STANDARD TREATMENT WORKFLOW (STW)

Postpartum Haemorrhage (PPH)

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CITATION
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Standard Treatment Workflow (STW) for the Management of POSTPARTUM HAEMORRHAGE (PPH)

ICD 072

More than 500 ml of blood loss or any amount of bleeding which causes derangement of vital parameters is PPH

RED FLAG SIGN:
- Call for help
- Rapid Initial Assessment - evaluate vital signs: PR, BP, RR and Temperature
- Establish two IV lines with wide bore cannula (16-18 gauge)
- Draw blood for grouping and cross matching
- Start RL/NS, infuse 1 L in 15-20 minutes *
- Give Oxygen @ 6-8 L/minute by mask.
- Insert indwelling Catheter and connect to urobag
- Check vitals and blood loss frequency - at least every 15 minutes
- Monitor input and output

SUPPORTIVE MANAGEMENT
- Monitoring of vitals
- Measurement of input and output
- Give blood transfusion as indicated

- Give inj. Oxytocin 10 IU IM (if not given after delivery)
- Start Oxytocin infusion : 20 IU in 500 ml RL/NS @ 40-60 drops per minute
- IV bolus of oxytocin should NOT be given
- Check to see if placenta has been delivered.
Tripathi R, et al.: Postpartum Haemorrhage (PPH)

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ICD 072

More than 500 ml of blood loss or any amount of bleeding which causes derangement of vital parameters is PPH

**Rapid Initial Assessment:**
- Call for help
- Rapid Initial Assessment - evaluate vital signs, PR, BP, HR and Temperature
- Establish IV access (preferably in the emergency department)
- Draw blood for grouping and cross matching
- Start R/NS, urine 1 L, in 15-20 minutes
- Give oxygen @ 6-8 L/minute by mask
- Insert Indwelling Catheter and connect to urine bag
- Check vital and blood loss - preferably - at every 15 minutes
- Mental input and output

**Supportive Management:**
- Monitoring of vital signs
- Measurement of input and output
- Give blood transfusion as indicated

**Placenta Not Delivered**
- Continue Oxytocin drip
- Prompt rupture of membranes
- Attempt controlled cord traction if uterus is contracted

**Placenta Delivered**
- Fundal Massage of uterus
- Inspect placenta for completeness
- Explore uterus for any retained placental/baby membranes complete and evacuate

**Uterus well contracted but bleeding continuing**
- Explore for cervical/vaginal parietal tears. Repair if present
- If bleeding persists despite repair of above, suspect inadequacy of repair
- Explore uterus or cervical dilatation
- Split to OT for exploration under C-A and hysterectomy

**Uterus flabby**
- Bimanual compression and exploration as per details below

**If bleeding continues without apparent cause check for sepsis/glycaemia**
- 3 ml of crystalloid solution should be used to replace every 1 ml of blood lost during the initial part of the acute bleeding phase

**Placenta Not Delivered**
- Continue oxytocin and uterine massage
- Check for completeness of placenta and membranes

**Placenta Delivered**
- Continue oxytocin and uterine massage
- Check for completeness of placenta and membranes

**Tranexamic Acid (1g slow IV)** has recently been recommended as an adjunctive treatment for PPH to be used as early as possible irrespective of cause but definitely within three hours of delivery. It can be repeated every 30 minutes if bleeding persists. Standard treatment for PPH must continue meanwhile.

**Management of Atonic PPH**

**Pharmacotherapy**

- Inj Methylergometrine 0.2 mg IM or IV slowly
- Or Tab Misoprostol (PGl) 800 mcg
- Or Inj Carboprost (PGF2 Alpha) 250 mcg IM
- Controversial in asthma

**Bleeding controlled**
- Repeat uterine massage every 15 minutes for first 2 hours
- Monitor vital every 10 minutes for 30 minutes, every 15 minutes for next 30 minutes and every 5 minutes for next 6 hours or until stable
- Inj Oxytocin infusion 8-10 units/hr (total Oxytocin not to exceed 300 IU in 24 hours)
- Intra uterine balloon tamponade using condom catheter
- Surgical intervention
- Uterine compression sutures
- Systematic uterine devascularisation by doing Uterine - Oswari - Internal iliac artery ligation
- Hysterectomy

**Bleeding still not controlled**
- Repeat uterine massage every 15 minutes for next 2 hours
- Monitor vital every 10 minutes for 30 minutes, every 15 minutes for next 30 minutes and every 5 minutes for next 6 hours or until stable
- Intra uterine balloon tamponade using condom catheter
- Surgical intervention
- Uterine compression sutures
- Systematic uterine devascularisation by doing Uterine - Oswari - Internal iliac artery ligation
- Hysterectomy

Timely Referral to a higher centre must be considered if facilities for blood transfusion or exploration and surgical intervention are not available. Patients must be transported with IV fluids containing oxytocin on route and preferably with uterine/vaginal tamponade in situ.

Aortic compression must be used as a short term measure to reduce blood loss while awaiting definitive steps.

Non-pneumatic anti-shock garment (NASG) should be used during transport if available.

Uterine artery embolisation may be offered in selected patients if facilities are available.

Counselling is an important adjunct to management

**Keep a High Threshold for Invasive Procedures**

This STW has been prepared by the National Society of India in collaboration with several leading obstetricians in the country. These broad guidelines are Advisory and are based on expert opinion and existing scientific evidence. There may be variations in the management of an individual patient based on their specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit our website www.jefi.org.in for more information.

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