

Massive Postpartum haemorrhage

– more needs to be done



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Introduction

Massive Postpartum haemorrhage is a life threatening obstetric emergency. Massive PPH is a National indicator in the Quality Assurance Programme and also a Key Performance Indicator in the Ministry of Health with a standard of <0.5% of total deliveries. A delay in correction of hypovolemia, defective coagulation and surgical control of bleeding can be fatal

Methodology

This was a review looking at Massive PPH from 14 tertiary hospitals in 2010 from the National Obstetric Registry. There were a total of 138,315 deliveries analysed from 1st January 2010 to 31st Dec 2010

Results

All 14 tertiary hospitals were able to achieve the NIA and KPI standards for Massive PPH at 0.09%. Placenta Previa accounted for 15.87 % of all Massive PPH while 11.90% of cases were due to uterine atony and this was closely followed by genital tract trauma at 11.11%. Of the patients that had an abdominal delivery massive postpartum haemorrhage was the highest among patients who had a hysterotomy at 8.33% followed by classical caesarean section at 1.84% as compared to lower segment caesarean section which was only 0.30% Significantly 15.08% of patients with Massive PPH were found to be anaemic at delivery.

Massive Postpartum Haemorrhage in Caesarean Section

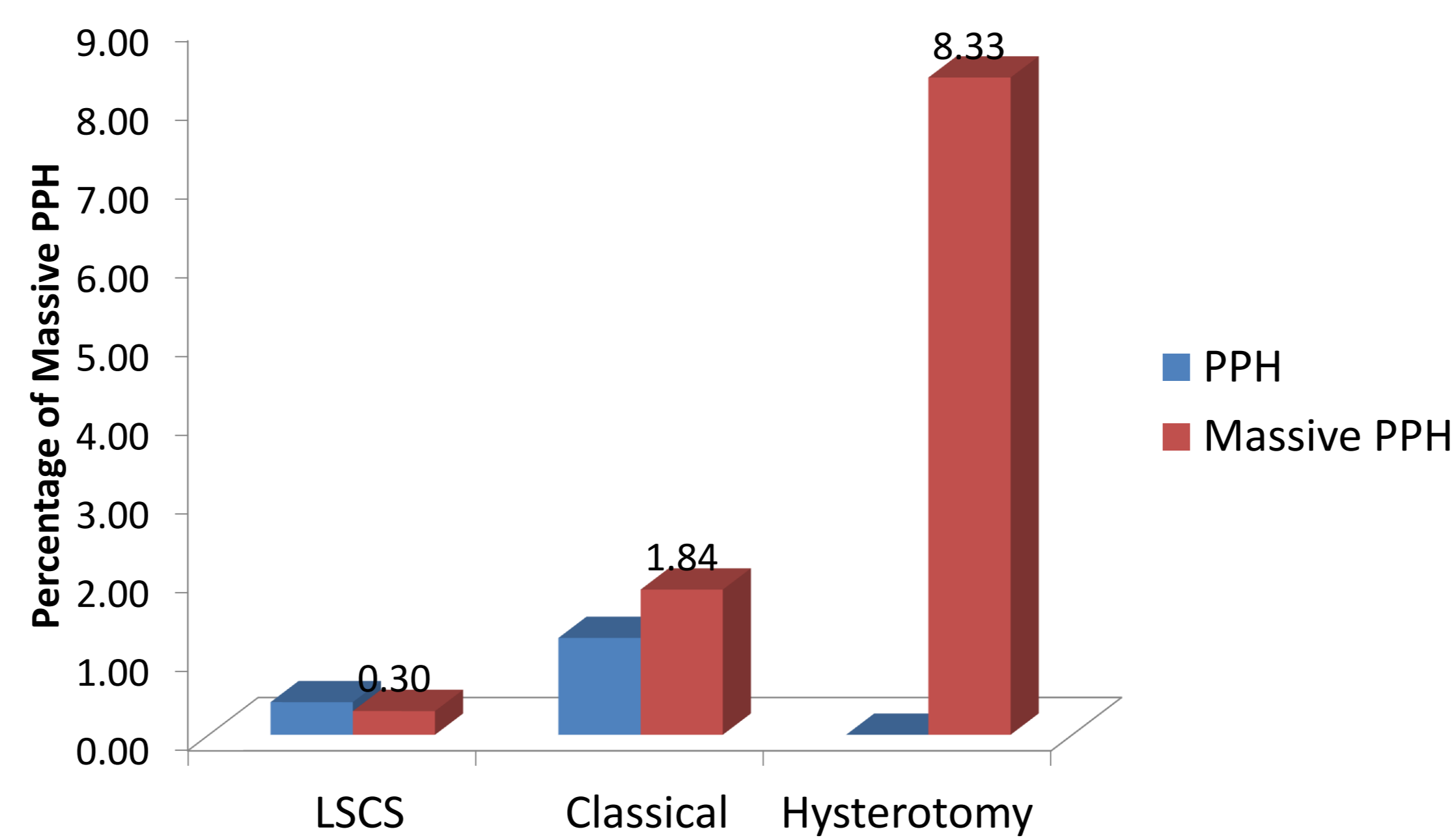


Figure 1: Bar graph showing blood loss to surgical mode of delivery

Participating of Tertiary Hospitals with Massive Postpartum Haemorrhage

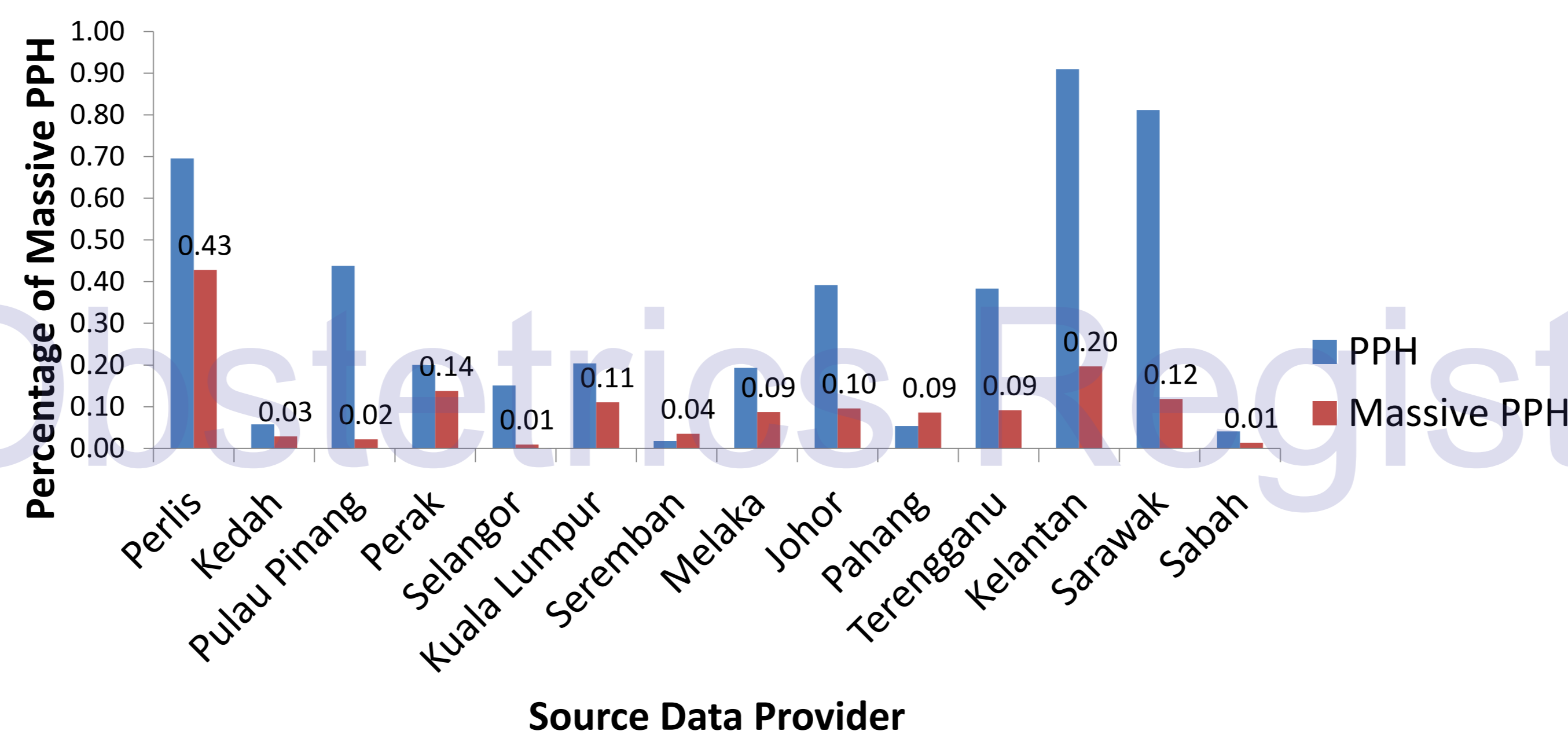


Figure 2: Bar graph shows Tertiary hospital in Malaysia with Massive Postpartum Haemorrhage

Causes of Massive Postpartum Haemorrhage

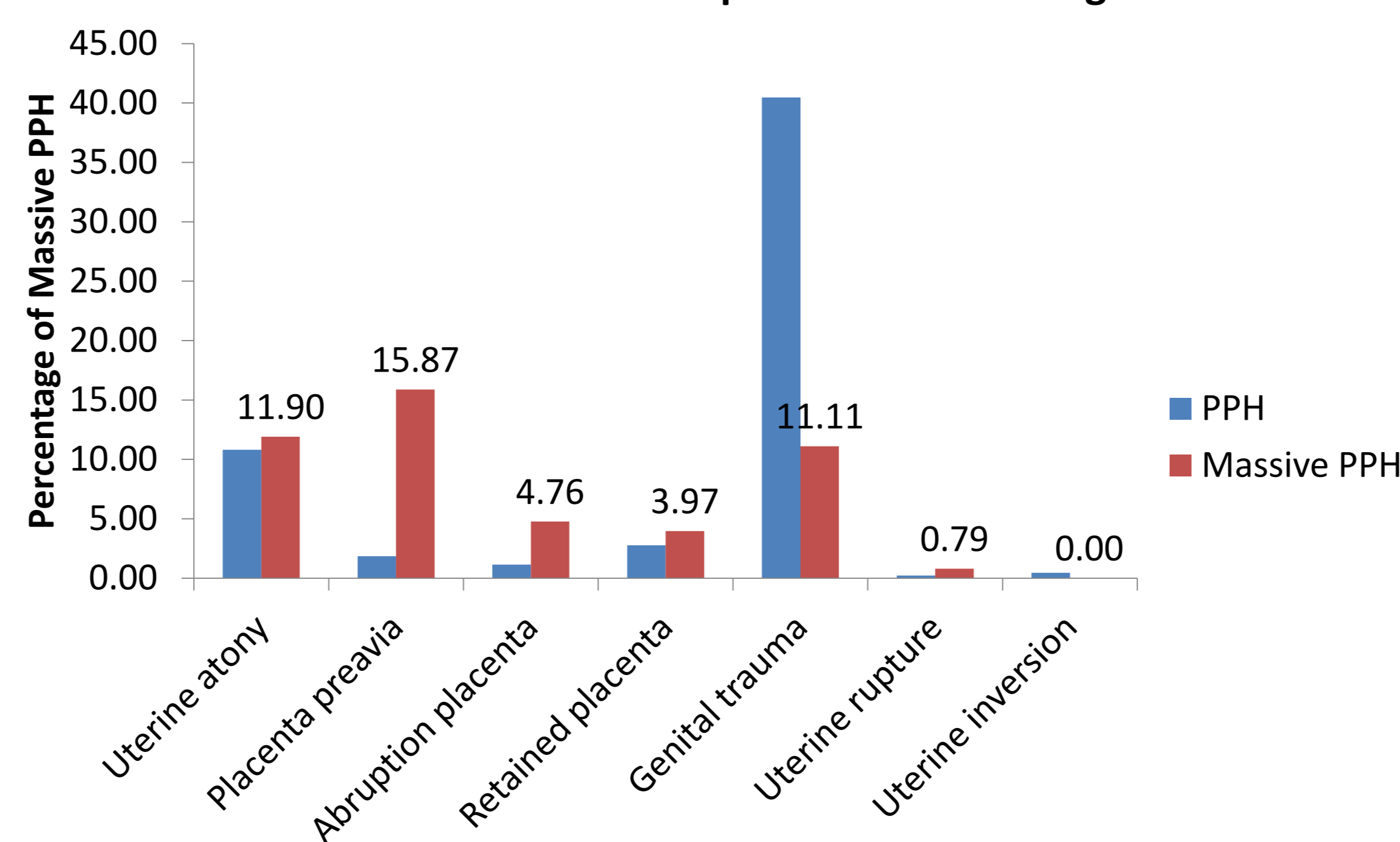


Figure 3: Bar graph showing causes of Massive Postpartum Haemorrhage

Discussion

Massive PPH is quantified as blood loss of >1500mls.. Anaemia should be diagnosed early and treated promptly to prevent further compromise of the patient. Blood loss has often been underestimated and this is probably true in this series as the incidence of PPH is low at 0.32%.

Placenta previa contributed to the highest number of Massive PPH, followed by uterine atony and genital tract trauma. Continuous training should be provided to all doctors and nursing staff on assessment of blood loss in labour and active management in the third stage. More objective methods of assessing blood loss such as weighing pads and swabs should be used as the extent of intravascular volume deficit is not reflected by visual estimates of vaginal bleeding. Alterations in blood pressure and pulse rate occurs only after large volumes of blood loss. Clinicians and nursing staff should review their usual practices regarding infant delivery technique to help lower the incidence of genital tract trauma.

Conclusion

Postpartum haemorrhage remains the leading cause of maternal mortality in Malaysia. Regular audits and discussion of cases with Massive Postpartum Haemorrhage should be carried out at departmental level. Recognizing blood loss and initiating prompt treatment is vital to prevent maternal mortality and morbidity.

Limitation of study

Significant number of not available data and missing data.

Reference

1. Trends in Postpartum Haemorrhage in high resource countries: a review and recommendations from the international Postpartum Haemorrhage Collaborative Group

Cause of PPH	PPH		Not Available		Missing	
	<1500 mls	≥1500 mls	n	%	n	%
Uterine atony	47	15	1	14.29	10	27.03
Uterine inversion	2	0	0	0.00	1	2.70
Placenta previa	8	20	0	0.00	3	8.11
Abruptio placenta	5	6	0	0.00	1	2.70
Retained placenta	12	5	1	14.29	2	5.41
Genital trauma	176	14	3	42.86	10	27.03
Uterine rupture	1	1	0	0.00	0	0.00

Table 1: Causes of PPH