CMG 26c – OTHER OBSTETRIC & GYNAECOLOGICAL EMERGENCIES

(Revised: May 2017)

ANTEPARTUM HAEMORRHAGE (APH):

Antepartum haemorrhage is defined as any bleed from the genital tract after the 20th week of pregnancy, occurring before labour. It is a complication that affects 2 – 5% of pregnancies. APH may or may not be associated with accompanying contractions. The bleed can be concealed internally (fully or partially), and this may present with severe abdominal or pelvic pain, with a tense, tender uterus and signs of shock.

Causes of APH include: placenta praevia, placental abruption, trauma, genital infections, vasa praevia, etc. (check the mother's antenatal card, if available).

ICP	Reassurance	**AP**
ICP	DO NOT palpate or massage the uterus (this may stimulate further bleeding and/or uterine activity)	**AP**
ICP	IV fluid as required – as per CMG 14	**AP**
ICP	Analgesia as required (avoid opiates if pain is thought to be associated with contractions)	**AP**
ICP	Early transport to obstetric or emergency facility (as appropriate), with early notification	**AP**
ICP	Women in advanced pregnancy (≥20 weeks gestation) are generally best treated/transported in the left lateral position	**AP**

PV HAEMORRHAGE IN EARLY PREGNANCY:

Vaginal haemorrhage from conception to 20 weeks gestation.

Causes include: spontaneous miscarriage, ruptured ectopic pregnancy, uterine rupture, etc.

ICP	Reassurance	**AP**
ICP	IV fluid as required – as per CMG 14	**AP**
ICP	Analgesia as required	**AP**
ICP	Early transport (usually to emergency department), with early notification	**AP**

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PRE-ECLAMPSIA / ECLAMPSIA:

Pre-eclampsia is a multi-system disorder of pregnancy, characterised by hypertension (sBP ≥140mmHg / dBP ≥90mmHg) and involvement of one or more other organ system and/or the foetus. Suspect pre-eclampsia in a pregnant, unwell patient (e.g. altered LOC, headache, abdominal pain, visual disturbances) with an increased blood pressure.

Eclampsia is rare, and is characterised by seizures. Seizures may occur antenatally, intra-partum or postnatally (usually within 24 hours of delivery, but occasionally later).

The only definitive treatment of pre-eclampsia/eclampsia is the birth of the baby.

ICP	Suspected pre-eclampsia: rapid transport to nearest appropriate facility	**AP**
ICP	High flow oxygen	**AP**
ICP	**Pre-eclampsia**: magnesium sulphate as per pharmacology	
ICP	**Eclampsia**: treat seizures as per CMG 22 (noting that IV / IO magnesium sulphate should be the first line treatment, if possible)	**AP**
ICP	Treat other associated conditions as per appropriate CMG	**AP**
ICP	**Urgent transport *with early notification* to the emergency department** (not birth suite) (women in advanced pregnancy [≥20 weeks gestation] are generally best treated/transported in the left lateral position)	**AP**

APPARENT ANTENATAL FOETAL DISTRESS:

This may be seen as decreased or absent foetal movement, presence of meconium in the liquor, etc. Note that non-specialist foetal heart beat auscultation should not be performed, as it is not accurate and can cause further distress to the woman.

ICP	Reassurance	**AP**
ICP	IV fluid as per CMG 14	**AP**
ICP	Early, rapid transport to obstetric facility, with early notification (women in advanced pregnancy [≥20 weeks gestation] are generally best treated/transported in the left lateral position)	**AP**

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POSTPARTUM HAEMORRHAGE (PPH)

Postpartum haemorrhage is generally defined as an acute haemorrhage with blood loss of ≥500ml occurring within 12 weeks post-delivery.

Severe PPH is defined as ≥ 1000ml of blood loss.

Causes of PPH are commonly known as "the four Ts" (and management is centred around addressing these as appropriate):

Tone – uterine atonia – the most common cause of PPH
Trauma – to the genital tract
Tissue – retained products (e.g. placenta or membranes)
Thrombin – coagulopathy – rarely the primary cause of PPH

Blood loss is extremely difficult to estimate, and is notoriously under-estimated. Assessment of severity must therefore focus on the patient's vital signs and the secondary survey. ***Any indication of shock up to 12 weeks following delivery must be managed as PPH.***

ICP	Position patient flat, and maintain body warmth	**AP**
ICP	High-flow oxygen	**AP**
ICP	IV fluids as per CMG 14 (warm fluids if possible)	**AP**
ICP	PLACENTA DELIVERED: massage fundus firmly and continuously (uterus may relax promptly if massage is ceased)	**AP**
ICP	PLACENTA IN SITU: *as a last resort*, in the event of torrential PPH with signs of hypovolaemia, it is permissible to apply fundal massage with the placenta in situ. THIS IS A LAST RESORT EXCEPTION.	**AP**
ICP	Examine genital tract for damage – apply pressure to bleeding areas	**AP**
ICP	Encourage mother to empty her bladder (if possible/practical) to promote uterine contraction	**AP**
ICP	Encourage breast feeding of infant (if possible/practical) to promote uterine contraction	**AP**
ICP	**Transport without delay to the emergency department** (not birth suite), notify hospital of situation *as early as possible*	**AP**
ICP	If possible, keep all pads/towels/swabs for volume-loss assessment at hospital (weighing these items is often the more accurate way to assess loss)	**AP**