Bleeding During Pregnancy Overview

Because bleeding during all phases of pregnancy may be dangerous, you should call your health care provider if you have any signs of vaginal bleeding during your pregnancy.

Vaginal bleeding is any blood coming from your vagina (the canal leading from the uterus to the external genitals). This usually refers to abnormal bleeding not associated with a regular menstrual period.

- First trimester bleeding is any vaginal bleeding during the first 3 months of pregnancy. Vaginal bleeding may vary from light spotting to severe bleeding with clots. Vaginal bleeding is a common problem in early pregnancy, complicating 20-30% of all pregnancies.

- Any vaginal bleeding during the second and third trimesters of pregnancy (the last 6 months of a 9-month pregnancy) involves concerns different from bleeding in the first 3 months of your pregnancy. Any bleeding during the second and third trimesters is abnormal.

- Bleeding from the vagina after the 28th week of pregnancy is a true emergency. The bleeding can range from very mild to extremely brisk and may or may not be accompanied by abdominal pain. Hemorrhage (another word for bleeding) is the most common cause of death of the mother in the United States. It complicates about 4% of all pregnancies.

Hemorrhage: Bleeding or the abnormal flow of blood.

The patient may have an internal hemorrhage that is invisible or an external hemorrhage that is visible on the outside of the body. Bleeding into the spleen or liver is internal hemorrhage. Bleeding from a cut on the face is an external hemorrhage.

The term "hemorrhagic" comes from the Greek "haima," blood + rhegnumai," to break forth = a free and forceful escape of blood.

Bleeding During Pregnancy Causes

First trimester bleeding

Vaginal bleeding in the first trimester of pregnancy can be caused by several different factors. Bleeding affects 20-30% of all pregnancies. Up to 50% of those who bleed may go on to have a miscarriage (lose the

baby). Of even more concern, however, is that about 3% of all pregnancies are ectopic in location (the fetus is not inside the uterus). An ectopic pregnancy may be life threatening to the mother. All bleeding associated with early pregnancy should prompt a call to your health care provider for immediate evaluation.

- Implantation bleeding: There can be a small amount of spotting associated with the normal implantation of the embryo into the uterine wall, called implantation bleeding. This is usually very minimal, but frequently occurs on or about the same day as your period was due. This can be very confusing if you mistake it for simply a mild period and don't realize you are pregnant. This is a normal part of pregnancy and no cause for concern.
- Threatened miscarriage: You may be told you have a threatened miscarriage if you are having some bleeding or cramping. The fetus is definitely still inside the uterus (based usually on an exam using ultrasound), but the outcome of your pregnancy is still in question. This may occur if you have an infection, such as a urinary tract infection, get dehydrated, use some drugs or medications, are involved in physical trauma, if the developing fetus is abnormal in some way, or for no apparent reason at all. Other than these reasons, threatened miscarriages are generally not caused by things you do, such as heavy lifting or having sex, or by emotional stress.
- Completed miscarriage: You may have a completed miscarriage (also called a spontaneous abortion) if your bleeding and cramping have slowed down and the uterus appears to be empty based on ultrasound evaluation. This means you have lost the pregnancy. The causes of this are the same as those for a threatened miscarriage. This is the most common cause of first trimester bleeding.
- Incomplete miscarriage: You may have an incomplete miscarriage (or a miscarriage in progress) if the pelvic exam shows your cervix is open and you are still passing blood, clots, or tissue. The cervix should not remain open for very long. If it does, it indicates the miscarriage is not completed. This may occur if the uterus begins to clamp down before all the tissue has passed, or if there is infection.
- Blighted ovum: You may have a blighted ovum (also called embryonic failure). An ultrasound would show evidence of an intrauterine pregnancy, but the embryo has failed to develop as it should in the proper location. This may occur if the fetus were abnormal in some way and not generally due to anything you did or didn't do.
- Intrauterine fetal demise: You may have an intrauterine fetal demise (also called IUFD, missed abortion, or embryonic demise) if the developing baby dies inside the uterus. This diagnosis would be based

on ultrasound results and can occur at any time during pregnancy. This may occur for any of the same reasons a threatened miscarriage occurs during the early stages of pregnancy. It is very uncommon for this to occur during the second and third trimesters of pregnancy. If it does, the causes also include separation of the placenta from the uterine wall (called placental abruption) or because the placenta didn't get sufficient blood flow.

- Ectopic pregnancy: You may have an ectopic pregnancy (also called tubal pregnancy). This would be based on your medical history and ultrasound, and in some cases laboratory results. Bleeding from an ectopic pregnancy is the most dangerous cause of first trimester bleeding. An ectopic pregnancy occurs when the fertilized egg implants outside of the uterus, most often in the fallopian tube. As the fertilized egg grows, it can rupture the fallopian tube and cause life-threatening bleeding. Symptoms are often variable and may include pain, bleeding, or lightheadedness. Most ectopic pregnancies will cause pain before the tenth week of pregnancy. The fetus is not going to develop and will die because of lack of supply of nutrients. This condition occurs in about 3% of all pregnancies.
  - There are risk factors for ectopic pregnancy. These include a history of prior ectopic pregnancy, history of pelvic inflammatory disease, history of fallopian tube surgery or ligation, history of infertility for more than 2 years, having an IUD (birth control device placed in the uterus) in place, smoking, or frequent (daily) douching. Only about 50% of women who have an ectopic pregnancy have any risk factors, however.
- Molar pregnancy: You may have a molar pregnancy (technically called gestational trophoblastic disease). Your ultrasound results may show the developing fetus is not actually a baby but is abnormal tissue. This is actually a type of cancer that occurs as a result of the hormones of pregnancy and is usually not life-threatening to you. However, in rare cases the abnormal tissue is cancerous. It can invade the uterine wall and spread throughout the body. The cause of this is generally unknown.

- Postcoital bleeding is vaginal bleeding after sexual intercourse. It may be normal during pregnancy.

- Bleeding may also be caused by reasons unrelated to pregnancy. For example, trauma or tears to the vaginal wall may bleed, and some infections may cause bleeding.

Late-pregnancy bleeding

The most common cause of late-pregnancy bleeding is problems with the placenta. Some bleeding can also be due to an abnormal cervix or vagina.

- Placenta previa: The placenta, which is a structure that connects the baby to the wall of your womb, can partially or completely cover the opening of your womb. When you bleed because of this, it is called placenta previa. Late in pregnancy as the opening of your womb, called the cervix, thins and dilates (widens) in preparation for labor, some blood vessels of the placenta stretch and rupture. This causes about 20% of third-trimester bleeding and happens in about 1 in 200 pregnancies. Risk factors for placenta previa include these conditions:
  - Multiple pregnancies
  - Prior placenta previa
  - Prior Cesarean delivery

- Placental abruption: This condition occurs when a normal placenta separates from the wall of the womb (uterus) prematurely and blood collects between the placenta and the uterus. Such separation occurs in 1 in 200 of all pregnancies. The cause is unknown. Risk factors for placental abruption include these conditions:
  - High blood pressure (140/90 or greater)
  - Trauma (usually a car accident or maternal battering)
  - Cocaine use
  - Tobacco use
  - Abruption in prior pregnancies (you have a 10% risk it will happen again)

- Uterine rupture: This is an abnormal splitting open of the uterus, causing the baby to be partially or completely expelled into the abdomen. Uterine rupture is rare but very dangerous for both mother and baby. About 40% of women who have uterine rupture had prior surgery of their uterus, including Cesarean delivery. The rupture may occur before or during labor or at the time of delivery. Other risk factors for uterine rupture are these conditions:
  - More than 4 pregnancies
  - Trauma
  - Excessive use of oxytocin (Pitocin), a medicine that helps strengthen contractions
  - A baby in any position other than head down

- Having the baby's shoulder get caught on the pubic bone during labor
- Certain types of forceps deliveries

- Fetal vessel rupture: This condition occurs in about 1 of every 1,000 pregnancies. The baby's blood vessels from the umbilical cord may attach to the membranes instead of the placenta. The baby's blood vessels pass over the entrance to the birth canal. This is called vasa previa and occurs in 1 in 5,000 pregnancies.

- Less common causes of late-pregnancy bleeding include injuries or lesions of the cervix and vagina, including polyps, cancer, and varicose veins.

- Inherited bleeding problems, such as hemophilia, are very rare, occurring in 1 in 10,000 women. If you have one of these conditions, such as von Willebrand disease, tell your doctor

What is oxytocin (Pitocin, Syntocinon)?

Oxytocin is a natural hormone that causes the uterus to contract.

Oxytocin is used to induce labor, strengthen labor contractions during childbirth, control bleeding after childbirth, or to induce an abortion.

Oxytocin may also be used for purposes other than those listed in this medication guide.

What are the possible side effects of oxytocin (Pitocin, Syntocinon)?

Side effects with oxytocin are not common. Serious side effects include:

- an allergic reaction (shortness of breath; closing of the throat; hives; swelling of the lips, face, or tongue; rash; or fainting);
- difficulty urinating;
- chest pain or irregular heart beat;
- difficulty breathing;
- confusion;
- sudden weight gain or excessive swelling;
- severe headache;
- rash;
- excessive vaginal bleeding; or
- seizures.

Other, less serious side effects may be more likely to occur. Talk to your doctor if you experience

- redness or irritation at the injection site;
- loss of appetite; or
- nausea or vomiting.

Side effects other than those listed here may also occur. Talk to your doctor about any side effect that seems unusual or that is especially bothersome.

What is the most important information I should know about oxytocin (Pitocin, Syntocinon)?

Oxytocin should be administered as an injection into a muscle or intravenously by a healthcare provider. It should be administered in a clinical setting where a healthcare provider can monitor uterine contractions and other vital signs (blood pressure, heart rates) and where an emergency situation can be handled properly.

Bleeding During Pregnancy Symptoms

It is helpful for your health care provider to know the amount and the quality of the bleeding that you have. Keep track of the number of pads used and passage of clots and tissue. If you pass a clump of tissue and are going to see your doctor, bring the tissue with you for examination.

- Other symptoms you may experience are increased fatigue, excessive thirst,dizziness, or fainting. Any of these may be signs of significant blood loss. You may notice a fast pulse rate that increases when you stand up from lying down or sitting. Dizziness may increase when you stand up as well.

- With late-pregnancy bleeding, you may have these specific symptoms:

  - Placenta previa: About 70% of women have painless bright red blood from the vagina. Another 20% have some cramping with the bleeding, and 10% have no symptoms.

  - Placental abruption: About 80% of women have dark blood or clots from the vagina, but 20% have no external bleeding. More than one-third have a tender uterus. About two-thirds of women with placental abruption have the classic "pain and bleeding." Over half of the time the baby shows signs of distress. Most abruptions occur before labor starts.

- Uterine rupture: Symptoms are highly variable. Classic uterine rupture is described as intense abdominal pain, heavy vaginal bleeding, and a "pulling back" from the birth canal of the baby's head. The pain may initially be intense, then get better with rupture, only to worsen as the lining of the abdomen is irritated. Bleeding can range from spotting to severe hemorrhage.

- Fetal bleeding: This condition may show up as vaginal bleeding. The baby's heart rate on the monitor will first be very fast, then slow, as the baby loses blood.

- Lower genital tract injury: This condition usually causes only mild spotting. Cervical cancer is very rare in women of childbearing age. Ayeast infection may cause a white or pink discharge and can be itchy. A ruptured vaginal varicose vein can cause heavy bleeding.
  - **Vasa previa:** A condition in which blood vessels within the placenta or the umbilical cord are trapped between the fetus and the opening to the birth canal, a situation that carries a high risk the fetus may die from hemorrhage due to a blood vessel tearing at the time the fetal membranes rupture or during labor and delivery. Another danger is lack of oxygen to the fetus.

  - Vasa previa often occurs with a low-lying placenta (due to scarring of the uterus by a previous miscarriage or a D&C), an unusually formed placenta (a bilobed placenta or succenturiate-lobed placenta), an in-vitro fertilization pregnancy, and multiple pregnancies (twins, triplets, etc). Vasa previa also may accompany velamentous insertion of the umbilical cord.

  - Vasa previa may not be suspected until the fetal vessel rupture occurs. Reduction in fetal mortality depends on prenatal diagnosis. When vasa previa is found before labor, the baby has a much greater chance of surviving. Vasa previa can be detected during pregnancy as early as the 16th week of pregnancy with use of transvaginal sonography in combination with color Doppler.

  - When vasa previa is diagnosed, C-section before labor begins can save the baby's life. The C-section should be done early enough to avoid an emergency, but late enough to avoid problems associated with prematurity.