“Fetomaternal Hemorrhage”
Blair J. Wylie, MD, MPH, and Mary E. D’Alton, MD
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Questions written by:
Scott Petersen, MD
LTC, MC, USA
National Naval Medical Center
Bethesda, MD

Responses written by:
Blair J. Wylie, MD, MPH
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Massachusetts General Hospital

Mary E. D’Alton, MD
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Columbia University Medical Center

1. If fetomaternal hemorrhage is suspected, should transfer to a tertiary care center with maternal-fetal medicine services be considered if the fetal status is not ominous?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
It depends upon a number of factors including the presentation of the fetomaternal hemorrhage, the fetal heart rate tracing, and gestational age of the fetus. If the maternal and fetal status appears stable, transfer may be considered if the fetus might benefit from an evaluation for intrauterine therapy.
2. Apart from calculation of Rh immune globulin dose, should fetomaternal hemorrhage be quantified as an absolute value, as a percentage of suspected fetal blood volume, or not quantified in favor of using middle cerebral artery Doppler to evaluate for fetal anemia?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:

As described in the text of the article, estimations of fetomaternal hemorrhage volume vary depending on which formula is used, reflecting different assumptions regarding the average maternal blood volume, maternal hematocrit, and average fetal hematocrit. Nonetheless, it is useful to estimate the fetomaternal hemorrhage volume as an absolute value to get an initial sense of the size of the bleed. Given how difficult it is to estimate the fetoplacental blood volume, we do not recommend estimating the fetomaternal hemorrhage as a percentage of fetal blood volume. Doppler evaluation is not a replacement for the fetomaternal hemorrhage estimation but rather an adjunctive assessment that can be used to evaluate whether the fetus may be moderate to severely anemic.

3. Given concerns that ABO incompatibility may lead to an underestimate of fetomaternal hemorrhage, should paternal blood typing be obtained for all type O mothers? Should type O mothers be triaged any differently if they present with the complaint of decreased fetal movements, particularly if the paternal blood type is not known?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:

This remains a research question. At this time, we do not recommend paternal blood typing for all type O mothers. Nor do we recommend triaging type O mothers differently if they present with decreased fetal movements regardless of the paternal blood type.
4. Are there any placental findings on inspection in the delivery room that should warrant evaluation for fetomaternal hemorrhage? Are there any pathologic findings that warrant investigation for fetomaternal hemorrhage?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
No. The placental findings are too nonspecific to warrant further investigations for fetomaternal hemorrhage.

5. Should all Rh-negative mothers who give birth to an Rh-positive neonate be evaluated by a quantitative measure of the amount of fetomaternal hemorrhage before administration of Rh immune globulin or only if fetomaternal hemorrhage is suspected?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
Rh-negative mothers giving birth to an Rh-positive neonate should be evaluated by a quantitative measurement of fetomaternal hemorrhage to insure the correct dosage of Rh immune globulin is given as fetomaternal hemorrhage volume may be greater than 30 mL even when unsuspected. If the estimate is approaching or greater than 30 mL and more than one vial of Rh immune globulin is being considered, we recommend inclusion of the maternal weight into estimates of the maternal blood volume and therefore into estimates of the fetomaternal hemorrhage for more accurate estimation.
6. Should patients with recurrent presentations for decreased fetal movements undergo an evaluation for fetomaternal hemorrhage or only if fetal testing is not reassuring?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
There is insufficient data at this time to recommend for or against this practice. In the situation of recurrent maternal perception of decreased fetal movement, we believe that a laboratory test for fetomaternal hemorrhage should be considered.

7. If fetomaternal hemorrhage is suspected at an early gestational age, should all patients be hospitalized or is there a role for outpatient management? If outpatient management is acceptable, what should be the frequency and method by which fetal testing is accomplished?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
Given the uncertain evolution of fetomaternal hemorrhage, we believe that initial management is best suited to an inpatient setting if the fetus is viable. The frequency and method of the ongoing testing has to be individualized and is based upon the certainty of the diagnosis, the ultrasound findings, results of the fetal testing, and the gestational age of the fetus.

8. Is there a gestational age at which delivery is mandated if fetomaternal hemorrhage is suspected and confirmed? If antenatal fetal testing is normal should delivery be delayed until 37 weeks of gestational age in order to avoid the adverse outcomes of late preterm birth?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:
This will depend upon the individual circumstances of a given case. There is insufficient information available in the literature to guide decisions about the optimal timing of delivery.
9. Is there a role for evaluation for fetomaternal hemorrhage in patients suspected to have poor placentation (eg, unexplained abnormal maternal serum AFP levels)?

Response from Drs. Blair J. Wylie and Mary E. D’Alton:

At this time, no.