**Evaluation and management of Vaginal Bleeding in Pregnancy**

Emily McGregor: Written/revised February 10th 2024

**1. Definition or Key Clinical Information***:* Roughly 15 to 25% of all pregnant individuals will experience vaginal bleeding in the first half of pregnancy (Jordan et al., 2019). Vaginal bleeding in pregnancy may be a number of different things, while bleeding and spotting doesn't always mean there is a problem, it can. Considerations include when in pregnancy is the bleeding happening, how much bleeding is taking place, accompanying signs or symptoms with the bleeding. Some common reasons for bleeding in the first half of pregnancy include: implantation bleeding, subchorionic hemorrhage, cervical irritation, miscarriage. Miscarriage can be further broken down into the following categories:

- **Chemical**: the products of conception are passed before the woman knows she is pregnant
- **Threatened**: any vaginal bleeding that occurs during the first half of the pregnancy
- **Inevitable**: when miscarriage is certain and cannot be stopped
- **Complete**: the products of conception are expelled entirely on its own in a short period of time
- **Incomplete**: all or part of the products of conception are not expelled on its own in a short period of time
- **Septic:** incomplete miscarriage with secondary ascending infection
- **Missed**: the fetus is not viable, but the contents are retained for a prolonged period
- **Habitual**: three or more consecutive miscarriages
- **Blighted Ovum**: embryonic reabsorption or anembryonic pregnancy with placenta and/or gestational sac present

Bleeding in the second half of pregnancy is more uncommon and is more often associated with pathological conditions such as placenta previa, vasa previa, uterine rupture. These conditions may or may not be associated with pain and the need to be managed closely and carefully. (Bunce & Heine, 2024)

**2. Assessment**

**i. Risk Factors** Risk factors will vary depending on the reason behind the vaginal bleeding during pregnancy. Some risk factors to consider include:

- Abnormal progesterone levels, Thyroid abnormalities
- Acute diseases, chronic disorders, autoimmune disorders
- STI exposure
- Hx of PID
- Lupus, connective tissue disorders, uncontrolled diabetes
- ABO incompatibilities
- Uterine abnormalities, incompetent cervix, uterine infection
- Corpus luteum insufficiency
- Developmental defects
- Myomas

- Teratogen exposure
- Trauma
- Use of drugs, alcohol, tobacco, cigarettes

**ii. Subjective Symptoms**

1st half of pregnancy:

- Spotting
- Increased bleeding, with or without clots (visualized passing tissue)
- Pains: neck, shoulder, lower back, cramping, aching

2nd half of pregnancy:

- Signs or symptoms that may look like labor
- Decreased, or very rapid increase of fetal movement
- Bleeding with or without pain: aches, cramps, sharp or dull

**iii. Objective Signs**

- Abnormal vital signs, including: low blood pressure, high pulse (tachycardia), fever (above 100.0 degrees)
- Signs of shock
- Cervical motion tenderness
- Bleeding, may be profuse

**iv. Clinical Impressions** Client appears to be concerned, heightened anxiety, or is overwhelmed with a feeling of "something is wrong"

**v. Clinical Test Considerations**

- Serial hCG draws (2-3 days apart), at least 2+ values need to be collected. If numbers appear to be inconsistent with dates additional draws should be considered
- Progesterone levels (serum)
- CBC including Rh status and sensitivity (if applicable)

  **In office evaluation**

  - FHT
  - Handheld US and/or → refer out for observation of cardiac evaluation. Please note full ultrasound reports are out of the scope of the LM, CPM this would be a simple observation to see if cardiac motion was detectable, this would **not** be diagnostic.

**vi. Differential Diagnosis**

Differential diagnosis is going to vary widely depending on the reason for the vaginal bleeding. Considerations to include would be gestational age, amount of bleeding, presence of pain or discomfort.

1st half of pregnancy: Implantation bleeding, threatened abortion, subchorionic hemorrhage, cervical polyps, vanishing twin, chorionic cyst

2nd half of pregnancy: PTL, bloody show, spotting post cervical irritation IE penetrative intercourse/masturbation or cervical/spec exam

**3. Management plan**

**i. Therapeutic measures to consider within the CPM scope** Please note: management of pathological vaginal bleeding during pregnancy is out of the scope of the LM, CPM, if the

wellbeing of the fetus or the birthing person is at risk this must be elevated to a higher level of care including the Emergency Room, OB or a PCP. All recommendations are for the comfort of the client during this time. Encouragement of pelvic rest, herbal support for the nerves such as: passion flower tincture, valerian root tincture. Herbal support for SAB: Motherwort tincture, black haw root and OTC pain relievers.

**ii. Therapeutic measures commonly used by other practitioners**

Depending on the cause of vaginal bleeding, treatment will vary greatly. Treatment may include:

- For SAB: Mifepristone, misoprostol, D&E, D&C, salpingectomy
- For uterine rupture, vasa previa, placenta previa: Emergency C/S
- For hemorrhage: Fluid replacement including IV fluids and or blood transfusion

**iii. Ongoing care**

Ongoing care will vary greatly depending on the reason for vaginal bleeding. Ongoing care may look like serial hCG draws, co management of care, complete transfer of care, or no change in care if client and fetus are stable and bleeding was benign. All follow up should include clear communication with the client as able (depending on severity of situation).

**iv. Indications for Consult, Collaboration, or Referral**

When bleeding is either putting the fetus or the birthing person at risk, referral and transfer of care are indicated. If it is unknown if bleeding is putting the client or fetus at risk, referral for additional surveillance is indicated.

**v. Client and family education**

Discussion about warning signs, when to call the midwife regarding vaginal bleeding in pregnancy.

**4. References** (can be on a separate page and are not included in the two-page limit)


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