### STANDARD TREATMENT WORKFLOW (STW)

## Postpartum Haemorrhage (PPH)

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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:** Systolic BP < 100 mm Ha SpO<sub>3</sub> < 95% 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

### · Cive 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.

## SUPPORTIVE MANAGEMENT

- Monitoring of vitals Measurement of
- · Give blood
- indicated





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Rapid Initial Assessment - evaluate vital signs: PR. BP. RR and Temperature
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Draw blood for grouping and cross matching
Start RL/ NS, infuse 1 L in 15-20 minutes
Cive 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 PR > 120/min Systolic BP < 100 mm Hg Tachypnea < 95% SpO<sub>2</sub> < 95% Deterioration of · Monitor input and output Give Inj. Oxytocin 10 IU IM (if not given after delivery)
 Start Oxytocin infusion: 20 IU in 500 ml RL/INS @ 40-60 drops per minute
 IV bolus of oxytocin should NOT be given
 Check to see if placenta has been delivered. PLACENTA NOT DELIVERED PLACENTA DELIVERED

#### Palpate uterus Inspect placenta for completeness Attempt controlled cord Explore uterus for any retained traction if uterus is placental bits/ membranes/ clots contracted and evacuate Uterus well contracted but eeding continuing PLACENTA DELIVERED PLACENTA NOT Continue oxytocin and uterine massage DELIVERED Shift for manual Check for completeness of placenta and membranes noval of placenta (MRP)

Continue Oxytocin drip

flabby TRAUMATIC PPH ATONIC PPH Explore for cervical/vaginal/perineal tears. Repair if

· Fundal Massage of the uterus

present
If bleeding persists despite repair of above, suspect inadequate repair, rupture uterus or scar dehiscence Shift to OT for exploration under GA and/or laparotomy

Bimanual compression and pharmacotherapy as per details below

SUPPORTIVE MANAGEMENT Monitoring of vitals

Measurement of input and output Give blood

transfusion as indicated

\* 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

### DHADM ACOTHED ADV

### 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) Inj Carboprost (PGF2 alpha) 250 µg IM · Contraindicated in asthma · Can be repeated every 20 minutes to a maximum of 8 doses (2 mg) Or Tab Misoprostol (PGE1) 800 μg Per rectal or sublingual Bleeding not controlled Bleeding controlled Repeat uterine massage every 15 minutes for first two hours
 Monitor vitals every 10 minutes for 30 minutes, every 15 minutes for next 30 minutes and every 30 minutes for next 3-6 hours or until stable Explore uterus for retained bits Continue bimanual compression & Oxytocin infusion @10-20 units /hr Continue Oxytocin infusion @5-10 units /hr (total Oxytocin not to exceed 100 IU in 24 hours) Bleeding not controlled Check for coagulation defects
 If present give blood and blood components Intra uterine balloon tamponade using condom catheter Tranexamic Acid (1g slow IV) has recently been recommended as an adjunctive treatment for PPH 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 after 30 minutes if bleeding persists. Standard treatment for PPH must continue meanwhile<sup>1,2</sup> Bleeding still not controlled Surgical intervention
- Uterine compression sutures
- Systematic uterine devascularisation by doing
Uterine — Ovarian — Internal Iliac artery ligation
- Hysterectomy 1 The WOMAN Irial, The Lancel, 2017 2 WHO update on Transxamic Acid, 2017

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 (IASC) 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 individence consequences. Kindly visit our web portal (gathernors) in for more information.

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