A primary postpartum haemorrhage (PPH) is defined as bleeding of 500ml or more, or an amount that has a detrimental effect on a woman’s wellbeing, from the genital tract within the first 24 hours after giving birth (WHO, 2012; Jangsten et al, 2011; Mousa and Alfirevic, 2007; NICE, 2007). A PPH may be accompanied by one or more clinical signs and/or symptoms depending on the amount of blood loss. Clinical signs of a PPH include palpitations, dizziness, tachycardia, weakness, sweating, restlessness and pallor, and ultimately collapse (Schuurmans et al, 2000).

If the blood loss is 500ml to 1000ml with no clinical signs of shock, then it is regarded as a minor PPH. When there is a loss of over 1000ml, or the woman has signs or symptoms of shock, then it is a major PPH (RCOG, 2011).

Once a PPH is identified, four components of management should be initiated simultaneously: communication and resuscitation, monitoring and investigation, as well as measures to control the bleeding (RCOG, 2011).

This article will primarily look at care within a hospital setting – management of such an emergency at home isn’t addressed here.

Communication
The midwife should communicate to the woman and her birth partner the need to summon help quickly and press the emergency buzzer. If it is a minor PPH, the midwife in charge and first-line obstetric and anaesthetic staff should be contacted in the first instance (RCOG, 2011). For a major PPH, summon the obstetric, anaesthetic and haematology consultants, as well as the blood transfusion laboratory and porters (RCOG, 2011). At a home birth or a standalone birth centre, contact the emergency services.

Once the PPH emergency equipment is in situ, coordinate the assistance. Helper one should assess, maintain and monitor the woman’s airway if needed, while helpers two and three should gain intravenous (IV) access, start IV fluids and take blood if needed. A designated person should note the time of relevant events.

Next comes resuscitation – the woman should be laid flat, her breathing assessed and she should be kept warm. If required, she should be given a high flow oxygen mask at 10 to 15 litres per minute.

In the event of a minor PPH, with no clinical signs of shock, insert one large bore cannula and start rapid fluid resuscitation with two litres of crystalloid (RCOG, 2011).

For a major PPH, or if the woman is displaying signs and symptoms of clinical shock, insert two large bore cannulae and transfuse blood as soon as possible. Until blood is available, start a rapid warmed infusion of 500 ml of colloid (Hartmann’s solution two litres) and/or one to two litres of colloid (RCOG, 2011).

Monitoring and investigation
In order to monitor the woman’s condition, her respiratory rate, pulse and blood pressure should be assessed and a modified obstetric early warning system chart should be completed.

For a minor PPH,Bloody groups for blood and screen, full blood count and coagulation screen should be taken and identified. The woman’s pulse, respiration rate, temperature and blood pressure should also be recorded every 15 minutes. A Foley catheter should be inserted and the woman’s urine output should be monitored.

For a major PPH, in addition to the management above, these measures should be considered: the woman’s blood being taken for crossmatch (four units minimum), a full blood count and renal and liver function for baseline. Also, the pulse oesymetry, blood pressure and respiratory rate should be continuously recorded (RCOG, 2011). It is important to try to identify the possible cause or causes of the PPH (see box, left). Then measures should be taken to stop the bleeding.

For references, visit the RCM website.