Mid Essex Hospital Services NHS
NHS Trust

ANTENATAL MANAGEMENT OF LOW LYING PLACENTA	**CLINICAL GUIDELINES** **Register No: 08017** **Status: Public**

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Contributes to CQC	Outcome 9, 11

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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 07072 Management of Antepartum Haemorrhage 09015 Ultrasound Management of Low Lying Placenta, Vasa Praevia and Placenta Accreta Identified at Anatomy Scan 04272 Maternity Care

Document History Review:

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1.0	Julie Bishop	March 2005
2.0	Ignathias Adams	February 2008
2.1	Sarah Moon: Equality and diversity; audit & monitoring update	March 2010
3.0	Sarah Moon	June 2011
3.1	Sarah Moon – Clarification to point 5.5, 8.0	August 2013
4.0	Reviewed by Vidya Thakur, Obstetric Consultant	June 2014
5.0	Vidya Thakur, Obstetric Consultant	7 November 2017

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1.0 Purpose

1.1 This guideline is designed to aid Maternity staff in the management of patients who have a low-lying placenta diagnosed at anatomy scan.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Definition

3.1 Placenta praevia exists when the placenta is located in the lower segment of the uterus as follows:

- A major praevia describes a placenta that overlaps or covers the internal os
- A minor praevia exists when the placenta reaches the internal os

4.0 Incidence

4.1 A low lying placenta is not an uncommon finding at second trimester scanning. 15% -20% of pregnancies have a low lying placenta. Fortunately only 5% remain low lying at 32 weeks and only a third of these are low lying at 37 weeks.

5.0 Screening and Diagnosis for Placenta Praevia

5.1 Clinical suspicion should be raised in all women with vaginal bleeding after 20 weeks of gestation. A high presenting part, an abnormal lie and painless or unprovoked bleeding, irrespective of previous imaging results, are more suggestive of a low-lying placenta but may not be present, and the definitive diagnosis usually relies on ultrasound imaging.

5.2 Routine ultrasound scanning at 20 weeks of gestation should include placental localisation.

5.3 Transvaginal scans improve the accuracy of placental localisation and are safe, so the suspected diagnosis of placenta praevia at 20 weeks of gestation by abdominal scan should be confirmed by transvaginal scan.

5.4 Following the 20 week scan, women will require a follow -up imaging at 32 weeks if the placenta covers or overlaps the cervical os.

5.5 If the placenta covers the cervical os, an antenatal appointment should be made for the woman to be reviewed by the obstetric consultant at the next available antenatal appointment. In addition, the woman should be reviewed by the anaesthetic consultant at the next available antenatal appointment.
(Refer to the guideline entitled ‘Maternity Care’ (04272)

5.6 Patients with a previous caesarean section require a higher index of suspicion as there are two problems to exclude: placenta praevia and placenta accreta.
If the placenta lies anteriorly and reaches the cervical os at 20 weeks, a follow-up scan can help identify the position of the placenta in relation to the cervical os and the caesarean scar.

(Refer to the guideline entitled ‘Ultrasound management of low lying placenta, vasa praevia and placenta accreta identified at anatomy scan; register number 09015

5.7 If there is a high index of suspicion regarding placenta accrete, the woman should be referred to the Fetal Medicine Clinic.

5.8 In cases of asymptomatic patients with suspected minor praevia, follow-up imaging can be left until 36 weeks of gestation. It is important for all patients attending the 36 week scan to have a full bladder which improves the visualisation of the lower edge of the placenta.

5.9 In cases with asymptomatic suspected major placenta praevia or a question of placenta accreta, imaging should be performed at around 32 weeks gestation to clarify the diagnosis and allow planning for third-trimester management. If there is a high index of suspicion regarding placenta praevia, the woman should be referred to the Antenatal and Newborn Screening Midwife to arrange a fetal medicine scan.

5.10 If the sonographer is unable to visualise the placenta clearly, then it may be necessary to use a transvaginal probe to clarify the diagnosis. Furthermore, this will allow adequate time for planning, management and delivery.
(Refer to the guideline entitled ‘Ultrasound management of low lying placenta, vasa praevia and placenta accreta identified at anatomy scan; register number 09015)

6.0 Antenatal Management

6.1 Prevention and treatment of anaemia during the antenatal period is recommended.

6.2 Patients with placenta praevia in the third trimester should be counselled about the risks of preterm delivery and obstetric haemorrhage, and their care should be tailored to their individual needs.

6.3 Patients who bleed during the course of the remaining pregnancy should be managed according to their needs. An individual management plan should be discussed and formulated in conjunction with the obstetric registrar/consultant on call and the patient. This discussion and plan should be documented in the patient’s healthcare records.
(Refer to the guidelines entitled ‘Management of a patient reporting an antepartum haemorrhage’; register number 07072; ‘Guideline for maternity record keeping including documentation in handheld records’; register number 06036)

6.4 Patients with major placenta praevia who have previously bled should be admitted and managed as inpatients from 34 weeks gestation. Asymptomatic cases require careful counselling before considering outpatient care. Plan of care requires close proximity with the hospital, constant presence of a responsible adult and full informed consent from the patients. It should be made clear that she should attend immediately if she experiences any bleeding or pain including vague suprapubic period like aches. The patient’s obstetric consultant must be informed if outpatient care is being considered.
(Refer to the guideline entitled ‘Guideline for maternity record keeping including documentation in handheld records’; register number 06036)

6.5 Elective delivery by caesarean section in asymptomatic patients is not recommended before 38 weeks of gestation for placenta praevia.

6.6 Decisions regarding blood availability during inpatient antenatal care should be based on clinical factors relating to individual cases as well as on local blood bank services.

Patients with atypical antibodies form a particularly high-risk group and discussions in these cases should involve the local haematologist and blood bank.

6.7 Placenta praevia without a previous caesarean section carries a risk of massive obstetric haemorrhage and hysterectomy and should be carried out in a unit with a blood bank and facilities for high dependency care.

6.6 If the scan shows that the placenta is no longer low lying and there are no other risk factors in the current pregnancy, then the patient's care will return to low-risk antenatal care.

7.0 Staffing and Training

7.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

7.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

8.0 Professional Midwifery Advocates

8.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

9.0 Infection Prevention

9.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

10.0 Audit and Monitoring

10.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

10.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

10.3 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

10.4 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

10.5 Key findings and learning points will be disseminated to relevant staff.

11.0 Guideline Management

11.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

11.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

11.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

11.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

12.0 Communication

12.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

12.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

12.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

12.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

13.0 References

Royal College of Obstetricians and Gynaecologists (2011) Placenta Praevia and Placenta praevia Accreta and Vasa Praevia: Diagnosis and Management. Green top guideline No. 27. London: RCOG
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_27.pdf

National Institute for Health and Care Excellence (2008) Antenatal care for uncomplicated pregnancies. Clinical Guideline CG62. Updated 2017. London: NICE
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Oyelese, Y; Smulian, J.C. (2006) Placenta praevia, placenta accreta and vasa praevia. Obstetrics and Gynaecology. Volume 107.(4): pp 927-941.