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# Antepartum Haemorrhage: A Surprise!.

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**ABSTRACT**

Antepartum hemorrhage is nothing but bleeding from genital tract. Abruptio placentae is defined as the premature separation of the normally located placenta from the uterine wall resulting in bleeding before delivery which could be concealed or revealed type. Patients with abruption present typically with pain abdomen, tense abdomen, bleeding per vaginum and fetal distress. A significant cause of third-trimester bleeding associated with fetal and maternal morbidity and mortality is placental abruption must be considered whenever bleeding is encountered in the second half of pregnancy. Here we have a case of antepartum hemorrhage of unknown origin which ended up as an abruptio placenta - concealed type without any symptoms.

**Keywords:** concealed hemorrhage,abruption placenta, retroplacental clots.

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## INTRODUCTION

Antepartum haemorrhage (APH) is defined as bleeding from or in to the genital tract, occurring from 24 $^{+0}$ weeks of pregnancy and prior to the birth of the baby. Placenta praevia and Abruptio placenta remains the most important cause of APH. 3-5%of pregnancies are complicated by APH and it remains main cause of maternal and perinatal mortality worldwide. Obstetric haemorrhage remains one of the major causes of maternal death in developing countries and up to 50% of the estimated 500 000 maternal deaths that occur globally each year [1-4].

**Case presentation**

A 22yr old $G_2P_1L_1$ , GA:$36^{+2}$wk as per LMP and 35+/-1wk as per USG with EDD 14.10.2014 with previous full term normal vaginal delivery with last child birth 21/2year back with regular cycles, Non consanguineous marriage came to us with, C/O Bleeding per vaginum for1 hour initially associated with pain abdomen and later no C/O pain abdomen. H/O Intermittent lower abdominal pain. H/O Coitus in the morning. She was able to perceive foetal movements well. No H/O trauma or injury to the abdomen. She is a booked case outside. She had no other co-morbidities and no significant family history. On examination patient general condition fair afebrile, pallor++, no pedal edema, not icteric not cyanosed, spine normal.

Systemic examination,

CVS: $S_1S_2$ heard,
RS: NVBS heard,

Abdomen examination:

Uterus 36 wks, relaxed, not tense, not tender, cephalic, head 4/5$^{th}$ palpable, Liquor clinically normal,
Estimated foetal weight 2.8 – 3kg, FHS good.
L/E fresh bleed present,
P/S Cervix congested bleeding through os present,
P/VCervix-25%effaced, Os admits 1 finger, membrane-present,head-belowbrim, pelvis adequate.
? exaggerated show.

One previous USG at15-16 wk scan showed placenta anterior and lower edge of placenta close to internal os.

Suspecting exaggerated show or local pathology or placenta previa or abruption patient, sent for USG which showed SLIUG ,GA 35+/- 1wk, anterior and fundal grade III no retroplacental clot margin of placenta well above the os.

No features suggestive of APH Internal os free.

HC-8.8cm ($35^{+6}$wk), AC-29cm ($33^{+1}$wk), FL-7.0cm ($33^{+6}$wk), AFI : 6cm.

Patient was admitted and anaemia evaluation done and found to have Dimorphic anaemia and so treated with neurobion. Patient had on and off spotting p/v and no further pain abdomen and she was kept under close observation.

A week later she had pain abdomen and got into labour with P/A Uterus term acting mildly, head just fixed, FHS good, Liquor clinically adequate. P/V cervix 25% effaced, Os admits 2 finger, membrane present, vertex at brim, pelvis gynaecoid, show +, no draining P/V.

In view of $G_2P_1L_1$ with term gestation with unexplained APH / undiagnosed cervical pathology in labour patient is taken up for EMERGENCY LSCS.

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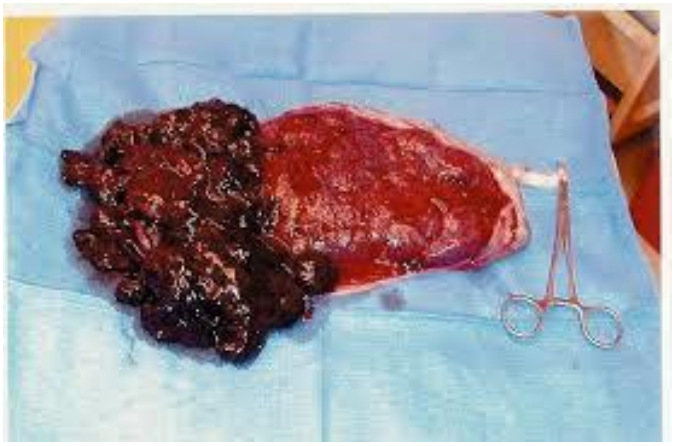
Intra-OP finding

Liquor - thin meconium stained, profuse bleeding after baby delivery. Placenta was anterior and low lying. On removal of placenta, there was retro placental clot of about 200gm. Placenta with membranes removed in Toto. Haemostasis secured and then abdomen closed in layers. Procedure went uneventful. Patient delivered an alive term girl baby of 3kg weight with APGAR 8/10&9/10.



Post OP period uneventful. Suture removal done on day 7 repeat haemoglobin 8.9gm%. patient discharged with iron and calcium supplementation.

## DISCUSSION

Once the patient comes with signs and symptoms of placental abruption we being the clinicians should be alert and cautious. From our case report, if a patient with APH of unknown origin comes, we have to be little cautious even when the USG comes as normal. The intervention and trearment is individualized and it depends on mother's condition, fetal response to hemorrhage and the extent of abruptio pkacenta. Placental abruption is concealed in 20–35% and revealed in 65–80% of cases [3]. About half of the cases of APH is APH of unknown origin. Abruptio placenta is always a clinical diagnosis.

For the purpose of management of abruption, Sher and Statland divided placental abruption into three degrees of severity [5].

These are mild (grade 1): not recognized clinically before delivery and usually diagnosed by the presence of a retroplacental clot; moderate (grade 2): intermediate, the classical signs of abruption are present but the fetus is still alive; and severe (grade 3): the fetus is dead and coagulopathy may be present. Management of APH can be either to terminate pregnancy by cesatean / vaginal delivery or expectant management to continue the pregnancy [5-7].

In our case report we kept all differential diagnosis of antepartum haemorrhage and we observed her closely by both clinical examination and USG and fetal wellbeing also monitored closely and we followed expectant management for her and allowed the fetus to mature enough. As we suspected she had the retroplacental clots intraoperatively suggesting concealed abruption. Luckily she didn't have any complications of abruption.

## CONCLUSION

Even though our medicine field has advanced a lot in obstetrics Abruptio placenta remains chalenging. From this case report we should be extra cautious when we come across Antepartum hamorrhage especially when we suspect abruption which is mainly a clinical diagnosis. As because there is no definite laboratory tests to diagnose abruption and USG can help us but only to certain extent and the clinical suspicion helps us in these kind of unknown APH.

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