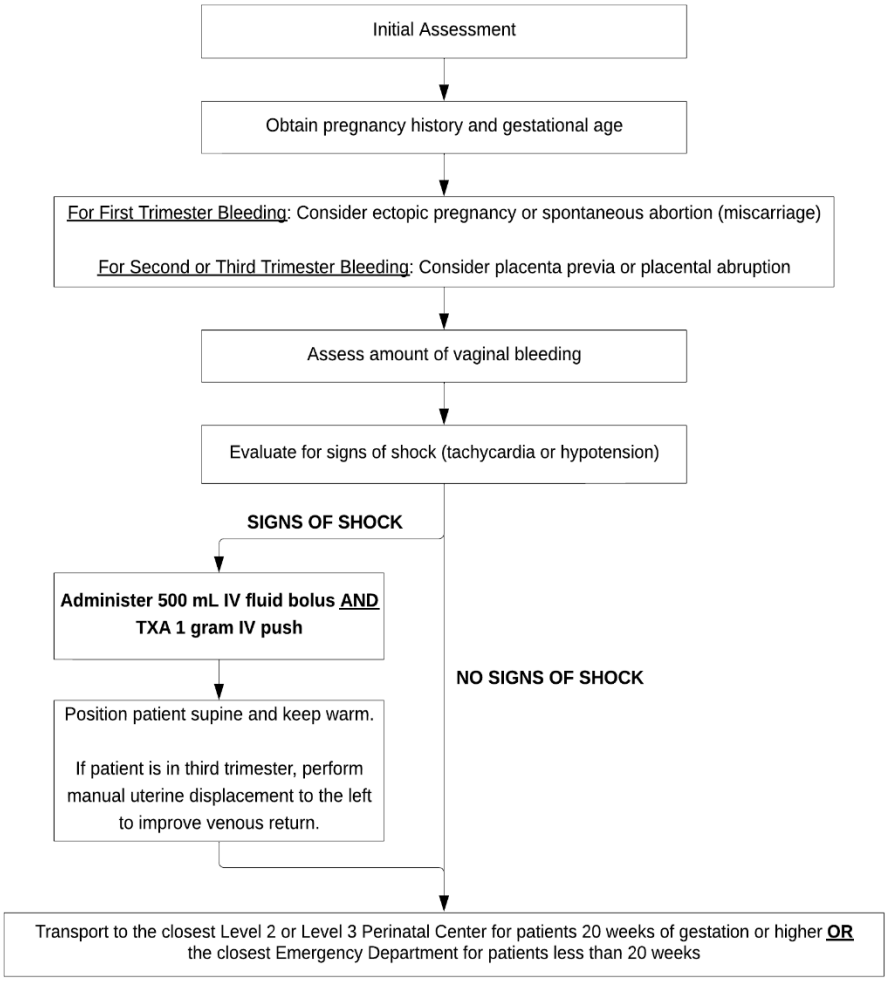
REGION 11 CHICAGO EMS SYSTEM PROTOCOL	Title: Bleeding in Pregnancy – BLS/ALS
	Section: Obstetrics
	Approved: EMS Medical Directors Consortium
	Effective: December 17, 2025

BLEEDING IN PREGNANCY - BLS/ALS



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BLEEDING IN PREGNANCY – BLS/ALS

I. PATIENT CARE GOALS

1. Recognize serious conditions associated with hemorrhage during pregnancy even when hemorrhage or pregnancy is not apparent (e.g., ectopic pregnancy, placenta previa, placental abruption).

2. Provide adequate resuscitation for hypovolemia.

II. PATIENT PRESENTATION

A. Inclusion Criteria

1. Pregnant patient with vaginal bleeding in any trimester.

2. Patient with pelvic pain or possible ectopic pregnancy.

3. Consider pregnancy in any female between the ages of 10–60 years of age.

B. Exclusion Criteria

1. Childbirth and active labor (refer to Childbirth Protocol)

2. Postpartum hemorrhage (refer to Childbirth Protocol)

C. Differential Diagnosis

1. Ectopic Pregnancy: Pregnancy located outside the uterus

    a. First trimester
    b. Abdominal or pelvic pain with or without vaginal bleeding.
    c. Shock is possible even with minimal or no vaginal bleeding.

2. Spontaneous Abortion (miscarriage): Loss of pregnancy

    a. Generally occurs in the first trimester.
    b. Intermittent pelvic pain (uterine contractions) with vaginal bleeding/passage of clots or fetal tissue.

3. Placenta Previa: Placenta covers part or all of the cervical opening.

    a. Identified in second or third trimester.
    b. Painless vaginal bleeding, unless in active labor.
    c. For management during active labor see Childbirth Protocol.

4. Placental Abruption: Most frequently occurs in third trimester of pregnancy; placenta prematurely separates from the uterus causing intrauterine bleeding.

a. Can be difficult to assess for in the prehospital setting. Symptoms may include:
   - Lower abdominal pain, uterine rigidity (often not present until abruption is advanced)
   - Vaginal bleeding (may or may not be present, depending on location and characteristics of abruption)
   - Shock, even with minimal or no vaginal bleeding

b. Clinical index of suspicion for abruption (history of trauma or intimate partner violence, elevated blood pressure concerning for pre-eclampsia, maternal drug use especially cocaine).

III. PATIENT MANAGEMENT

A. Assessment

1. Obtain history

   a. Obstetrical history
   b. Abdominal pain – onset, duration, quality, radiation, provoking or relieving factors
   c. Vaginal bleeding – onset, duration, quantity (pads saturated), passage of fetal tissue
   d. Syncope or lightheadedness
   e. Nausea or vomiting
   f. Fever or history of recent fever

2. Monitoring

   a. ECG and cardiac monitoring if history of syncope or lightheadedness
   b. Pulse oximetry

B. Treatment and Interventions

1. If signs of shock (including tachycardia, hypotension or elevated shock index):

   a. Position patient supine and keep patient warm. If patient is in third trimester, perform manual uterine displacement to the left to improve venous return.
   b. Place large bore IV, above the diaphragm preferred, in third trimester patients.
   c. Volume resuscitation: Administer 500 mL IV fluid bolus.
   d. Reassess vital signs and response to fluid resuscitation, repeat bolus as indicated.
   e. TXA is safe in pregnancy and 1 gram IV push should be given if concern for obstetric hemorrhage causing shock.

2. For patients with moderate or severe pain, fentanyl 1 mcg/kg IV/IM/IN can be administered (maximum dose 100 mcg).

3. Transport to the closest appropriate hospital based on estimated or known gestational age. Contact Online Medical Control as appropriate and provide a pre-notification call.

   a. Patients with bleeding in pregnancy less than 20 weeks may be transported to the closest Emergency Department.

b. Patients with bleeding in pregnancy more than 20 weeks should be transported to the closest Perinatal Center (Refer to Perinatal Patient Destination Policy).

C. Patient Safety Considerations

1. Patients in third trimester of pregnancy with signs of shock should be transported on left side or with uterus manually displaced to left to improve maternal perfusion and venous return.

2. Recognition of hemorrhage in obstetric patients is complicated by the normal physiologic changes that occur during pregnancy.

IV. NOTES/EDUCATIONAL PEARLS

A. Key Considerations

1. Syncope can be a presenting symptom of intraabdominal hemorrhage from ectopic pregnancy or antepartum hemorrhage from spontaneous abortion, placental abruption, or placenta previa.

2. Pregnancy is a high-risk period for intimate partner violence (IPV). IPV can increase risk of hemorrhagic obstetric complications such as placental abruption.