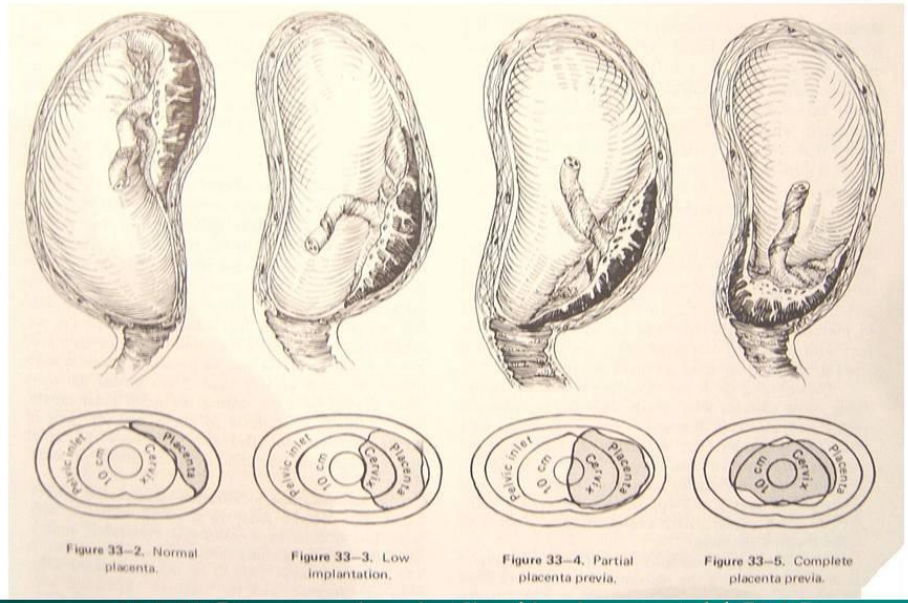


Figure 33–2. Normal placenta. Figure 33–3. Low implantation. Figure 33–4. Partial placenta previa. Figure 33–5. Complete placenta previa.

PHÂN LOẠI

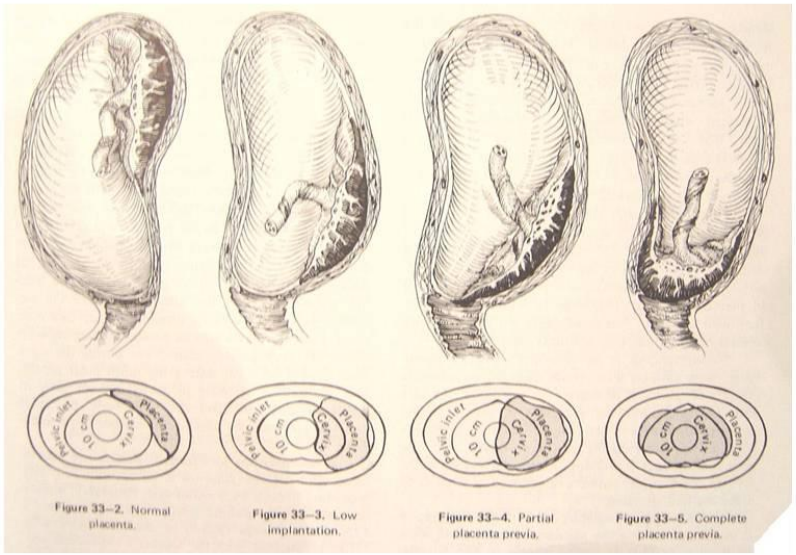


Figure 33–2. Normal placenta. Figure 33–3. Low implantation. Figure 33–4. Partial placenta previa. Figure 33–5. Complete placenta previa.

Placenta Praevia

- Detected on ultrasound scans in about 25% of all pregnancies
- As the pregnancy progresses the lower uterine segment stretches and placental site moves up the uterine wall – in placenta praevia – the placenta does not move up

NHAU TIỀN ĐẠO

- Phát hiện qua siêu âm khoảng 25% trong tất cả các thai kỳ
- Khi thai kỳ tiến triển, đoạn dưới tử cung bị kéo giãn ra và bánh nhau bị kéo lên cao – trong nhau tiền đạo –bánh nhau không di chuyển lên

Causes of Placenta Praevia

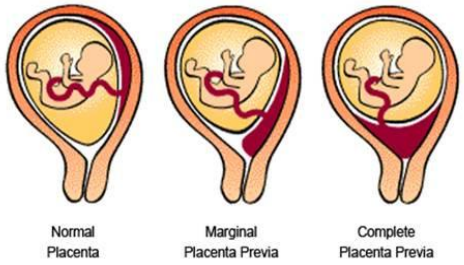
- Multiparity
- Multiple pregnancy
- Age
- Previous scarring
- Smoking
- Placental abnormality
- Fetal sex
- Number of prior curettes or terminations
- Asian mothers

NGUYÊN NHÂN

- Đa sản
- Đa thai
- Lớn tuổi
- Sẹo cũ
- Hút thuốc
- Bất thường bánh nhau
- Giới tính thai
- Số lần nạo phá thai hoặc sẩy thai
- Nhóm bà mẹ Châu Á

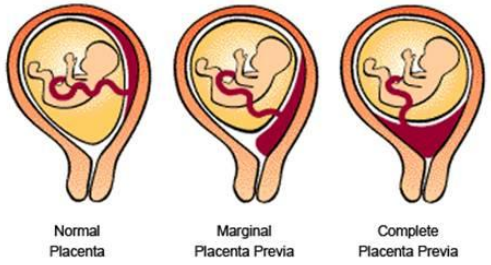
Symptoms of Placenta Praevia

- **PAINLESS** vaginal bleeding after 20 weeks
- Malpresentation of fetus – often breech
- Non-engagement of presenting part
- Post-coital bleeding



TRIỆU CHỨNG

- Chảy máu âm đạo không gây đau sau 20 tuần
- Ngôi thai bất thường –thường là ngôi mông
- Ngôi thai cao
- Chảy máu sau giao hợp



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Diagnosis

- Detected on ultrasound scan
- Post-coital bleeding
- High presenting part and malpresentation of the fetus
- Vaginal haemorrhage – anaemia and shock
- Sterile speculum examination as vaginal examination can cause life-threatening haemorrhage

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CHẨN ĐOÁN

- Phát hiện qua siêu âm
- Chảy máu sau giao hợp
- Ngôi thai cao và bất thường
- Xuất huyết âm đạo – thiếu máu và sốc
- Khám bằng mỏ vịt vì khám âm đạo có thể gây chảy máu nhiều nguy hiểm tính mạng

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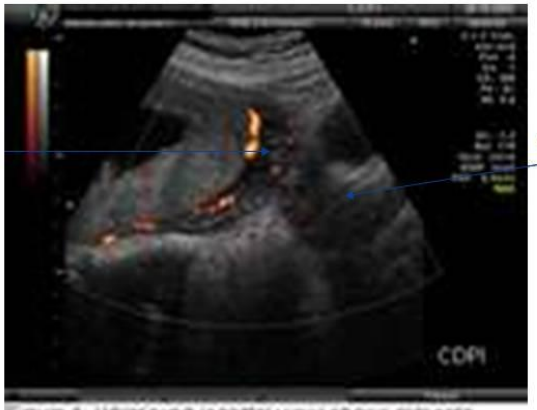
Diagnosis

Can you see the placenta previa?

placenta



cervix

Figure 1: Ultrasound (sagittal view) shows placenta previa

CHẨN ĐOÁN

Bạn có thể nhìn thấy nhau tiền đạo?

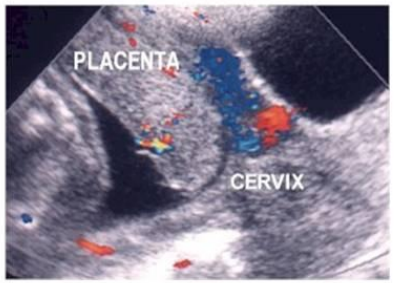
bánh nhau cung

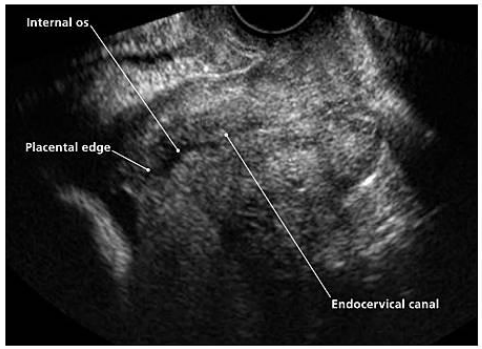
cổ tử

Figure 1: Ultrasound (sagittal view) shows placenta previa

Diagnosis

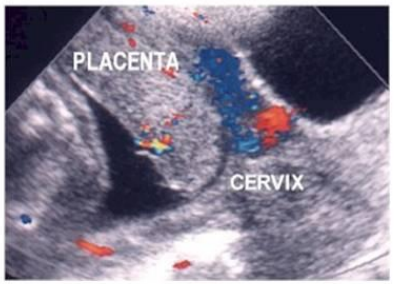
More examples…

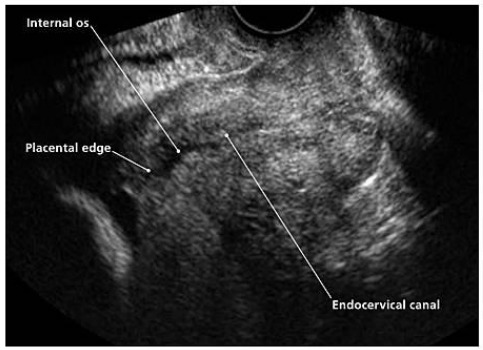


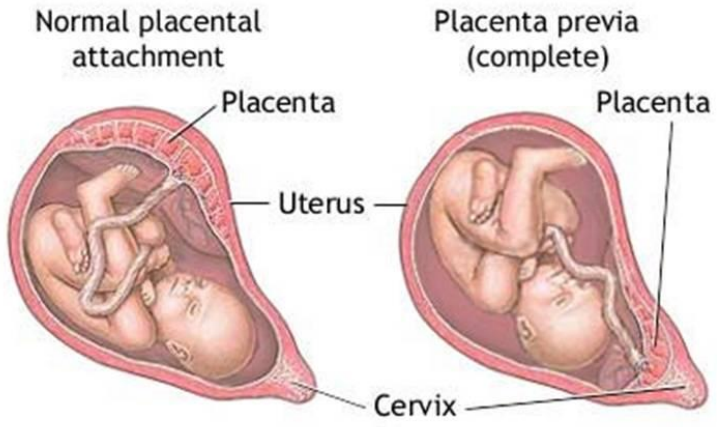


CHẨN ĐOÁN

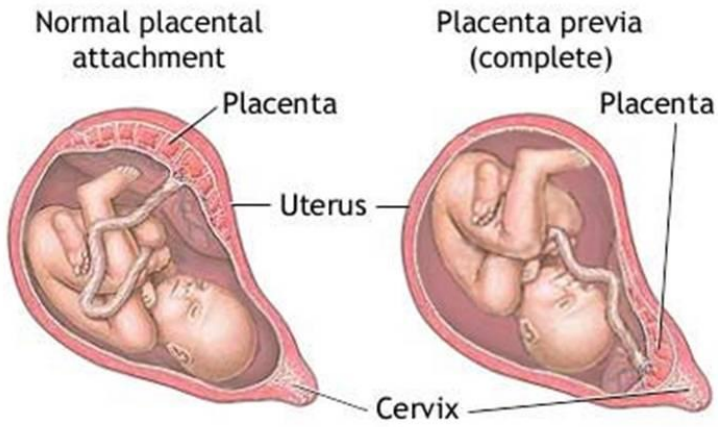
Những ví dụ khác…







ADAM.



ADAM.

Placenta Praevia

Is a major life-threatening complication of pregnancy

NHAU TIỀN ĐẠO

Là một biến chứng quan trọng đe dọa tính mạng trong thai kỳ

Management

- Maternal pulse and BP 4/24 when actively bleeding
- Administer oxygen if signs of shock
- Pad check 4/24 when bleeding, otherwise daily
- Fetal heart twice daily – more frequent if PV loss significant, perform CTG
- Rhesus status – anti D if needed
- If vasa praevia and fresh PV bleeding – code pink
- Blood tests – FBC, Rhesus factor, group and X match + ? coagulation studies

ĐIỀU TRỊ

- Đếm mạch, đo huyết áp ngày 4 lần khi đang ra huyết
- Cho thở thêm oxy nếu có dấu hiệu của sốc
- Kiểm tra băng lót ngày 4 lần khi có ra huyết, nếu không ra huyết thì kiểm tra 1 lần mỗi ngày
- Theo dõi tim thai ngày 2 lần – thường xuyên hơn nếu có mất máu nghiêm trọng, có thể đo CTG
- Tình trạng Rhesus – tiêm anti D nếu cần thiết
- Nếu sa dây rốn và mất máu âm đạo đỏ tươi – mã hóa hồng
- XN máu: Huyết đồ, yếu tố Rhesus, nhóm máu và phản ứng chéo, XN đông máu

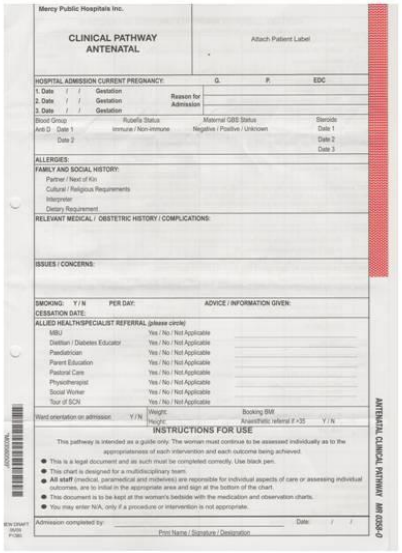
Management

- Decision for caesarean section is not made until after 36 weeks, as the placenta will often migrate
- Expectant management if fetus is immature and no active bleeding – bed rest
- Urgent/emergent cesarean delivery for active or persistent bleeding or fetal distress
- Documentation in mothers' chart

ĐIỀU TRỊ

- Quyết định cho mổ lấy thai được thực hiện sau 36 tuần, vì bánh nhau thường sẽ di chuyển
- Điều trị bảo tồn nếu thai nhi còn non và không có ra huyết nhiều – nghỉ ngơi tại giường
- Mổ cấp cứu khi có mất máu nhiều hoặc kéo dài dai dẳng hoặc tim thai suy
- Ghi nhận biểu đồ của mẹ

Care Plan



Mercy Public Hospitals Inc.

CLINICAL PATHWAY
ANTENATAL

Attach Patient Label

HOSPITAL ADMISSION CURRENT PREGNANCY: G. P. EDC

1. Date / / Gestation
2. Date / / Gestation — Reason for Admission
3. Date / / Gestation

Blood Group — Rubella Status — Maternal GBS Status — Steroids
Anti D Date 1 — Immune / Non-immune — Negative / Positive / Unknown — Date 1
Date 2 — Date 2
Date 3 — Date 3

ALLERGIES:

FAMILY AND SOCIAL HISTORY:
Partner / Next of Kin
Cultural / Religious Requirements
Interpreter
Dietary Requirement

RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:

ISSUES / CONCERNS:

SMOKING: Y / N PER DAY: ADVICE / INFORMATION GIVEN:
CESSATION DATE:

ALLIED HEALTH/SPECIALIST REFERRAL (please circle)

MBU	Yes / No / Not Applicable
Dietitian / Diabetes Educator	Yes / No / Not Applicable
Paediatrician	Yes / No / Not Applicable
Parent Education	Yes / No / Not Applicable
Pastoral Care	Yes / No / Not Applicable
Physiotherapist	Yes / No / Not Applicable
Social Worker	Yes / No / Not Applicable
Tour of SCN	Yes / No / Not Applicable

Ward orientation on admission Y / N — Weight: — Booking BMI — Height: — Anaesthetic referral if >35 Y / N

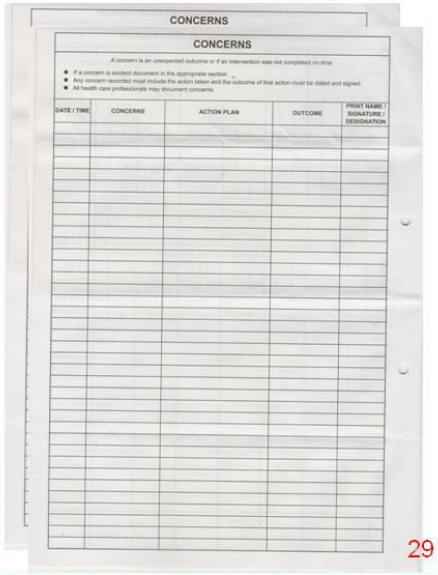
INSTRUCTIONS FOR USE

This pathway is intended as a guide only. The woman must continue to be assessed individually as to the appropriateness of each intervention and each outcome being achieved.

- This is a legal document and as such must be completed correctly. Use black pen.
- This chart is designed for a multidisciplinary team.
- **All staff** (medical, paramedical and midwives) are responsible for individual aspects of care or assessing individual outcomes, are to initial in the appropriate area and sign at the bottom of the chart.
- This document is to be kept at the woman's bedside with the medication and observation charts.
- You may enter N/A, only if a procedure or intervention is not appropriate.

Admission completed by: Date: / /
Print Name / Signature / Designation

ANTENATAL CLINICAL PATHWAY MR 0356-0



CONCERNS

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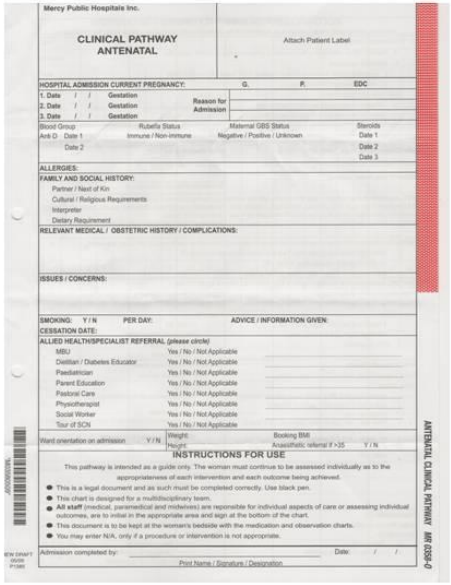
A concern is an unexpected outcome or if an intervention was not completed on time.

- If a concern is evident document in the appropriate section. _
- Any concern recorded must include the action taken and the outcome of that action must be dated and signed.
- All health care professionals may document concerns.

DATE / TIME	CONCERNS	ACTION PLAN	OUTCOME	PRINT NAME / SIGNATURE / DESIGNATION

KẾ HOẠCH CHĂM SÓC



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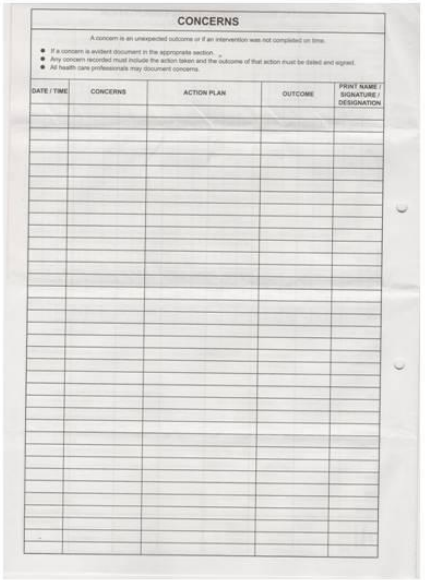
ANTENATAL CLINICAL PATHWAY MR 0356-0



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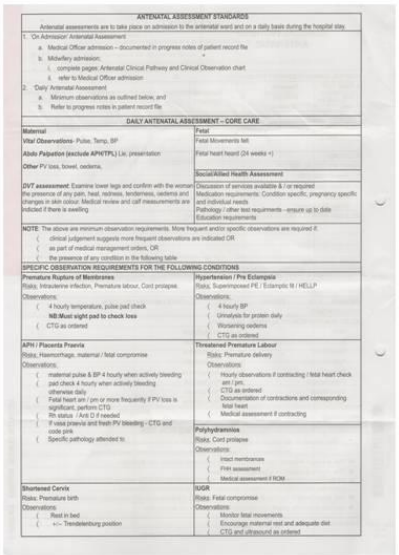

ANTENATAL ASSESSMENT STANDARDS

Antenatal assessments are to take place on admission to the antenatal ward and on a daily basis during the hospital stay.

1. 'On Admission' Antenatal Assessment
   a. Medical Officer admission – documented in progress notes of patient record file
   b. Midwifery admission:
      i. complete pages: Antenatal Clinical Pathway and Clinical Observation chart
      ii. refer to Medical Officer admission
2. 'Daily' Antenatal Assessment
   a. Minimum observations as outlined below, and
   b. Refer to progress notes in patient record file

DAILY ANTENATAL ASSESSMENT – CORE CARE

Maternal	Fetal
Vital Observations- Pulse, Temp, BP	Fetal Movements felt
Abdo Palpation (exclude APH/TPL) Lie, presentation	Fetal heart heard (24 weeks +)
Other PV loss, bowel, oedema,	**Social/Allied Health Assessment**
DVT assessment: Examine lower legs and confirm with the woman the presence of any pain, heat, redness, tenderness, oedema and changes in skin colour. Medical review and calf measurements are indicated if there is swelling	Discussion of services available & / or required Medication requirements: Condition specific, pregnancy specific and individual needs Pathology / other test requirements - ensure up to date Education requirements

NOTE: The above are minimum observation requirements. More frequent and/or specific observations are required if:
(clinical judgement suggests more frequent observations are indicated OR
(as part of medical management orders, OR
(the presence of any condition in the following table

SPECIFIC OBSERVATION REQUIREMENTS FOR THE FOLLOWING CONDITIONS

Premature Rupture of Membranes Risks: Intrauterine infection, Premature labour, Cord prolapse. Observations: (4 hourly temperature, pulse pad check **NB:Must sight pad to check loss** (CTG as ordered	**Hypertension / Pre Eclampsia** Risks: Superimposed PE / Eclamptic fit / HELLP Observations: (4 hourly BP (Urinalysis for protein daily (Worsening oedema (CTG as ordered
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ANTENATAL RECORD OF CLINICAL OBSERVATION

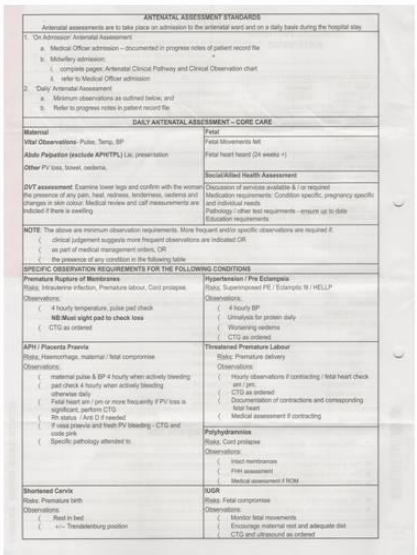
Date
Gestation
Time

BP/PULSE
TEMPERATURE
PAIN/PULSE

Pulse
Weight
Lie
Presentation
FHR / FM
CTG
Patient Activity
DVT Assessment
PV Loss
Oedema
Urinalysis
Bowel
Pathology

Name / Signature / Designation
AM
PM
ND

KẾ HOẠCH CHĂM SÓC



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Date
Gestation
Time

BP/PULSE
TEMPERATURE
PAIN/PULSE

Pulse
Weight
Lie
Presentation
FHR / FM
CTG
Patient Activity
DVT Assessment
PV Loss
Oedema
Urinalysis
Bowel
Pathology

Name / Signature / Designation
AM
PM
ND

References

Ailsworth, k, Anderson, J, Atwood, L, Bailey, R & Canavan, T et al. *Advanced Life Support in Obstetrics. 4th ed.* 2000. American Academy of Family Physicians: Kansas

Henderson, C & Macdonald, S. *Mayes' Midwifery: A textbook for midwives.* 2006. Bailliere Tindall: China

Oxorn, H. *Human Labour & Birth.* 1986. Prentice-Hall:USA

TÀI LIỆU THAM KHẢO

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THANK YOU

CHÂN THÀNH CÁM ƠN