Placenta Previa

Placenta previa occurs when the placenta covers the cervical os and results in painless, bright red vaginal bleeding. Interventions for the stable fetus include bed rest and observation. The unstable fetus will likely need a c-section delivery. Be aware of the increased risk for shock, consider magnesium sulfate if delivery is indicated before 32 weeks gestation, and consider tocolytic agents such as nifedipine.



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Mechanism

Placenta Covers Cervical Os
Placenta-present covering Cervix-certificate
Placenta previa occurs when the placenta covers the cervical os. The four classifications include: total (placenta completely covers the internal cervical os), partial (placenta partially covers the internal cervical os), marginal (placenta is at the margin of the internal cervical os), and low-lying placenta (placenta is implanted in the lower uterine segment in close proximity to the internal cervical os).

Assessment

Painless
No Pain-bolts sign
The classic presentation of a placenta previa is painless uterine bleeding.

Bright Red Vaginal Bleeding
Bright Red Blood from Vagina-flower
Bright red vaginal bleeding, usually near the end of the 2nd trimester or in the 3rd trimester of pregnancy, occurs due to placental separation from the internal cervical os or lower uterine segment and the inability of the uterus to contract at the vessel sites. It can range from light to heavy bleeding, and a vaginal exam is contraindicated as this can result in dislodgment of the placenta from maternal tissues.

Interventions

Stable Fetus
Stable-ground Fetus
Prolonging pregnancy and delaying delivery may be possible when the maternal and fetal status is stable and bleeding is minimal. This expectant or conservative management occurs when the fetus is premature (less than 36 weeks gestation) to allow for fetal lung maturity. If indicated, corticosteroids may be given to facilitate fetal lung maturity.

Bed Rest
Bed
Bed rest will be recommended as walking and other movements can induce contractions. A side lying position is ideal as this reduces the pressure of the uterus on the inferior vena cava and improves blood flow.

Observation
Observatory
Close observation will be initiated to monitor blood loss, uterine tenderness, fetal activity, and vital signs. An external electronic fetal monitoring device may be applied to assess maternal and fetal heart rate. No vaginal or rectal exams are performed (pelvic rest - nothing in vagina).

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Unstable Fetus

Unstable-ground Dying-fetus

Excessive bleeding disrupts the uteroplacental blood flow, resulting in progressive deterioration of fetal status. A mature fetus (usually over 36 weeks gestation) should be prepared for immediate delivery.

C-section Delivery

C-section

Cesarean delivery is necessary in practically all women with placenta previa as the placenta is at the cervix, and labor with cervical dilation could result in placental hemorrhage. Vaginal delivery may be attempted if a minor placenta previa of 2-3 cm from the cervical os is present, and one could proceed with an emergency cesarean if necessary.

Considerations

Risk for Shock

Up-arrow Risk Shocking

Excessive bleeding places the mother at risk for hypovolemic shock. Monitor vital signs for increased pulse and respiratory rate and falling blood pressure every 5-15 minutes if active bleeding. Maintain IV access with a large-bore IV for a blood transfusion if needed.

Magnesium Sulfate

Magnesium-magazine with Sulfur-match

In actively bleeding patients with placenta previa, delivery may be indicated. In pregnancies less than 32 weeks gestation, magnesium sulfate should be administered for fetal neuroprotection.

Tocolysis

Taco-lights

Tocolytic drugs, such as nifedipine, are medications that slow down or inhibit labor. In some cases, these may be given to a patient with placenta previa to prevent labor

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