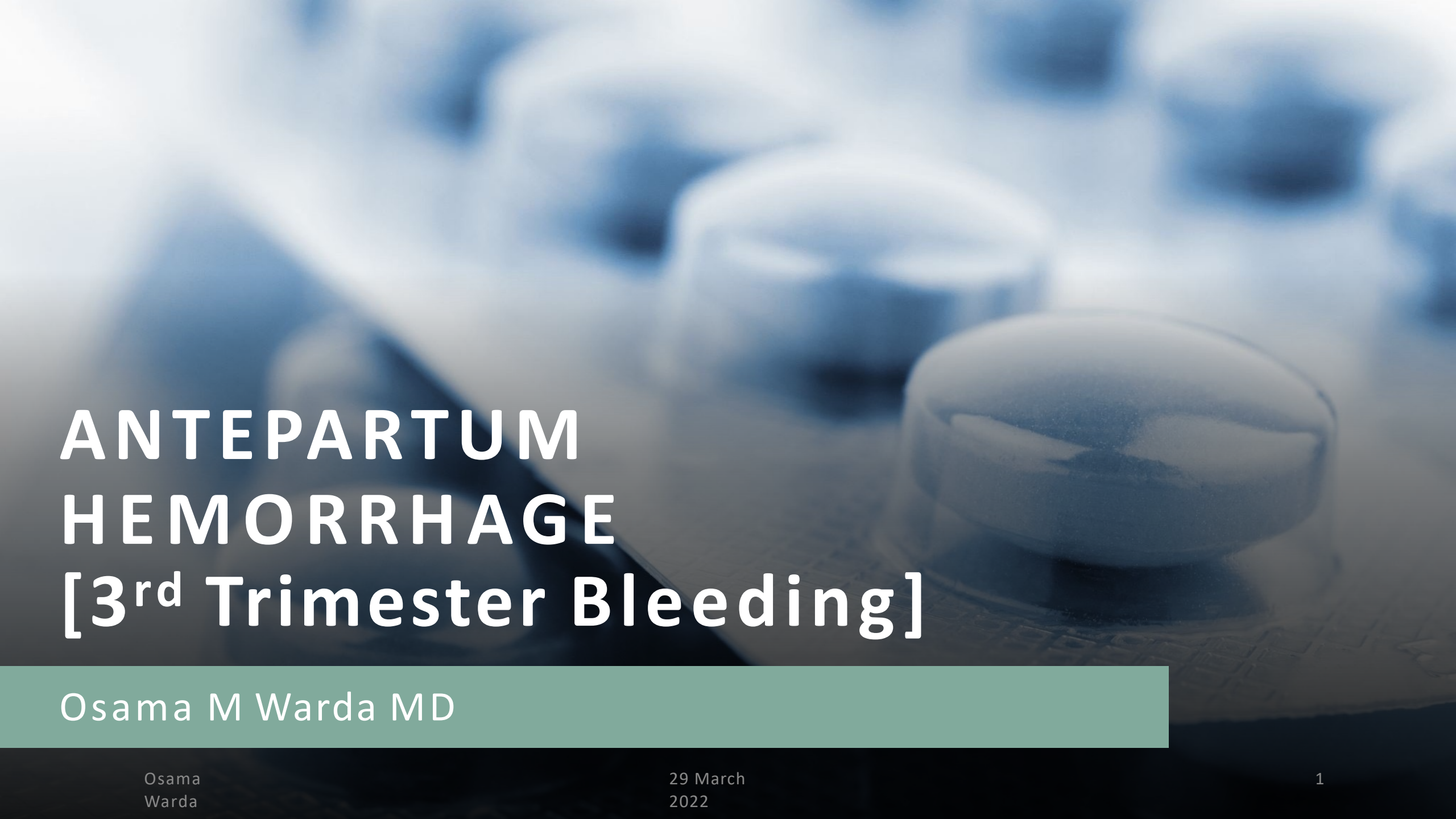


ANTEPARTUM HEMORRHAGE [3rd Trimester Bleeding]

Osama M Warda MD

CASE #1

- 30 years lady,33 weeks pregnancy came to emergency unit of OBS/GYNE Department of mansoura university hospital complaining of bleeding per vagina.History taking revealed that she is 3rd gravida, primipara, with previous one cesarean delivery for breech presentation and one surgical evacuation of a 1st trimester missed abortion. She had a previous attak of vaginal bleeding while asleep 3 week ago.

CASE#1

- On examination, BP=110/60 mmHg, pulse 110 bpm, RR=22CPM, Abdomen is lax, not tender. The fundal level at 32 weeks gestational size. FHR=140bpm.Vaginal bleeding is moderate bright red in color with small blood clots.

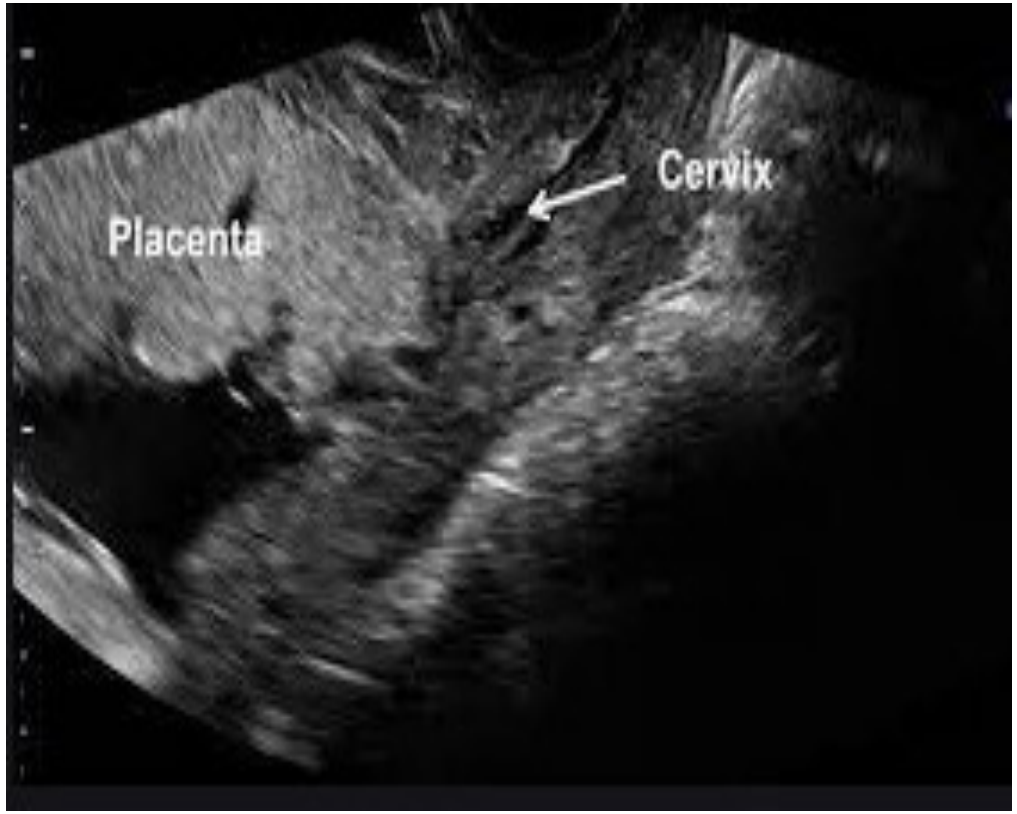
Q1: What is the differential diagnosis?

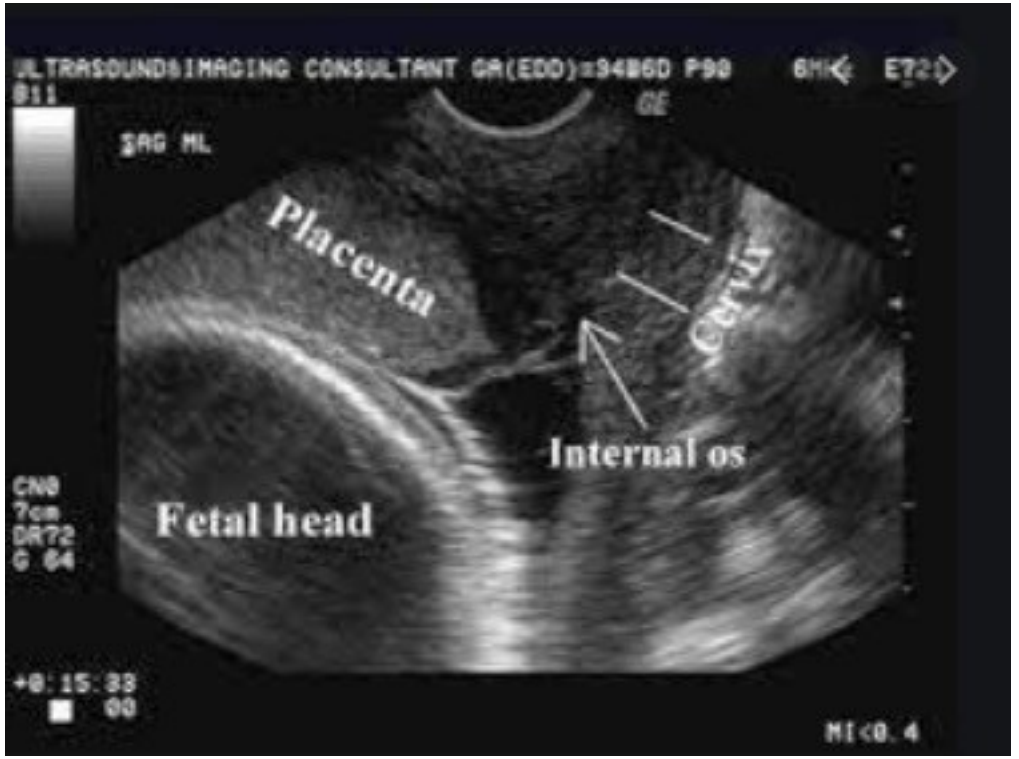
Q2:How can you confirm the most probable diagnosis.

3rd trimester bleeding; Antepartum Hemorrhage

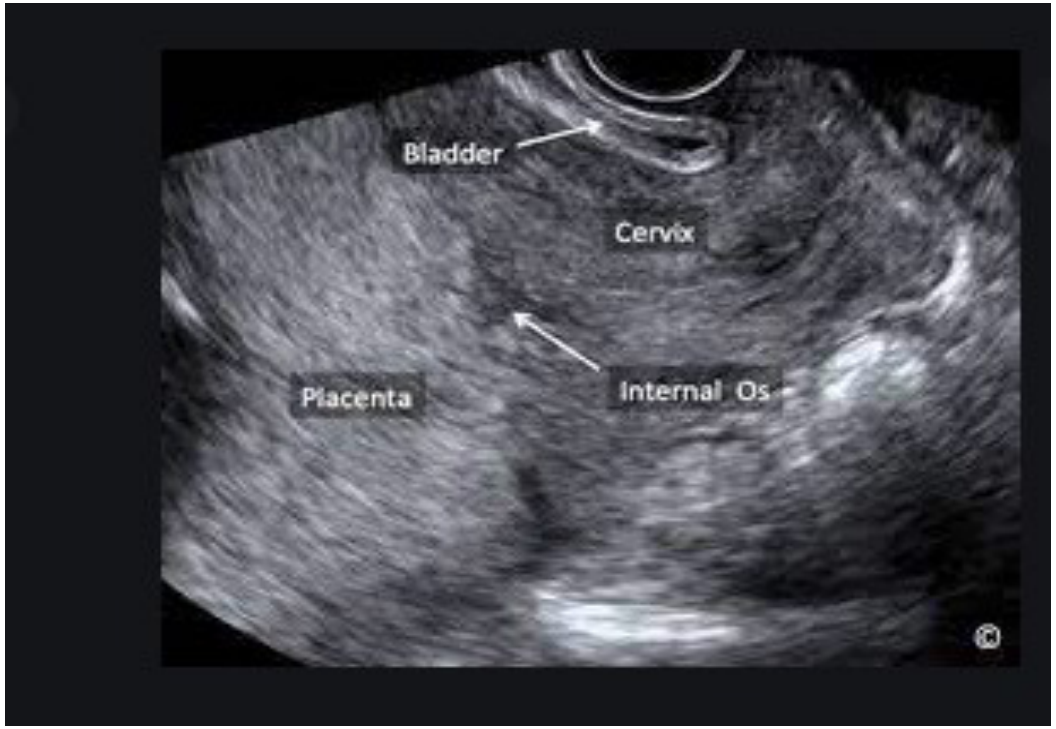
1. Placenta previa
2. Placental abruption
3. Vasa previa
4. **Rupture uterus during pregnancy**
5. Local gynecologic cause (infection-tumor- trauma)
6. General cause of bleeding

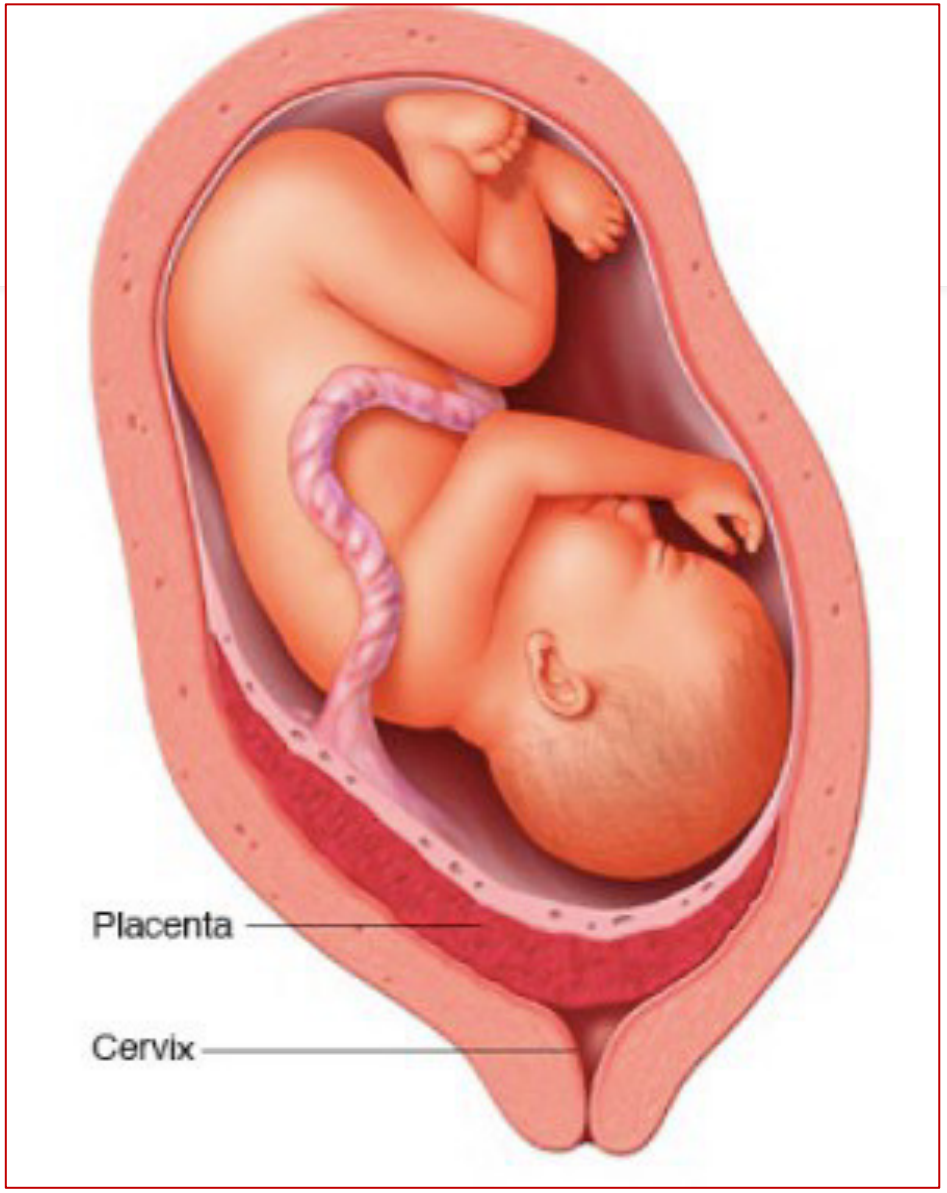
Ultrasonography



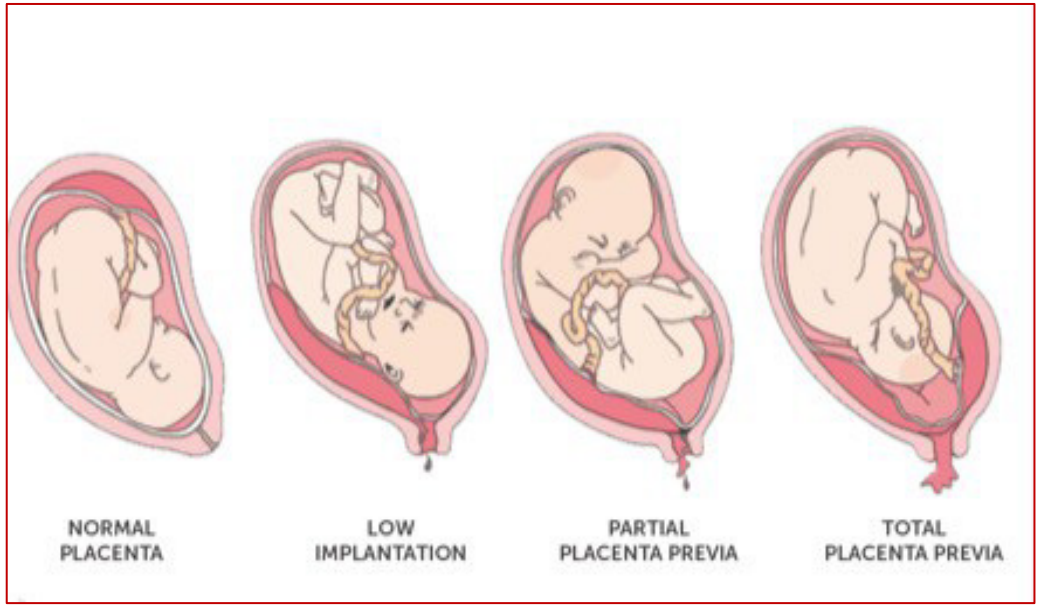


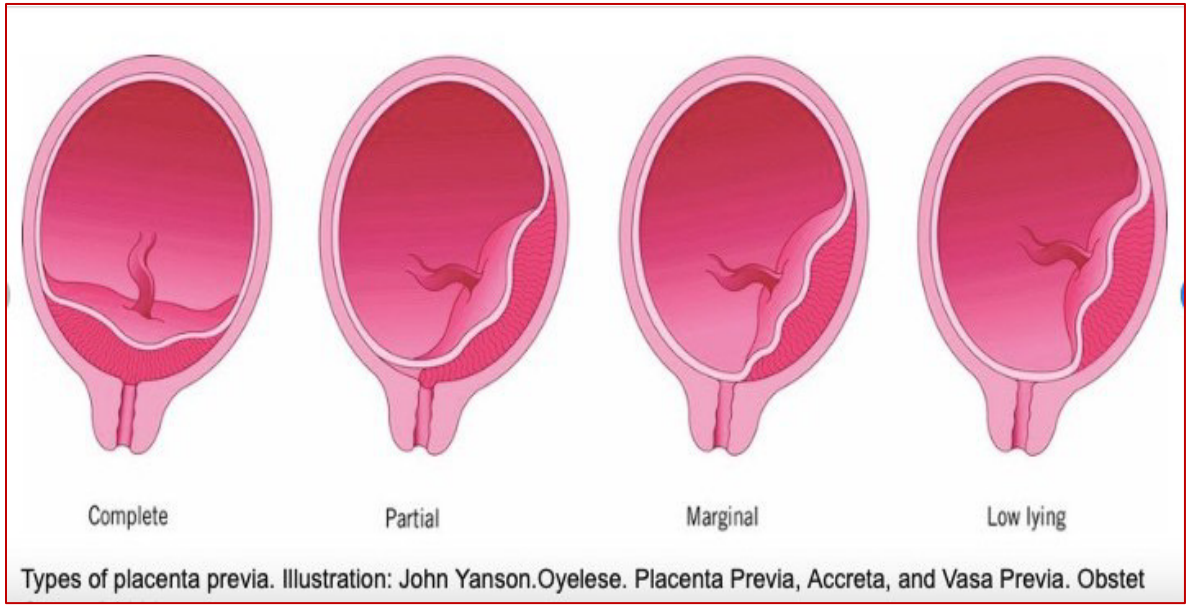
Placenta previa





Placenta previa





Types of placenta previa. Illustration: John Yanson.Oyelese. Placenta Previa, Accreta, and Vasa Previa. Obstet

Painless, causeless, recurrent bleeding per vagina

CASE #2

- 30 years lady,34 weeks pregnancy came to emergency unit of OBS/GYNE Department of mansoura university hospital complaining of bleeding per vagina.
- History taking revealed that she is 3rd gravida, primipara, with previous one cesarean delivery *for severe preeclampsia and unfavourable cervix* and one surgical evacuation of a 1st trimester missed abortion. She had **NO** previous attaks of vaginal bleeding.

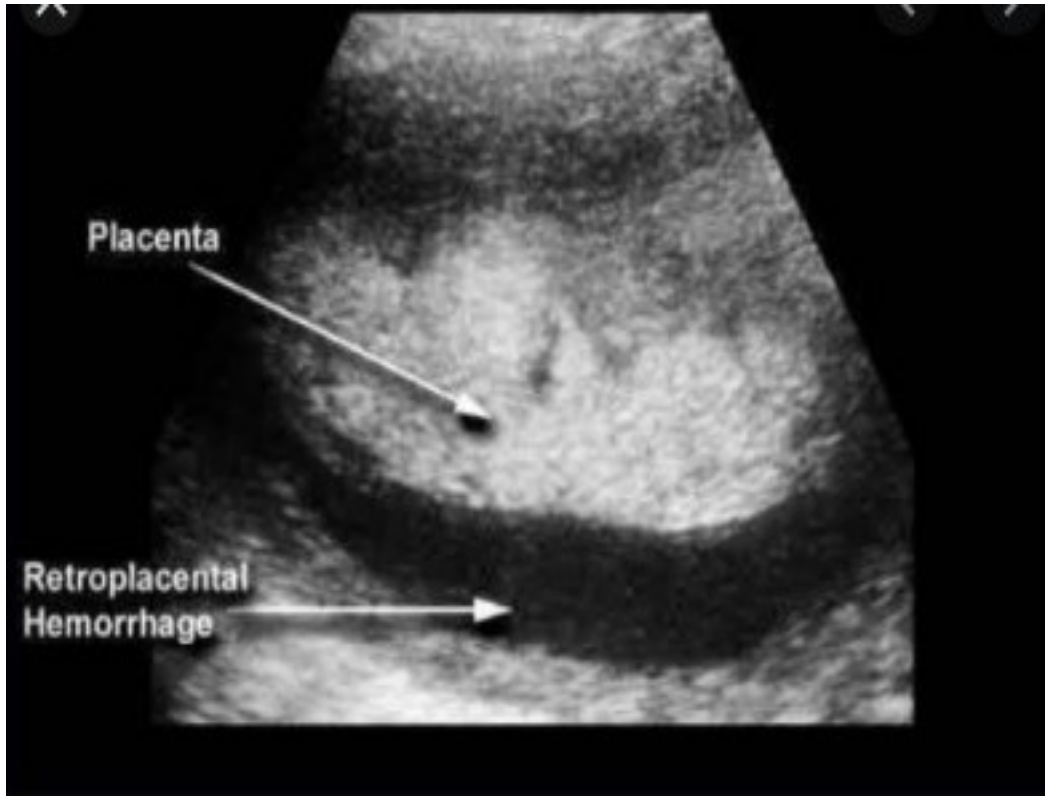
CASE#2

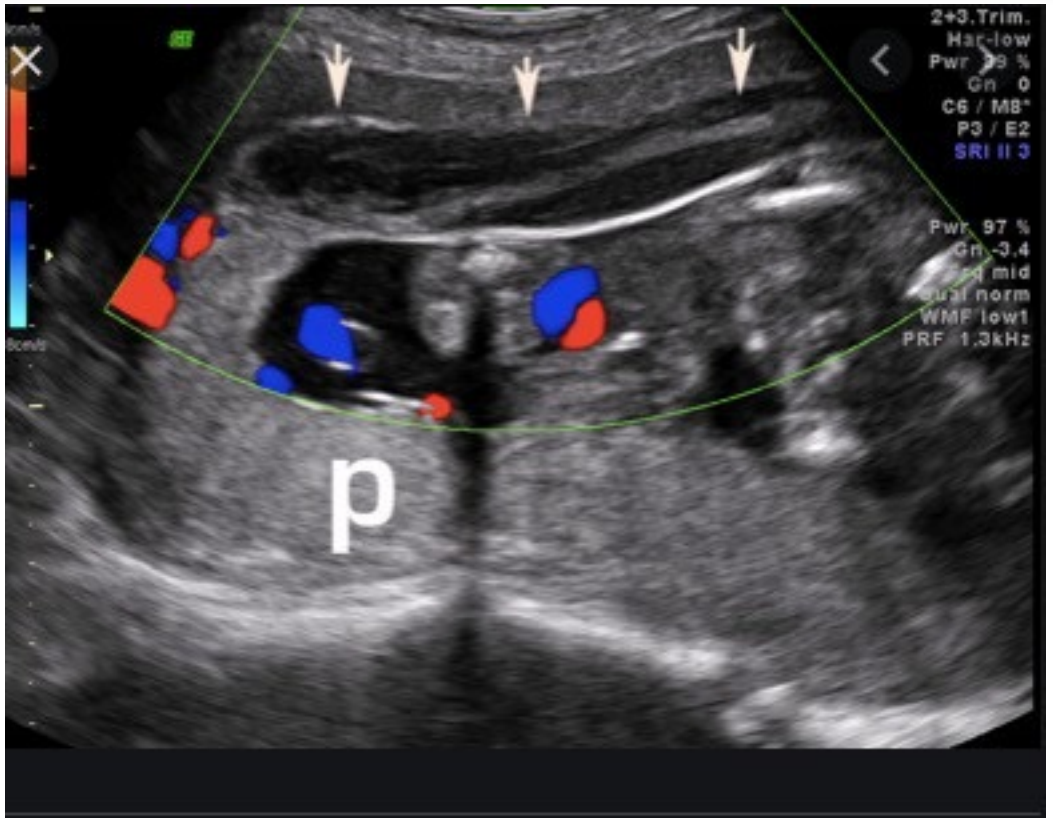
- On examination, BP=160/100 mmHg, pulse 120 bpm, RR=22CPM, Abdomen is hard boargd-like, very tender on plapation. The fundal level at 36 weeks gestational size. Vaginal bleeding is moderate brick red in color with small blood clots.

Q1: What is the differential diagnosis?

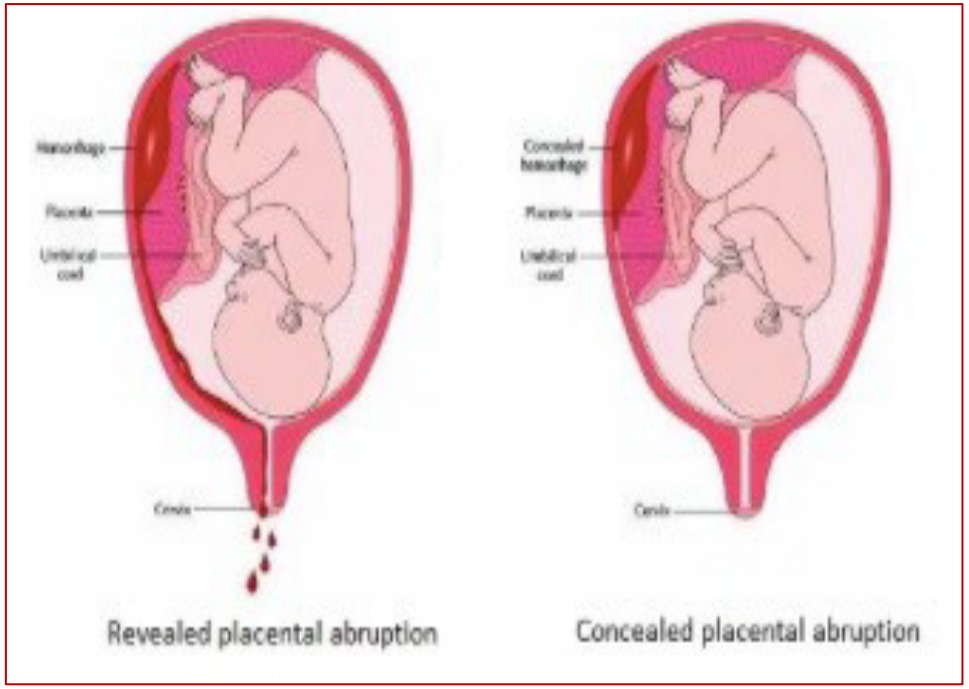
Q2:How can you confirm the most probable diagnosis.

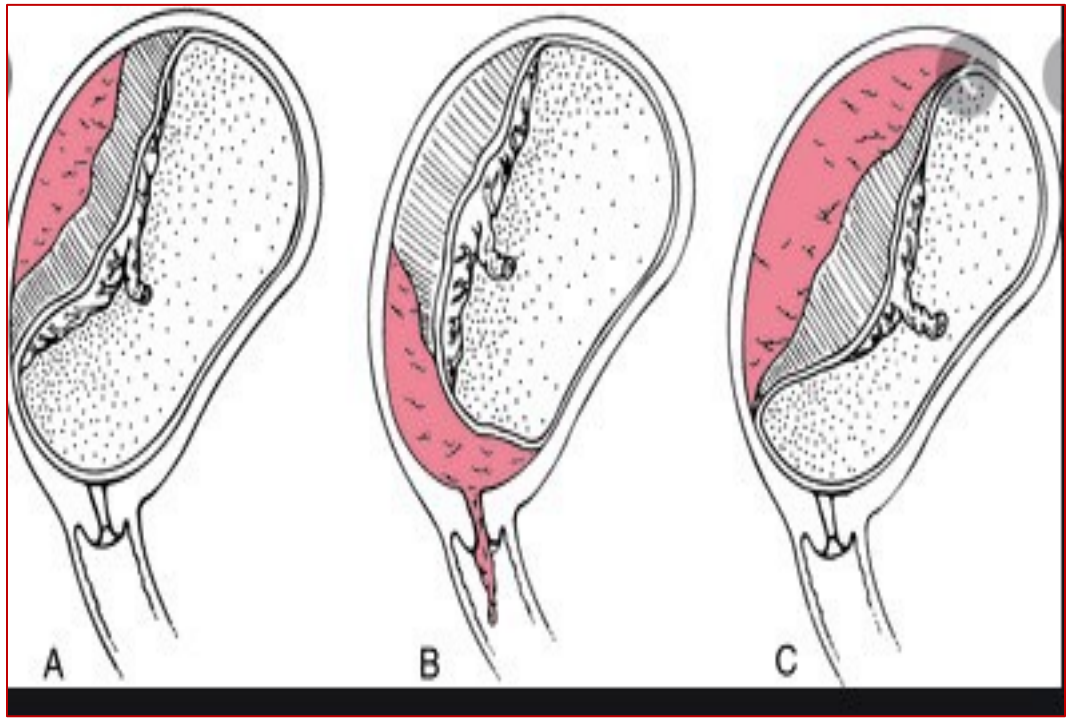
Abdominal Ultrasonography





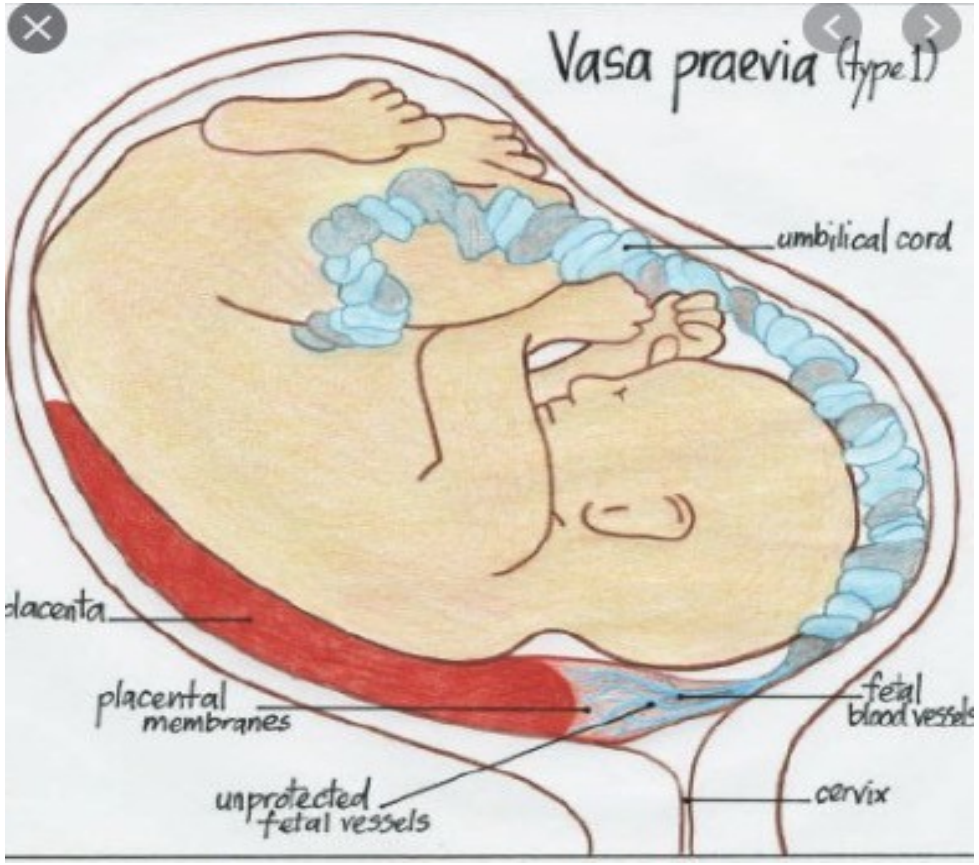
Abruptio Placentae

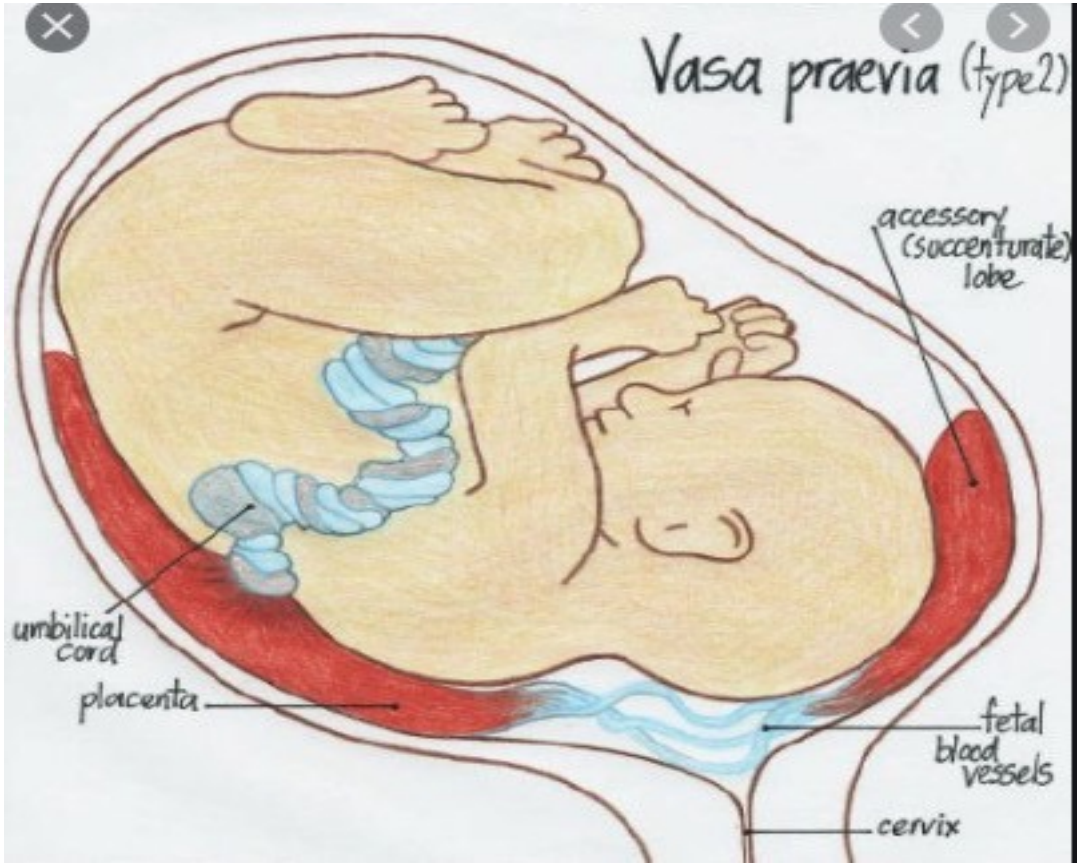




Character	Placenta previa	Placental abruption
Pain	Painless	constant
Obstetric shock	obsetric shock in proportion to amount of vaginal loss	the actual amount of bleeding may be far in excess of vaginal loss
Uterus	uterus is non-tender	uterus is tender and tense
Fetal lie	may have abnormal presentation and/ or lie	normal presentation and lie
Fetal heart	in general, fetal heart normal	fetal heart distressed/absent
Associated problems:	small antepartum hemorrhage may occur before larger bleed	may be a complication of pre-eclampsia, may cause disseminated intravascular coagulation

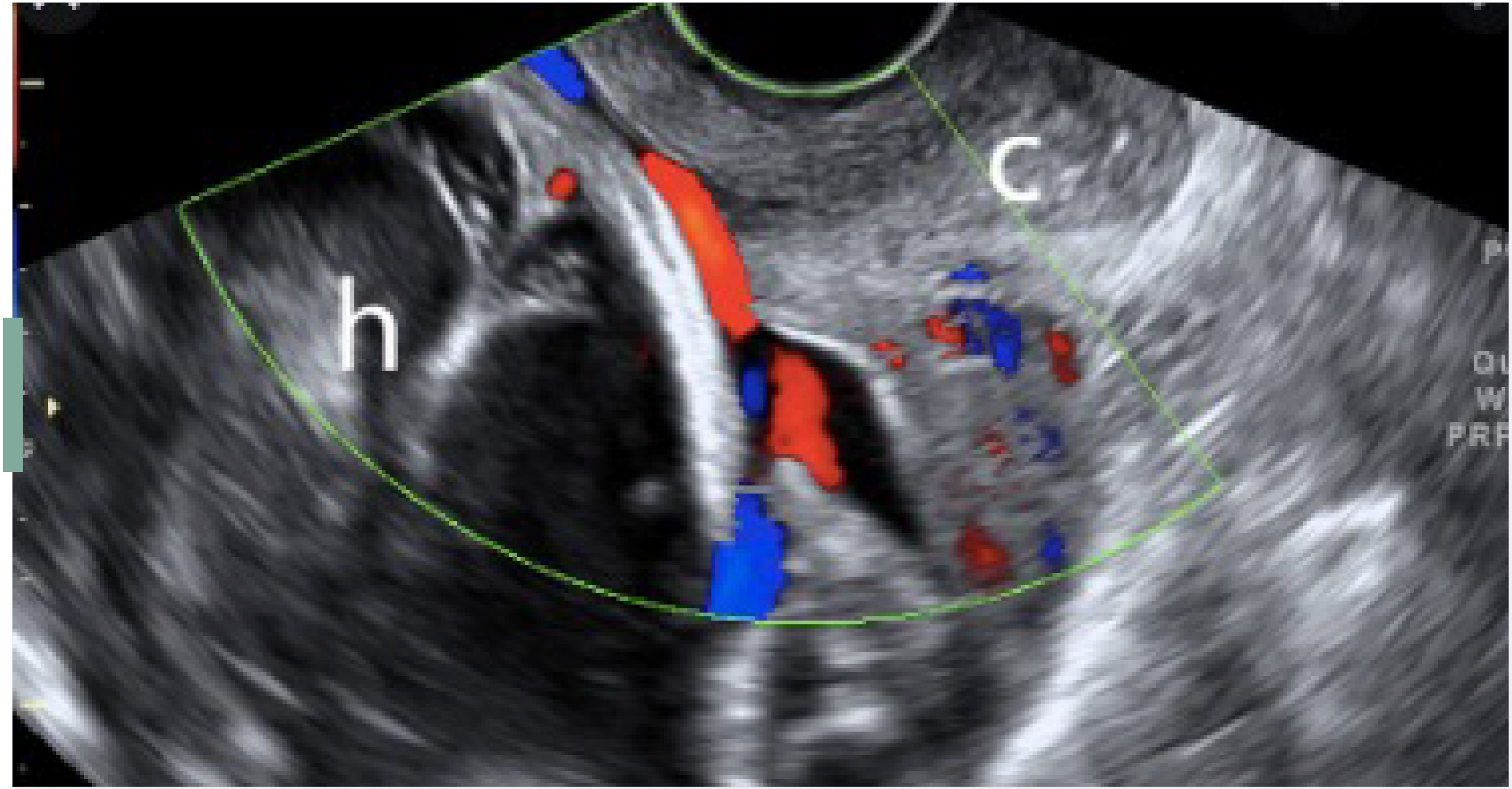
VASA PREVIA


Vasa praevia (type 1)
umbilical cord
placenta
placental membranes
fetal blood vessels
unprotected fetal vessels
cervix


Vasa praevia (type 2)
accessory (succenturiate) lobe
umbilical cord
placenta
fetal blood vessels
cervix

VASA PREVIA

- Vasa previa may be accompanied by other placental abnormalities, such as velamentous insertion, which increases the risk of fetal hemorrhage when the fetal membranes rupture.
- Suspect vasa previa based on symptoms and (painless vaginal bleeding, rupture of membranes, fetal bradycardia) and/or findings during routine prenatal ultrasonography.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VASA PREVIA

- Use transvaginal ultrasonography to confirm vasa previa and to distinguish it (fixed umbilical cord) from funic presentation (movable cord).
- Check for compression of the cord using nonstress testing, possibly twice a week beginning at 28 to 30 weeks.
- Schedule cesarean delivery, or if premature rupture of the membranes occurs, vaginal bleeding continues, or fetal status is non-reassuring, do emergency cesarean delivery.

UTERINE RUPTURE IN PREGNANCY

Uterine rupture during pregnancy is a rare event [0.012%] and frequently results in life-threatening maternal and fetal compromise. It can either occur in women with

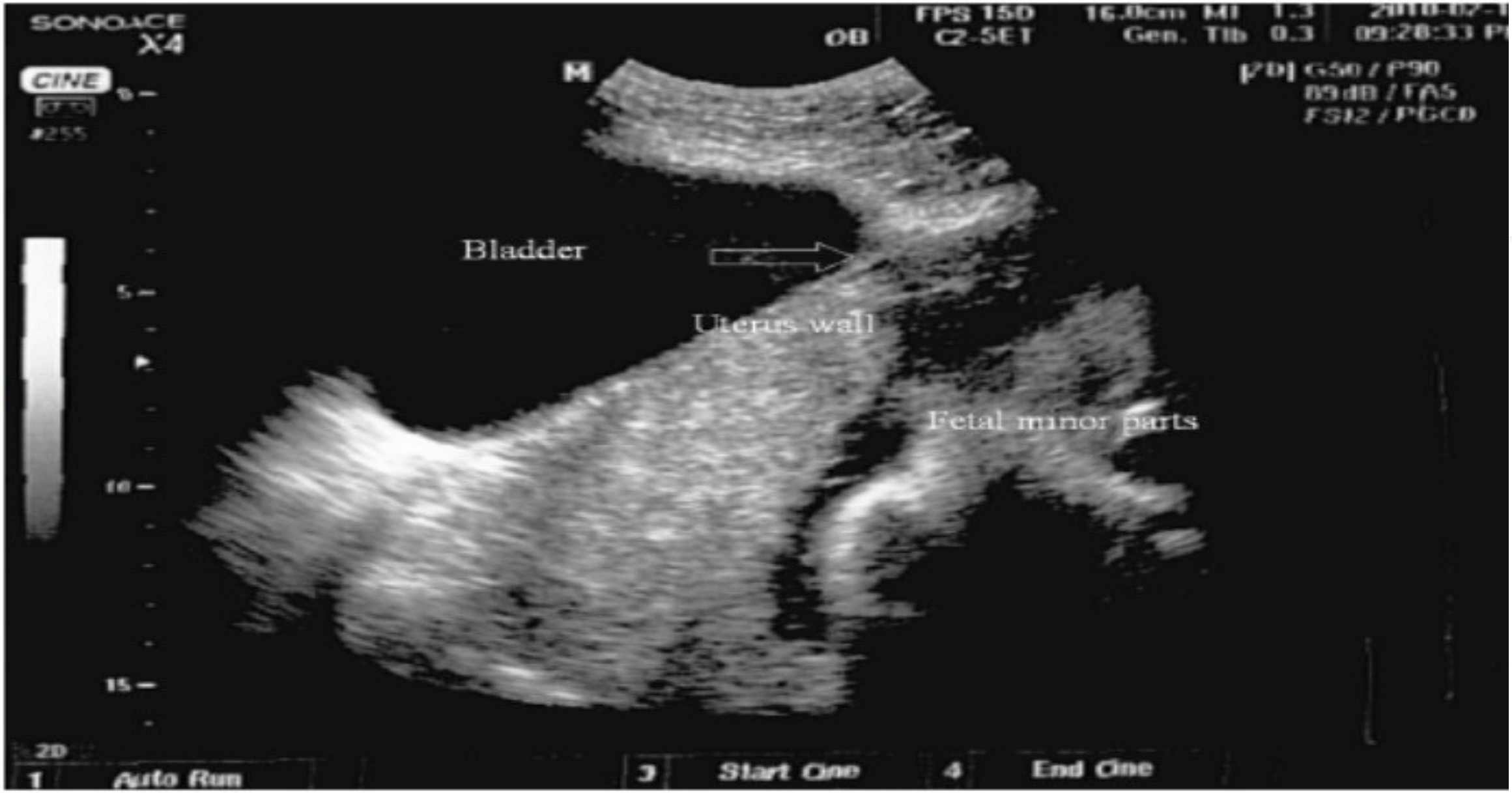
(1) a native, unscarred uterus or

(2) a uterus with a surgical scar from previous surgery.

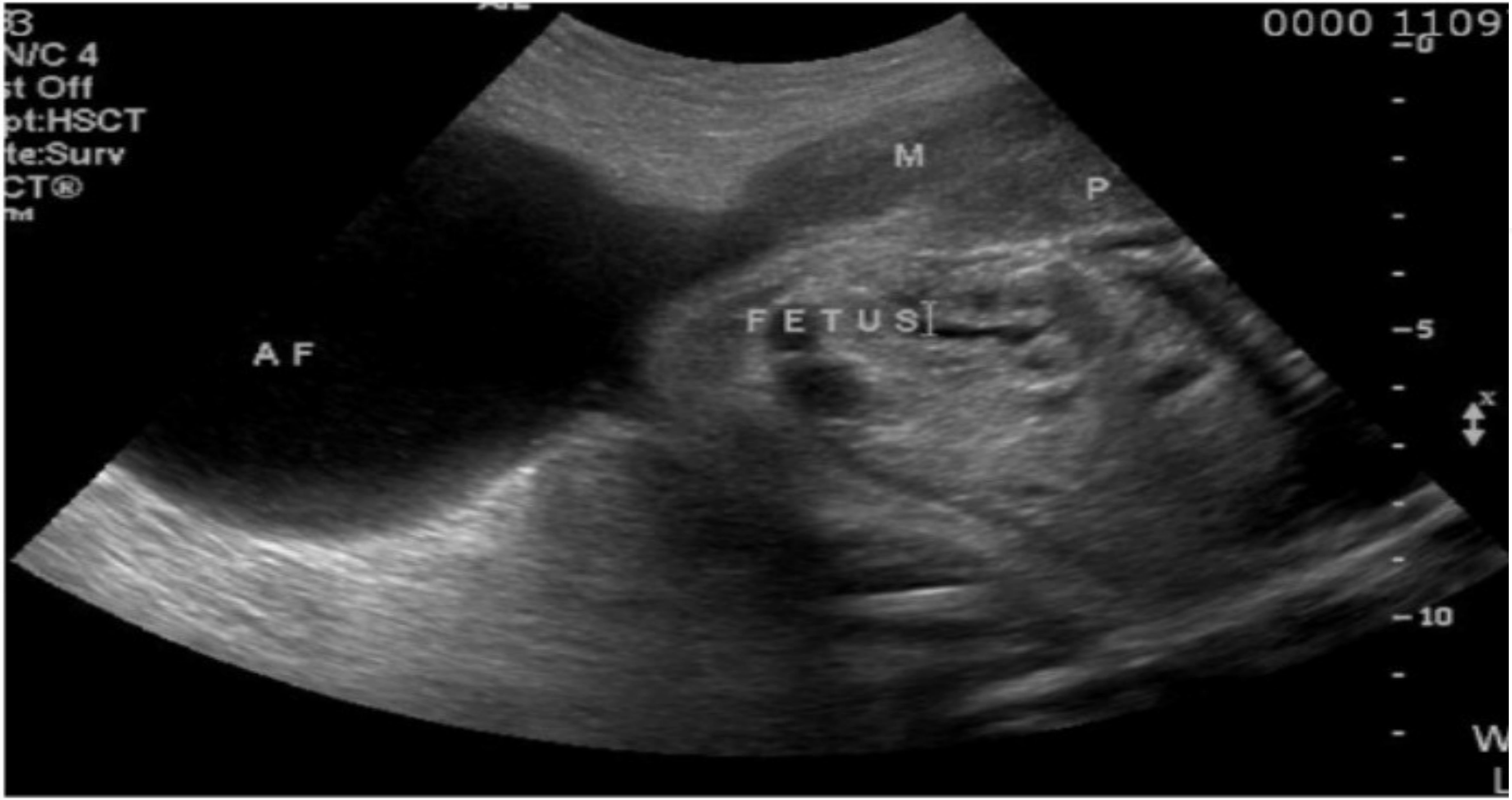
UTERINE RUPTURE IN PREGNANCY

- **Uterine rupture occurs when a full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum (uterine serosa) is present. it is associated with the following:**

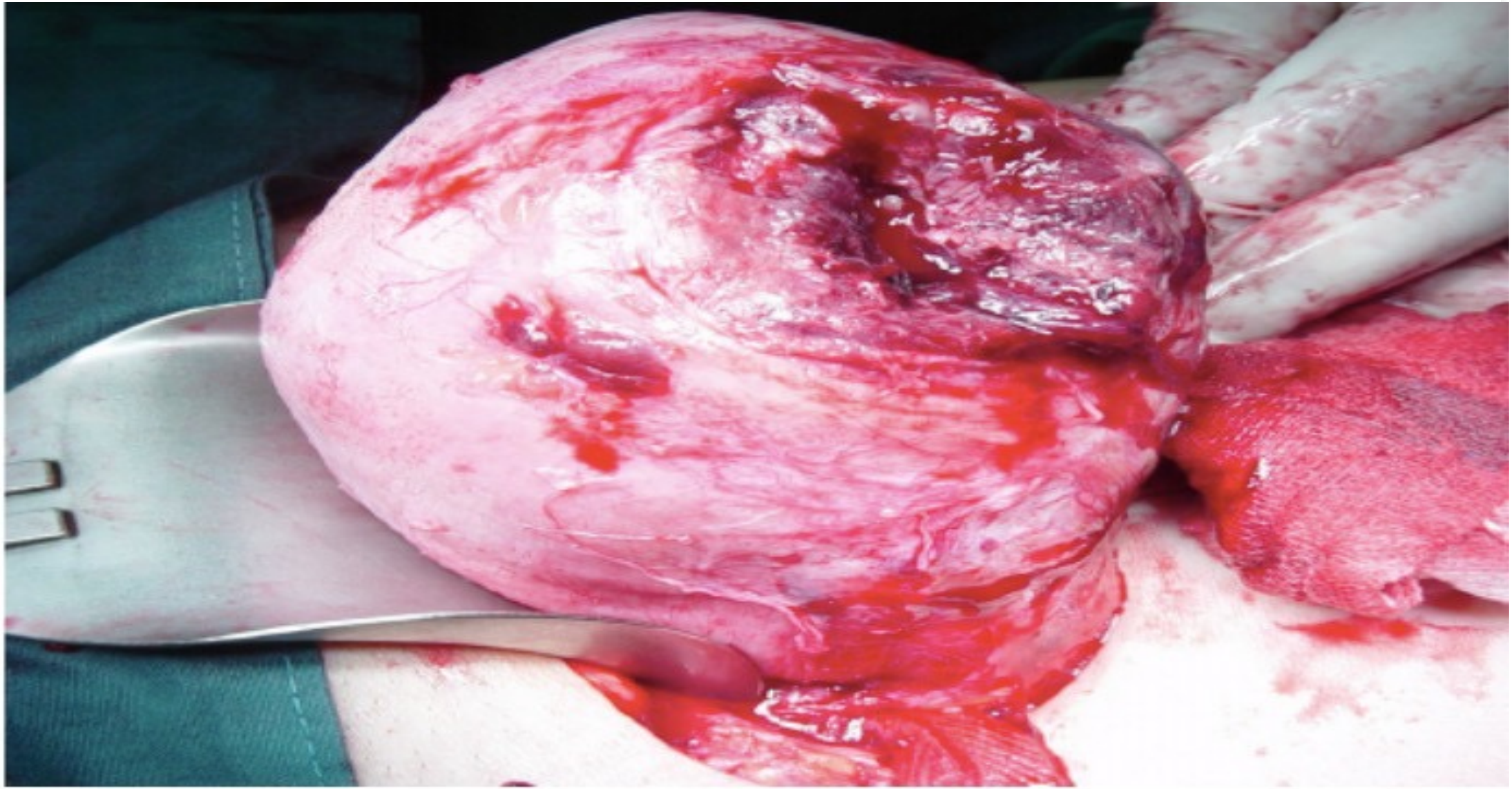
1. **Clinically significant uterine bleeding**
2. **Fetal distress**
3. **Protrusion or expulsion of the fetus and/or placenta into the abdominal cavity**
4. **Need for prompt cesarean delivery**
5. **Uterine repair or hysterectomy**



An abdominal ultrasound image of the thin uterine wall (arrow) and the fetal minor part during the 2nd uterine rupture.



Uterine wall defect and extruded amniotic sac with the fetal buttocks during the 1st uterine rupture. AF, amniotic fluid; M, myometrium; P, placenta.



Rupture site in upper posterior wall of the uterus during the 2nd uterine rupture.

UTERINE RUPTURE IN PREGNANCY

- In contrast to frank uterine rupture, uterine scar dehiscence involves the disruption and separation of a preexisting uterine scar. Uterine scar dehiscence is a more common event than uterine rupture and seldom results in major maternal or fetal complications.

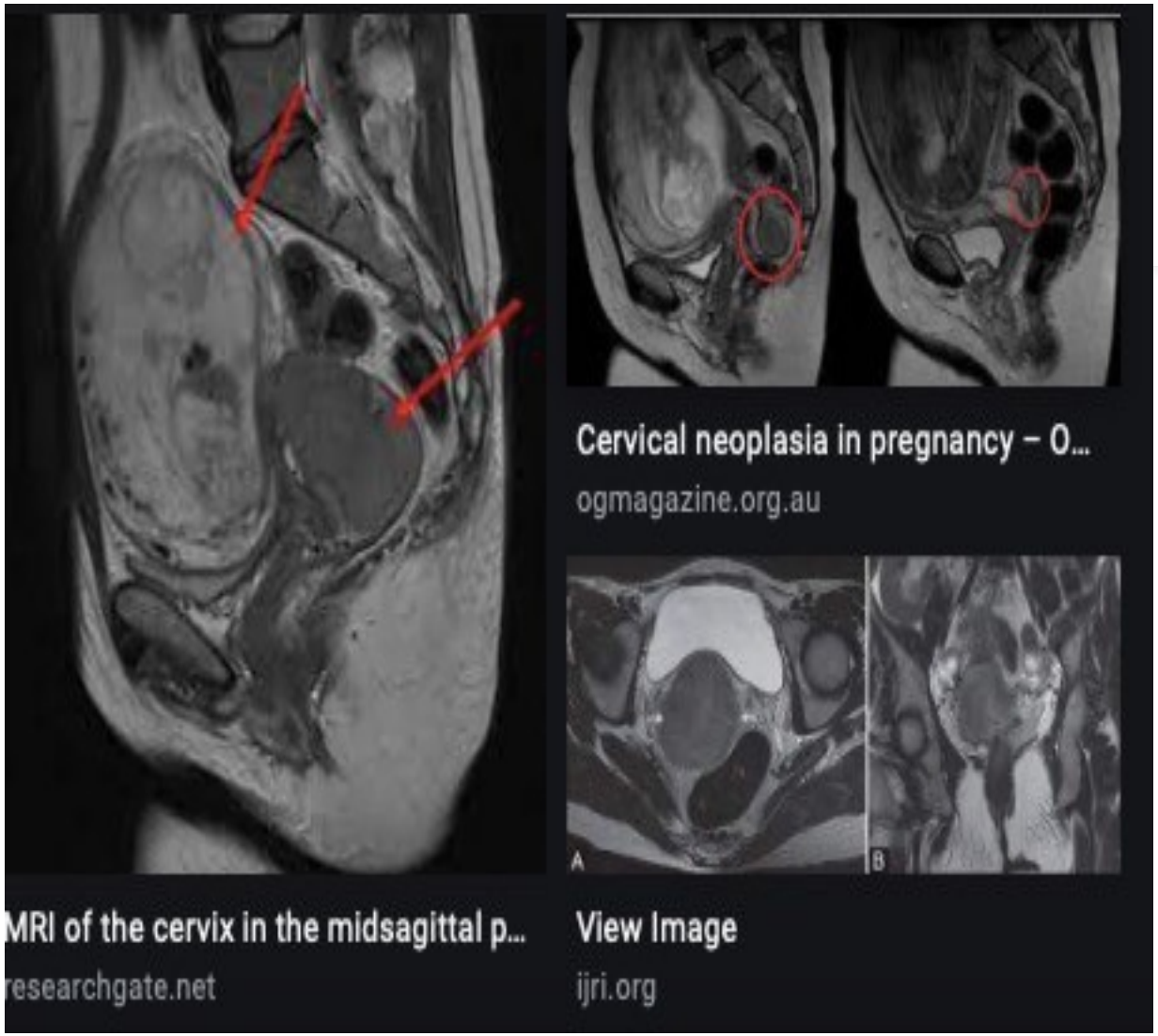
UTERINE RUPTURE IN PREGNANCY

All the following increase the risk of uterine rupture,

1.Congenital uterine anomalies, **2**.multiparity, **3.**previous uterine myomectomy,**4.** the number and type of previous cesarean deliveries,**5.** fetal macrosomia, **6.**labor induction, **7.**uterine instrumentation, and **8**. uterine trauma

Other causes of antepartum hemorrhage

1. Local gynecologic cause (infection-tumor- trauma)
2. General cause of bleeding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