

## STANDARD TREATMENT WORKFLOW (STW)

# Postpartum Haemorrhage (PPH)

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

ICD O72

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

### RED FLAG SIGN:

- PR > 120/min
- Systolic BP < 100 mm Hg
- Tachypnea < 95%
- SpO<sub>2</sub> < 95%
- Deterioration of sensorium

- 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 frequently - at least every 15 minutes
- Monitor input and output

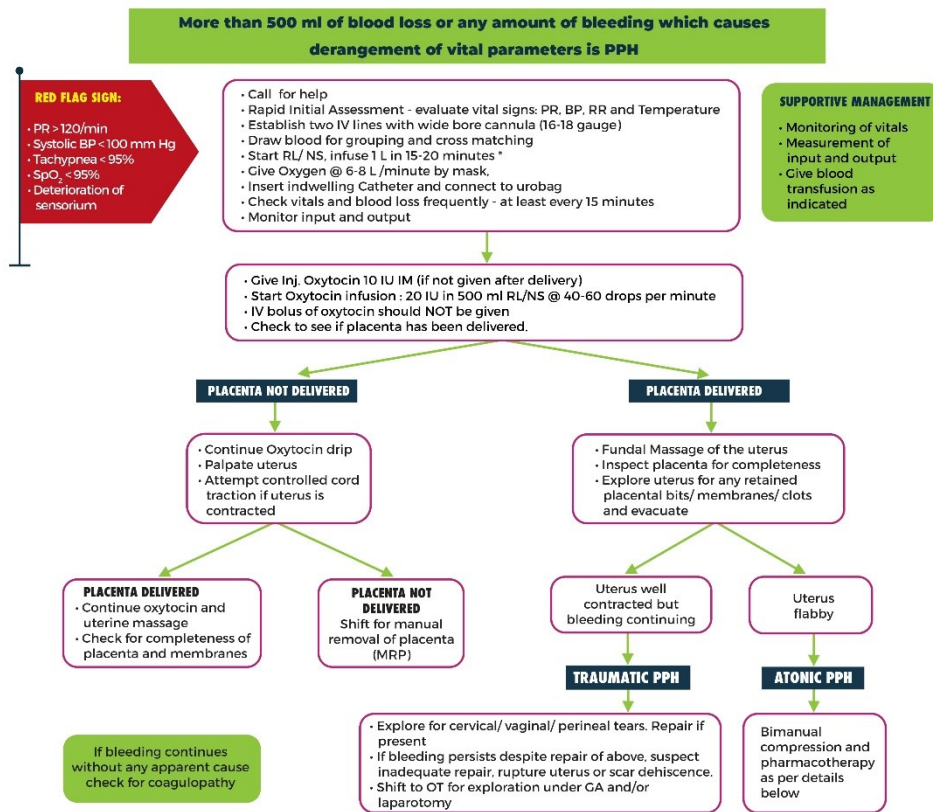
### SUPPORTIVE MANAGEMENT

- 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.

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\* Arrange for blood / blood product at the earliest  
3 ml of crystalloid solution should be used to replace every ml of blood lost during the initial part of the acute bleeding phase

**MANAGEMENT OF ATONIC PPH**

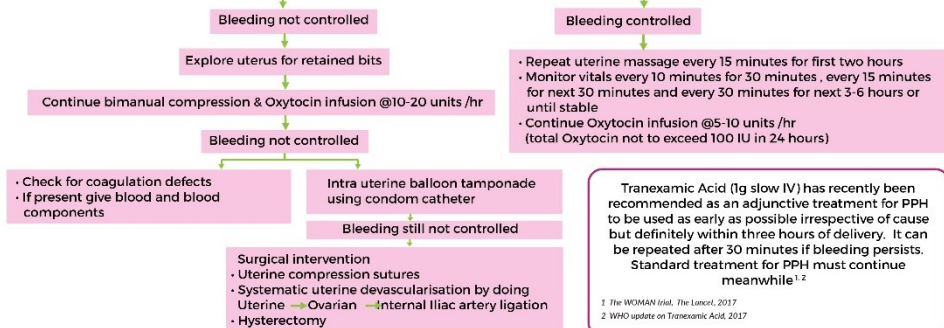
**PHARMACOTHERAPY**

ANY OF THE FOLLOWING OPTIONS CAN BE USED EITHER ALONE OR COMBINATION AS PER AVAILABILITY

Inj Methyl Ergometrine 0.2 mg IM or IV slowly  
 - Contraindicated in hypertension, severe anemia, heart disease  
 - Can be repeated after 15 minutes to a maximum of 5 doses (1mg)

Or Tab Misoprostol (PGE1) 800 µg  
 Per rectal or sublingual

Or Inj Carboprost (PGF2 alpha) 250 µg IM  
 - Contraindicated in asthma  
 - Can be repeated every 20 minutes to a maximum of 8 doses (2 mg)



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

- Aortic compression may be used as a short time measure to reduce blood loss while awaiting definitive steps.
- Non- pneumatic anti-shock garment (NASG) should be used during transport if available
- Uterine artery embolization 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 national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory, and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit our web portal ([atw.icmr.org.in](http://atw.icmr.org.in)) for more information.  
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