

Placenta Previa

Placenta previa means the baby's food-and-oxygen blanket is planted right over the exit door. When the door starts to open in late pregnancy, the blanket tears and bright red blood pours out—painless but scary. Never put fingers or anything inside the vagina or you'll tear it more. The baby must come out by cesarean before labor starts.

THE ONE-LINE TRUTH

The placenta covers the cervix (the exit door for the baby), so when the cervix stretches or opens, the placenta tears and bleeds.

The chain — how it unfolds

1. The placenta implants low, covering or touching the cervix. — why: Risk factors—prior cesarean scar (the healed cut changes the uterine lining), multiple prior pregnancies (the lining is thinner and less 'choosy'), maternal age over 35 (older lining, less blood flow), smoking (damages small vessels), and prior uterine surgery or curettage (scraping leaves scars)—all make the lower uterus more likely to accept the embryo and the upper wall less ideal.
2. Painless, bright-red vaginal bleeding begins in the late second or third trimester (often around 28–32 weeks, but can be earlier or later). — why: As the pregnancy grows, the lower uterus stretches and the cervix starts to soften and thin (efface). The placenta cannot stretch, so its edge tears away from the uterine wall. Large maternal spiral arteries open and bleed into the vagina. There is no pain because the cervix has almost no pain nerves, and there are no contractions yet.
3. Bleeding may stop on its own, then come back heavier. — why: A small tear can clot and seal temporarily, but as the cervix continues to thin and the uterus contracts (even gently), the placenta tears again. Each episode tends to be heavier than the last.
4. The mother's heart rate rises and blood pressure may stay normal at first, but urine output drops and she feels dizzy or weak. — why: She is losing blood volume. The body speeds up the heart, clamps down blood vessels, and holds onto fluid to keep blood pressure up—but these tricks only work for a while. If bleeding continues, shock will follow.

5. The fetal heart rate drops or shows late decelerations on the monitor. — why: When the mother loses blood, less oxygen reaches the placenta, so less reaches the baby. The baby's heart slows to conserve energy. This warns that the baby is in distress and delivery must happen soon.
6. Digital or speculum exam can trigger massive, uncontrollable bleeding (hemorrhage). — why: Touching the cervix can tear the overlying placenta wide open, ripping large vessels. That is why no one should ever perform a vaginal exam until ultrasound has ruled out placenta previa.
7. If labor starts or contractions begin, bleeding becomes life-threatening. — why: Contractions pull the cervix open and shear the placenta off the wall over a large area. Bleeding (Hemorrhage) can be sudden and massive, leading to shock, disseminated intravascular coagulation (DIC—the clotting system burns out and the blood won't clot), and death of mother or baby.
8. Cesarean delivery before labor is the only safe option. — why: Removing the baby and placenta together, before the cervix opens, stops the bleeding and saves both lives. Timing depends on bleeding severity, gestational age, and fetal well-being—typically planned around 36–37 weeks if stable, or emergently if bleeding is heavy or the baby shows distress.

Spot it — what you see, and why

- Painless bright-red vaginal bleeding in the second or third trimester (especially after 20 weeks): The placenta (the organ that feeds the baby) is sitting over or very near the cervix (the opening of the uterus). As the lower part of the uterus stretches and the cervix starts to thin and soften in late pregnancy, small blood vessels in the placenta tear open, causing bleeding. Because the placenta itself has no pain nerves, this bleeding does NOT hurt — that is the signature clue.
- Bleeding that stops and starts again (intermittent bleeding): Each time the cervix stretches a little more — from the baby's weight, contractions, or normal late-pregnancy changes — new tiny tears can open in the placenta's blood vessels. The bleeding may stop on its own when clotting plugs the tear, then start again days or weeks later when a new area tears.
- The baby is lying sideways or bottom-first (breech or transverse position) late in pregnancy: When the placenta covers the cervix, there is no clear space at the bottom of the uterus for the baby's head to settle into. So the baby often ends up in an unusual position — breech (bottom or feet down) or transverse (lying sideways across the uterus).
- The top of the uterus (fundus) feels higher than expected for how far along the pregnancy is: Because the placenta is blocking the lower uterus and the baby cannot drop down into the pelvis, the baby stays higher up, pushing the top of the uterus higher than it would normally be at that week of pregnancy.

- Uterus feels soft and not tender when pressed: In placenta previa, the uterus itself is not injured or inflamed — the bleeding is coming from torn blood vessels in the placenta. So when the doctor gently presses the belly, the uterus feels normal and soft, not hard or painful (which would suggest a different problem like abruption).
- Sudden heavy bleeding that soaks through pads quickly: If a larger blood vessel in the placenta tears — especially during labor, after a fall, or if the cervix suddenly opens wider — bleeding can become very heavy very fast. The body may not be able to clot the blood quickly enough, and the mother can lose a dangerous amount of blood in minutes.

Red flags — act now

- Sudden heavy vaginal bleeding that soaks a pad in less than an hour
- Signs of shock: pale or gray skin, cold and clammy, very fast or weak pulse, dizziness, confusion, or trouble staying awake
- Bleeding that starts or gets much worse during labor or after the water breaks
- A digital (finger) pelvic exam was done before ultrasound confirmed where the placenta is (this can cause dangerous bleeding and should NEVER be done when previa is suspected)

Treat it — in this order

1. Large-bore IV line, type and crossmatch blood, keep matched units ready → Creates immediate access to replace blood volume fast if bleeding starts again. Crossmatched units mean compatible blood is waiting in the blood bank and can be running into the mother's vein within minutes, keeping blood pressure and oxygen delivery stable.
2. Absolute prohibition of digital cervical exam and speculum exam → Prevents catastrophic bleeding (hemorrhage) by keeping fingers and instruments away from the placenta. Even gentle pressure on a previa placenta tears it open, causing bleeding the uterus cannot clamp down on because the cervix cannot contract.
3. Antenatal corticosteroids (betamethasone 12 mg IM every 24 hours × 2 doses, or dexamethasone 6 mg IM every 12 hours × 4 doses) if gestational age is 24 to 34 weeks → Speeds maturation of the baby's lungs by triggering surfactant production in the alveoli (the tiny air sacs). Surfactant keeps the sacs open so the baby can breathe air after birth. Maximum benefit occurs 24 hours to 7 days after the first dose, buying critical safety if preterm delivery becomes necessary.
4. Hospital admission for continuous monitoring and modified bed rest during active bleeding → Keeps the mother lying down so blood pressure does not drop suddenly with position changes. Minimizes uterine irritability that can trigger more placental shearing. Positions the team to act within minutes if massive bleeding starts, and allows continuous fetal monitoring to catch early distress.

5. Scheduled cesarean delivery at 36 0/7 to 37 6/7 weeks (or emergently if life-threatening bleeding (hemorrhage) occurs earlier) → Removes the baby and then the placenta before labor can tear the placenta open and cause uncontrollable bleeding. Cesarean avoids the cervix entirely, so the placenta is never stretched or pulled. Timing at 36 to 37 weeks balances lung maturity against bleeding risk. If bleeding becomes massive before that window, delivery happens immediately regardless of gestational age to save the mother's life.

Your top priorities at the bedside

1. Place two large-bore IV lines (18 gauge or bigger) and draw blood for type and crossmatch, complete blood count, and coagulation studies immediately — why: Two IV lines allow rapid infusion of fluids and blood products if sudden heavy bleeding starts, and crossmatched blood takes 30 to 60 minutes to prepare so we must order it early
2. Place external fetal monitor on mother abdomen to track baby heart rate and check for contractions, and keep monitoring continuously — why: The baby can become oxygen-starved (hypoxic) (low oxygen) if the placenta tears or bleeds heavily, and the monitor shows fetal distress patterns that require immediate cesarean deliver
3. Keep the patient on strict pelvic rest with nothing inserted into the vagina - no finger exams, no speculum exams, no tampons, and no intercourse — why: Any pressure on the cervix can tear the placenta tissue covering it and cause sudden massive bleeding (hemorrhage) (severe bleeding) that can kill mother and baby within minutes