ABRUPTIO PLACENTA

OVERVIEW

Definition
Refers to bleeding into the genital tract after at or after 26 weeks of gestation and before delivery in a normally situated placenta(fundus)
Causes or Predisposing factors to abruptio placenta

- Previous history of abruptio placenta
- Direct trauma to the abdomen
- Hypertensive disorders of pregnancy
- Polyhydramnios
- Short cord
- Chorioamnionitis
- Uncontrolled Artificial Rupture of Membranes
- Folate deficiency
- Smoking
- External cephalic version (ECV)

Differential diagnosis of abruptio placenta

- Placenta previa
- Uterine rupture
- Vasa previa
- Trauma to the abdomen
- Degenerating fibroids
- Severe cystitis
- Pyelonephritis
- Ovarian cyst torsion
- Bleeding ectopion
- Cervical polyps or malignancy

WORKUP

Investigations

- Blood grouping and cross-matching, book blood products preferably packed red blood cells or whole blood and platelets

- Blood for CBC/Hb, platelet count
- Ultrasound scan
- Bedside clotting time, prothrombin time (PT), activated partial thromboplastin time (aPTT)
- Urinalysis (for proteinuria to exclude pre-eclampsia commonly associated with abruptio)

MANAGEMENT

Treatment for abruptio placenta

- Initiate continuous foetal heart rate monitoring since the foetus is at risk of becoming hypoxemic and developing acidosis.
- Secure intravenous access. Place one wide-bore intravenous line (16G); two if the patient presents with signs of moderate or severe abruption, such as
  - moderate to heavy bleeding,
  - hypotension,
  - tachysystole,
  - uterine hypertonicity and tenderness,
  - coagulopathy, or an abnormal foetal heart rate pattern
- Notify the anaesthetic team in moderate to severe abruptio to help in management of hemodynamic instability, bleeding disorders and potential need for emergency CS.
- Maintain crystalloids to keep urine output to 30mls/hr
- Anticipate delivery within 24 hours

a) Abruptio Placenta with alive foetus:

- If the mother is haemodynamically stable with cervical dilatation more than 7cm or in second stage, with no contraindication to vaginal delivery, do artificial rupture of membranes and allow the mother deliver vaginally with close monitoring (monitor every 15 minutes).
- If the maternal condition deteriorates (Per vaginal bleeding, haemodynamic state), deliver by emergency caesarean section
- Perform bedside ultrasound scan to determine the presence of abruptio placenta
- If delivery is remote or more than 1 hour, proceed to deliver by emergency caesarean section
- Prepare for neonatal resuscitation (refer to neonatal resuscitation section

b) Abruptio placenta with dead foetus

- If there is no contraindication to vaginal delivery and the mother is haemodynamically stable, rupture the membranes, augment labour with Oxytocin 2.5-5 IU (see Section on Induction and Augmentation of labour) in 500mls of saline and allow the mother deliver vaginally.
- However, if the condition of the mother is deteriorating, proceed to deliver by caesarean section.
- Anticipate and prepare for PPH due to atony and Couvelaire uterus.

- PROTOCOL

gure 28: Protocol on Abruptio Placenta