

Original Article

Assessment of cases antepartum hemorrhage- A clinical study

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ABSTRACT:

Background: Antepartum hemorrhage is bleeding from the genital tract from the time of viability of pregnancy for extra-uterine survival to the delivery of the baby. The present study was conducted to assess the cases of antepartum hemorrhage in females.

Materials & Methods: The present study was conducted on 52 cases of antepartum hemorrhage. Equal number of normal pregnancy without any associated complications (control) was also included. Patients with the complaint of bleeding per vaginam were carefully examined clinically.

Results: Age group 20-24 year had 7 in group I and 10 in group II, 25- 29 years had 14 in group I and 12 in group II, 30-34 had 20 in group I and 22 in group II and >35 had 11 in group I and 8 in group II. The difference was significant ($P < 0.05$). Abruptio placentae comprised of 26, placenta previa had 20, 3 patients were of undetermined, 2 of local causes and 1 of vasa previa. Out of 26 patients of abruptio placenta, 12 patients had grade 1, 10 had grade 2 and 4 had grade 3. Out of 20 cases of placenta previa, type I & II placenta previa was seen in 6 each followed by type II in 4 and type IV placenta previa with Accreta in 1.

Conclusion: Antepartum hemorrhage is a major cause of maternal and perinatal morbidity and mortality. Common causes were abruptio placentae, placenta previa, undetermined, local causes and vasa previa.

Key words: Antepartum hemorrhage, Females, Placenta previa

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INTRODUCTION

Antepartum hemorrhage (APH) is defined as bleeding from the genital tract from the time of viability of pregnancy for extrauterine survival to the delivery of the baby.¹ Antepartum hemorrhage (APH) is a major cause of maternal and perinatal morbidity and mortality even in modern day obstetrics and is one of the most frequent emergencies in obstetrics.²

APH complicates 3-5% of pregnancies. In a small proportion where placenta previa and abruptio have been excluded, the cause may be related to local lesions of the cervix and vagina, e.g., cervicitis, cervical erosion, genital tumors, vulvar varicosities, ruptured vasa previa and heavy show.³

In a comparison of maternal risk factors, research reports concluded that abruptio is more likely to be related to conditions occurring during pregnancy (preeclampsia, abdominal trauma, intrauterine infections, prelabor rupture of membranes, polyhydramnios elevated maternal serum alpha-fetoprotein, smoking, and substance abuse) and placenta previa related to conditions existing prior to the pregnancy (uterine scar, manual removal of placenta, curettage, advanced maternal age, multiparity, and previous placenta previa).⁴ The precise cause of abruptio is unknown; however, hypertension is the most consistent predisposing factor.⁵ The present study was conducted to assess the cases of antepartum hemorrhage in females.

MATERIALS & METHODS

The present study was conducted in the department of Gynaecology & Obstetrics. It included 52 cases of antepartum hemorrhage. Equal number of normal pregnancy without any associated complications (control) was also included. All were informed regarding the study and written consent was obtained. Ethical clearance was obtained prior to the study.

General information such as name, age, etc. was recorded. Patients with the complaint of bleeding per vaginum were carefully examined clinically. Causes of APH and risk factors were recorded. All patients were subjected to Ultrasonography (USG). Results thus obtained were subjected to statistical analysis. P value less than 0.05 was considered.

RESULTS

Table I Age wise distribution in both groups

Age Group (Years)	Group I (Cases)	Group II (Control)	P value
20-24	7	10	0.05
25-29	14	12	
30-34	20	22	
>35	11	8	

Table I, graph I shows that age group 20-24 year had 7 in group I and 10 in group II, 25- 29 years had 14 in group I and 12 in group II, 30-34 had 20 in group I and 22 in group II and >35 had 11 in group I and 8 in group II. The difference was significant (P< 0.05).

Graph I Age wise distribution in both groups

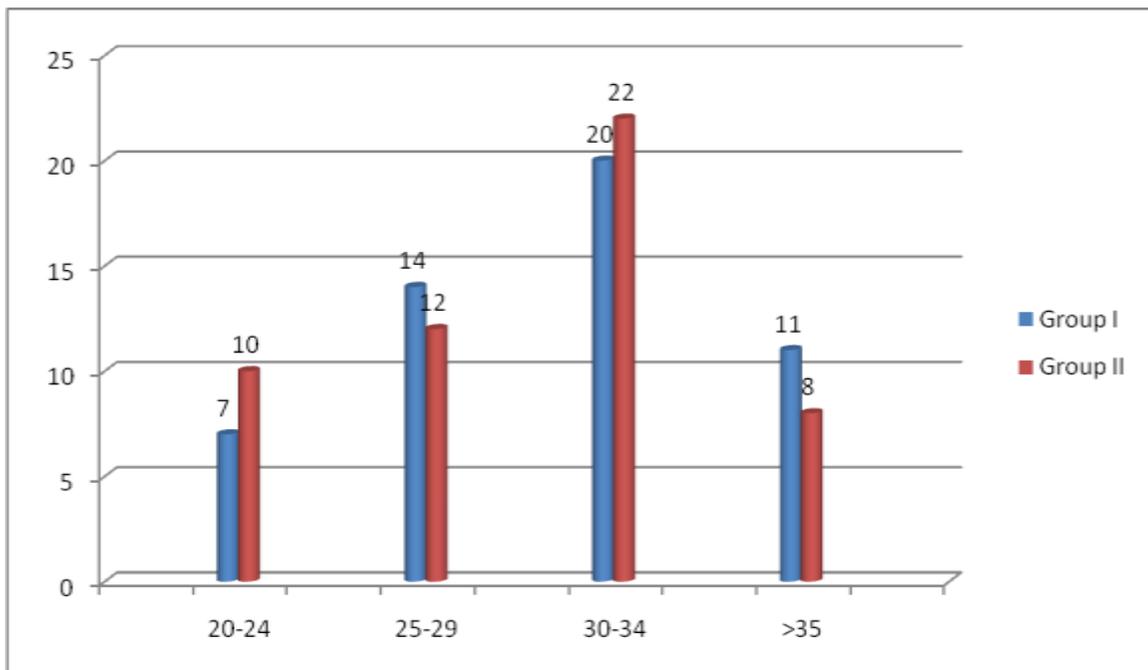
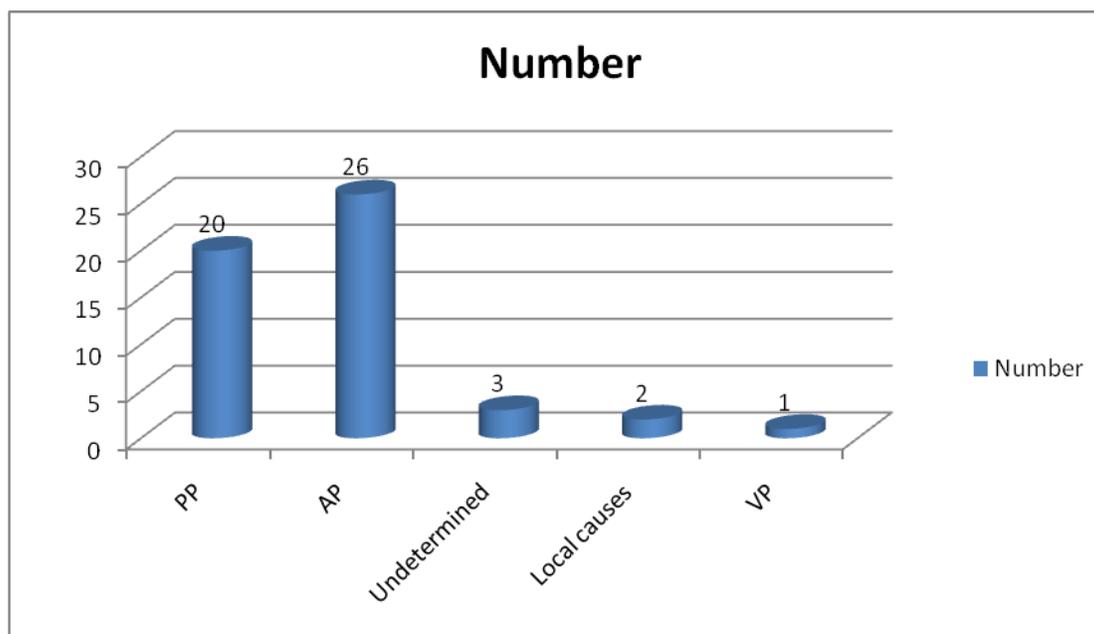


Table 2 Causes of APH

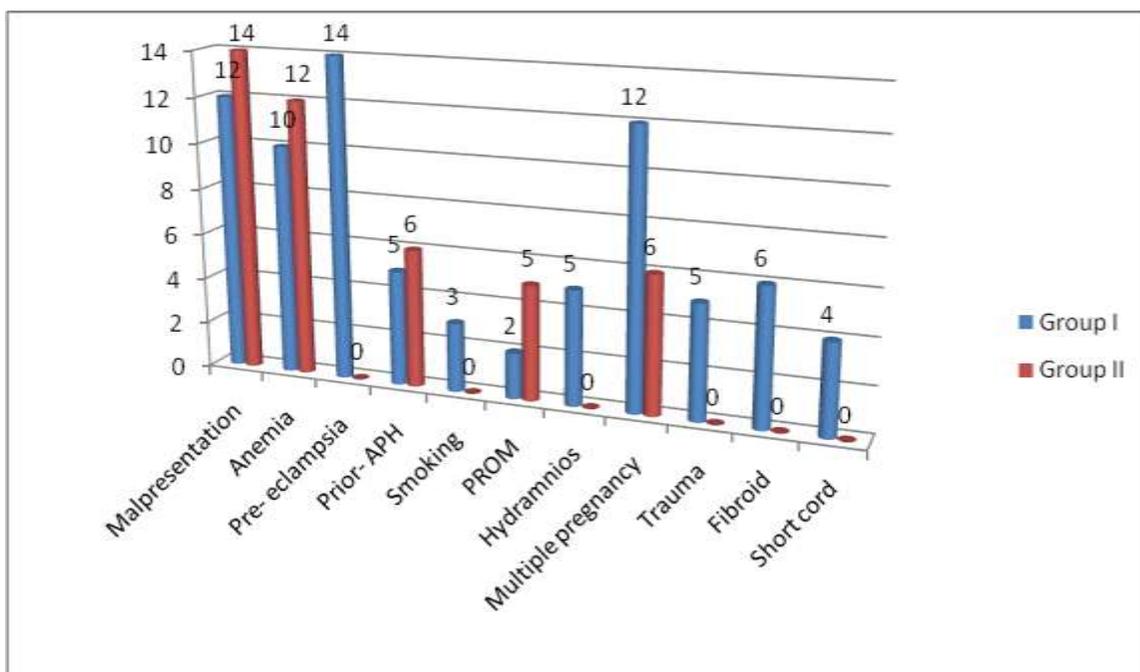
Causes		Number	Total
Placenta Previa Types	Type I	6	20
	Type II	4	
	Type III	3	
	Type IV	6	
	Type IV+ A°	1	
Abruptio Placentae Grade	Grade 1	12	26
	Grade 2	10	
	Grade 3	4	
Undetermined		3	3
Local causes		2	2
Vasa Previa		1	1

Table II, graph II shows that abruptio placentae comprised of 26, placenta previa had 20, 3 patients were of undetermined, 2 of local causes and 1 of vasa previa. Out of 26 patients of abruptio placenta, 12 patients had grade 1, 10 had grade 2 and 4 had grade 3. Out of 20 cases of placenta previa, type I & II placenta previa was seen in 6 each followed by type II in 4 and type IV placenta previa with Accreta in 1.

Graph II Causes of APH



Graph III Associated risk factors



Graph III shows that malpresentations were seen in group I (12) and group II (14). Group I showed maximum number of anemic patients (10) while group II had 12 anemic patients. Group I showed 14 cases of pre-eclampsia. Similarly, group I showed risk factors of smoking in 3, prior APH in 5, PROM in 2, hydramnios in 5, multiple pregnancy in 12, trauma in 5, fibroid in 6 and short cord in 4. There was significant difference ($P < 0.05$).

DISCUSSION

Antepartum hemorrhage (APH) defined as bleeding from the genital tract in the second half of pregnancy, is still an important cause of perinatal mortality and maternal morbidity in the world.⁶ It is found that there is a strong relationship between APH and later development of intrapartum bleeding necessitating cesarean delivery.⁷ Some women necessitate preterm cesarean section and hysterectomy for life-threatening APH, whereas others undergo elective cesarean section at term without hemorrhagic complications.⁸ In addition to unknown origin, the major causes of APH are placenta previa and abruption placenta. Placenta previa is one of the most serious complications during pregnancy and is associated with numerous adverse maternal and fetal-neonatal complications.⁹ The present study was conducted to assess the cases of antepartum hemorrhage in females. In present study, age group 20-24 year had 7 in group I and 10 in group II, 25- 29 years had 14 in group I and 12 in group II, 30-34 had 20 in group I and 22 in group II and >35 had 11 in group I and 8 in group II.

A et al¹⁰ found that maternal complications of APH include hypovolemic shock, disseminated intravascular coagulation, and acute renal failure. It also includes higher rates of cesarean sections as high as 83.3% for placenta previa, peripartum hysterectomies (2.1%), and postoperative anemia (7.3%). The maternal mortality rate was 1% in both studies.

Fetal complications are premature delivery, low birth weight, birth asphyxia, and intrauterine fetal death. Up to one-fifth of very preterm babies are born in association with APH, and the known association of APH with cerebral palsy can be explained by preterm delivery.

We found that abruption placentae comprised of 26, placenta previa had 20, 3 patients were of undetermined, 2 of local causes and 1 of vasa previa. Out of 26 patients of abruption placenta, 12 patients had grade 1, 10 had grade 2 and 4 had grade 3. Out of 20 cases of placenta previa, type I & II placenta previa was seen in 6 each followed by type II in 4 and type IV placenta previa with Accreta in 1. A

retrospective observational study found that women with unexplained APH are at greater risk of preterm delivery, and their babies are more likely to develop hyperbilirubinemia. Furthermore, women with unexplained APH were more likely to have smaller babies, and this difference remained statistically significant when the birth weight was adjusted for gestational age at delivery and other confounders.¹¹

We observed that malpresentations were seen in group I (12) and group II (14). Group I showed maximum number of anemic patients (10) while group II had 12 anemic patients. Group I showed 14 cases of pre-eclampsia. Similarly, group I showed risk factors of smoking in 3, prior APH in 5, PROM in 2, hydramnios in 5, multiple pregnancy in 12, trauma in 5, fibroid in 6 and short cord in 4.

Differences among prevalence estimates in different countries in women with placenta previa may be due to a number of factors. For instance, demographic and socioeconomic characteristics, cultural terms, lifestyles and health statuses vary greatly between countries at different stages of development. Evidence has existed that normal gestational length was longer in white European than Black and Asian in nulliparous women with singleton live fetuses at the time of spontaneous labour.¹²

CONCLUSION

Antepartum hemorrhage is a major cause of maternal and perinatal morbidity and mortality. Common causes were abruptio placentae, placenta previa, undetermined, local causes and vasa previa.

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