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Evaluation and Management of Vaginal Bleeding in Pregnancy

1. Definition or Key Clinical Information: it is called Early pregnancy bleeding up to 20 weeks and Antepartum bleeding 20+ weeks. Bleeding during the first trimester of pregnancy occurs in an estimated 15-40% of pregnant people. Vaginal bleeding has many potential etiologies. Benign bleeding may be caused by implantation spotting (1-2wks after fertilization), postcoital spotting, vulvar varicosities, and cervical prolapse. Pathological may be caused by SAB, ectopic pregnancy, anembryonic pregnancy, uterine fibroids, molar pregnancy, subchorionic hemorrhage, vaginitis, cervicitis, hemorrhagic cystitis, vaginal trauma (Delaney, 2020). Refer to appropriate PGs for management of spontaneous, missed, or threatened abortion, ectopic pregnancy, molar pregnancy, or preterm labor.

2. Assessment

i. Risk Factors · Prior early pregnancy loss (risk of SAB)
· Advanced maternal age (risk of SAB)
· Prior ectopic pregnancy (risk of ectopic pregnancy)
· Prior molar pregnancy (risk of molar pregnancy)
· History of vaginal infections (chlamydia, gonorrhea, trichomoniasis, HPV)
· Uterine fibroids
· Multiparity (increased risk of cervical polyps)
· Hypertensive disorder (especially chronic hypertension with superimposed preeclampsia) (risk of abruption)
· Smoking (risk of abruption)
· Cocaine use (risk of abruption)
· Cervicitis
· Cervical lesions
· Cervical polyp
· Vaginitis
· Postcoital bleeding
· Implantation bleeding
· Hemorrhagic cystitis
· Perineal lesions
· Vulvar varicosities

ii. Subjective Symptoms Bleeding - intermittent or continuous, spotting, cramping, passing clots/tissue, abdominal or shoulder pain

iii. Objective Signs Consider the following related signs during clinical evaluation: cervical polyp, cervicitis, perineal lesions, vulvar varicosities, hemorrhoids, abdominal tenderness/pain,

abdominal mass, rebound tenderness, CVAT, cervical dilation/effacement, CMT, adnexal masses or pain.

iv. Clinical Test Considerations

Evaluation of First Trimester Bleeding-

Physical exam to determine if it really is vaginal bleeding
and not another type (UTI). Vaginal/abdominal ultrasound. Serial quantitative measurement of beta-hCG levels to determine the viability of the pregnancy.
Testing for progesterone levels may also be recommended, if the serum progesterone value is 20 ng/mL or more, it is likely that the pregnancy is viable. A value of 5 ng/mL or less is consistent with an abnormal or failing pregnancy, but the progesterone value alone does not give information about the site of the pregnancy.
Evaluation of Bleeding in the Second Half of Pregnancy- Review chart for blood type, Rh, risk factors, and placental location; Obtain menstrual, maternal and gynecologic history; Abdominal palpation for uterine tone, tenderness; CBC If suspected abruption, do vital signs, FHTs, transfer; If suspected previa has not been ruled out by previous ultrasound, DO NOT do vaginal exam, transfer; Evaluate for presence of labor; Cervical exam as indicated; Ultrasound as indicated; Speculum exam if cervical inspection indicated; As indicated, do necessary labs as outlined above

3. Management plan

i. Therapeutic measures to consider Post coital bleeding - no treatment necessary, subchorionic hemorrhage - pelvic rest. Spontaneous or threatened abortion, missed or incomplete pregnancy loss - see PG on SAB and TAB. Each pathological condition is treated based on specific diagnosis.

ii. **Complementary measures to consider** During pregnancy with increasing hCG: red raspberry leaf tea, wild yam root, false unicorn root, black haw, partridge berry, cramp bark, chasteberry, Vitamin C 1,000 daily, Vitamin E 800 mg IU daily for up to 3 weeks, magnesium, increased rest, chamomile daily to reduce stress, rescue remedy.
Subchorionic hemorrhage- prioritize nutrition including adequate protein and hydration and plenty of fruits, vegetables, and beneficial fats
For missed or incomplete abortion: See PG on spontaneous and therapeutic abortion-
For healing after complete SAB- see PG on spontaneous and therapeutic abortion
Ectopic pregnancy- see PG on ectopic pregnancy
Molar pregnancy- see PG on molar pregnancy

iii. Considerations for pregnancy, delivery and lactation Highly dependent on cause of bleeding.

iv. Client and family education Routine education for all clients about the major causes of bleeding in pregnancy and birth, as well as education on warning s/s - cramping, spotting, sudden onset of new symptoms, etc. - and how to reach the midwife. In childbirth classes, provide education on the importance of nutrition as prevention of anemia, and the connection between anemia and heavier bleeding. Consider educating on herbal and complementary birth preparation measures for anemia and hemorrhage prevention. Clients who have been diagnosed with specific conditions, such as subchorionic hematoma or placenta previa, will require education on the condition itself, its significance, recommended follow-up, related reasons to contact the midwife, and warning signs that are indications to seek immediate medical care.

v. Follow-up

Kleihauer-Betke blood test to determine the appropriate dose of Rh immunoglobulin for

RH negative client
hCG levels:
48-96 hours in case of threatened SAB
Repeat q 3-5 days until either clear regression or appropriate increase
Ultrasound:
Subchorionic bleeding on U/S:
Follow-up U/S for anomalies
Follow-up hCG levels
Offer repeat ultrasound q- 4 weeks until chorionic hemorrhage is resolved
Placenta previa:
Follow-up U/S by 28-32 weeks to assess placenta position
Discuss implication of U/S report with client
Evaluate for:
Molar pregnancy
Choriocarcinoma
Ectopic pregnancy
Incomplete SAB
Consider iron-replacement therapy/supplementation for anemia

4. Indications for Consult, Collaboration or Referral
Diagnostic testing, such as sonohysteroscopy ,
Uterine fibroids or polyps
Ectopic pregnancy, or pregnancy of an undetermined location
Incomplete abortion
Persistent and progressive bleeding Unresponsive to herbal or hormone therapy
Previa in the 3rd trimester
Persistent subchorionic hemorrhage
Clients preference
For diagnosis or treatment outside the CPM's scope of practice

5.References

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