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ONE OF THE MOST COMMON CASES NOWADAYS IS DATA ON BLEEDING IN THE CASE OF CHILDBIRTH

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Annotation: this article covers bleeding in the case of childbirth, one of the most common cases. You can find out how to provide assistance in this case and the reasons for its origin in this article. The article is written in the case of using internet resources.

Key words: pregnancy, blood, lobar.

The most common cause of bleeding during late pregnancy is

- Bloody show of labor

Bloody show heralds onset of labor, is scant and mixed with mucus, and results from tearing of small veins as the cervix dilates and effaces at the start of labor.

More serious but less common causes (see table Some Causes of Bleeding During Late Pregnancy) include

- Placental abruption (
- Placenta previa
- Vasa previa (rare)
- Uterine rupture (rare)

Placental abruption is premature separation of a normally implanted placenta from the uterine wall. The mechanism is unclear, but it is probably a late consequence of chronic uteroplacental vascular insufficiency. Some cases follow trauma (eg, assault, motor vehicle crash). Because some or most of the bleeding may be concealed between the placenta and uterine wall, the amount of external (ie, vaginal) bleeding does not necessarily reflect the extent of blood loss or placental separation. Placental abruption is the most common life-threatening cause of bleeding during late pregnancy, accounting for about 30% of cases. It may occur at any time but is most common during the 3rd trimester.

Placenta previa is abnormal implantation of the placenta over or near the internal cervical os. It results from various risk factors. Bleeding may be spontaneous or triggered by digital examination or by onset of labor. Placenta previa accounts for about 20% of bleeding during late pregnancy and is most common during the 3rd trimester.

In **vasa previa,** the fetal blood vessels connecting the cord and placenta overlie the internal

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cervical os and are in front of the fetal presenting part. Usually, this abnormal connection occurs when vessels from the cord run through part of the chorionic membrane rather than directly into the placenta (velamentous insertion). The mechanical forces of labor can disrupt these small blood vessels, causing them to rupture. Because of the relatively small fetal blood volume, even a small blood loss due to vasa previa can represent catastrophic hemorrhage for the fetus and cause fetal death.

Uterine rupture may occur during labor—almost always in women who have had scarring of the uterus (eg, due to cesarean delivery, uterine surgery, or uterine infection)—or after severe abdominal trauma.

Bleeding may also result from nonobstetric disorders.

The evaluation of patients with vaginal bleeding during late pregnancy aims to exclude potentially serious causes of bleeding (placental abruption, placenta previa, vasa previa, uterine rupture). Bloody show of labor and placental abruption are diagnoses of exclusion.

History

History of present illness should include

- Estimated due date (and whether this is based on last menstrual period or ultrasonography)
- Any risk factors for obstetric complications and prior testing or complications during the current pregnancy
- Duration and volume of bleeding
- Amount and color (bright red vs dark) of blood
- Abdominal pain or uterine contractions

Important associated symptoms include abdominal pain and rupture of membranes. Clinicians should note whether these symptoms are present or not and describe them (eg, whether pain is intermittent and crampy, as in labor, or constant and severe, suggesting placental abruption or uterine rupture).

Review of systems should elicit any history of syncope or near syncope (suggesting major hemorrhage).

Past medical history should include the patient's gravidity (number of confirmed pregnancies), parity (number of deliveries after 20 weeks), and number of abortions (spontaneous or induced). It should note risk factors for major causes of bleeding (see table Some Risk Factors for Major Causes of Bleeding During Late Pregnancy), particularly previous cesarean delivery. Clinicians should determine whether patients have a history of hypertension, cigarette smoking, in vitro fertilization, or any illicit drug use (particularly cocaine).

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Physical examination

Examination starts with review of vital signs, particularly blood pressure, for signs of hypovolemia. Fetal heart rate is assessed, and continuous fetal monitoring is started if possible.

The abdomen is palpated for uterine size, tenderness, and tonicity (normal, increased, or decreased).

A digital cervical examination is contraindicated when bleeding occurs during late pregnancy until ultrasonography confirms normal placental and vessel location (and excludes placenta previa and vasa previa). Careful speculum examination can be done. If ultrasonography is normal, clinicians may proceed with a digital examination to determine cervical dilation and effacement.

Red flags

The following findings are of particular concern:

- Hypotension
- Tense, tender uterus
- Fetal distress (loss of heart sounds, bradycardia, variable or late decelerations detected during monitoring)
- Cessation of labor and atonic uterus

Vaginal bleeding may be mild despite maternal hypotension.

Interpretation of findings

If more than a few drops of blood are observed or there are signs of fetal distress, the more serious causes must be ruled out: placental abruption, placenta previa, vasa previa, and uterine rupture. However, some patients with placental abruption or uterine rupture have minimal visible bleeding despite major intra-abdominal or intrauterine hemorrhage.

Clinical findings help suggest a cause (see also table Some Causes of Bleeding During Late Pregnancy):

- Light bleeding with mucus suggests bloody show of labor.
- Sudden, painless bleeding with bright red blood suggests placenta previa or vasa previa.
- Dark red clotted blood suggests placental abruption or uterine rupture.
- A tense, contracted, tender uterus suggests placental abruption.
- An atonic or abnormally shaped uterus with abdominal tenderness suggests uterine rupture.

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Testing

The tests should include the following:

- Ultrasonography
- Complete blood count (CBC) and type and screen
- Sometimes, coagulation tests
- Possibly Kleihauer-Betke testing

All women with bleeding during late pregnancy require ultrasonography, done at the bedside if the patient is unstable. Transvaginal ultrasonography should be considered if normal placentation has not been previously confirmed. A normal placenta and normal cord and vessel insertion exclude placenta previa and vasa previa. Although ultrasonography sometimes shows placental abruption, this test is not sufficiently reliable to distinguish placental abruption from uterine rupture. These diagnoses are made clinically, based on risk factors and examination findings (a tense uterus is more common in placental abruption; loss of tone is more common in rupture). Rupture is confirmed during laparotomy.

In addition, CBC and type and screen (blood typing and screening for abnormal antibodies) should be done. If bleeding is severe, if moderate to severe placental abruption is suspected, or if maternal hypotension is present, several units of blood are cross-matched and tests for disseminated intravascular coagulation (prothrombin time/partial thromboplastin time [PT/PTT], fibrinogen level, D-dimer level) are done.

The Kleihauer-Betke test can be done to measure the amount of fetal blood in the maternal circulation and determine the need for additional doses of Rho(D) immune globulin to prevent maternal sensitization.

Treatment of vaginal bleeding during late pregnancy is aimed at the specific cause.

For placental abruption or placenta previa, the patient should be evaluated and, if delivery is not required, admission to the hospital is usually recommended.

If vasa previa is diagnosed before labor starts, doctors schedule a cesarean delivery before labor starts, typically at 34 to 37 weeks of gestation. Bleeding from vasa previa is fetal blood and blood loss can be rapid and fatal to the fetus. If bleeding occurs and this is suspected as the cause, immediate cesarean delivery is performed. If the baby has lost a lot of blood, the baby may require a blood transfusion.

If the uterus has ruptured, the baby is delivered immediately. The uterus is repaired surgically.

Patients with signs of hypovolemia require IV fluid resuscitation, starting with 20 mL/kg of

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normal saline solution.

Blood transfusion should be considered for patients who have any of the following:

- No response to 2 L of saline
- Abnormal vital signs or laboratory test results
- Continuing bleeding

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