STANDARD OPERATING PROCEDURE

Postpartum Haemorrhage

Special Region (1)

Union of Myanmar

Version: (1)

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Approved by: Internal Medicine Unit

Postpartum Haemorrhage

Primary PPH: defined as blood loss of >500ml from the genital tract occurring within 24h of delivery of fetus/fetuses. Secondary PPH: defined as excessive blood loss occurring between 24h and 6wks after delivery

- f fetus/fetuses.

Causes Primary PPH is usually due to 4Ts : Atonic uterus (tone) –

- General – previous PPH, raised BMI
- Distended uterus – multiple pregnancy, polyhydramnios
- Infection
- Anatomical distortion e.g., fibroids
- Functional problems; rapid labor, dystocia labor
- Uterine relaxants, e.g., magnesium, tocolytics
- Maternal blood loss and coagulopathy

Genital tract trauma

- Episiotomy / tear
- Paravaginal hematoma (severe postnatal rectal pain)
- Uterine rupture
- Uterine / cervical damage at CD
- Cervical tear at vaginal birth (rare)
- Broad ligament hematoma (chronic bleed, no pain)

Coagulopathy (thrombin) Retained products of conception (tissue)

- Retained whole or part of placenta
- Bleeding from placental bed
- Placenta accreta / abnormally invasive placenta

Initial resuscitation

- Call for help
- Insert large IV cannula, take blood for group and save, FBC, clotting
- Give IV crystalloid

- Monitor pulse, BP, respiratory rate every 15min
- Administer oxygen
- Check fibrinogen

The most common cause of primary PPH is uterine atony. Clinical examination must be undertaken to exclude other or additional causes:

- retained products (placenta, membranes, clots)
- vaginal / cervical lacerations or hematoma
- ruptured uterus
- broad ligament hematoma
- extragenital bleeding (for example, subcapsular liver rupture)
- uterine inversion

Management of uterine atony

- Should be accompanied by physical attempts to contract uterus, such as rubbing up

contractions and bimanual compression. This is very rapid and effective.

- Start oxytocin infusion (40IU)
- If the bleeding does not stop, 10U of oxytocin may be given IV
- If the bleeding persists (or ergometrine is contraindicated) then 800 micrograms of

misoprostol (tablets) is given rectally

- If the atony continues, carboprost 250 micrograms IM is given
- This is best directly into the myometrium if at CD (Caesarean delivery)
- Repeat at 15 min intervals up to a total of eight doses
- IV 500 micrograms of ergometrine can be given (may be given IM if difficulties with

IV access) if there is no contraindication.

- If pharmacological and initial measures fail to control the haemorrhage , initiate

surgical interventions sooner rather than later. Conservative surgical interventions

- balloon tamponade
- hemostatic brace suturing (such as using procedures described by B-Lynch or

modified compression sutures)

- bilateral ligation of uterine arteries
- bilateral ligation of internal iliac (hypogastric) arteries

- selective arterial embolization

Secondary PPH

- Secondary PPH is often associated with endometritis. When antibiotics are clinically

indicated, a combination of ampicillin (clindamycin if penicillin allergic) and metronidazole is appropriate.

- In cases of endo-myometritis (tender uterus) or overt sepsis, then the addition of

gentamicin is recommended.

- Surgical measures should be undertaken if there is excessive or continuing bleeding,

irrespective of ultrasound findings.

- A senior obstetrician should be involved in decisions and performance of any

evacuation of retained products of conception as these women are carrying a high risk for uterine perforation. Documentation It is important to record:

- the staff in attendance and the time they arrived
- the sequence of events
- the time of administration of different pharmacological agents given their timing and

sequence

- the time of surgical intervention, where relevant
- the condition of the mother throughout the different steps
- the timing of the fluid and blood products given

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