Caring for Women with higher levels of PPH

PPH

- Recap from PROMPT
- Prompt recognition and treatment of a Post Partum Haemorrhage (PPH) with a particular focus on the multi-professional approach to care.
- To improve outcomes for women who experience higher levels of PPH.

PPH

- MBRRACE Report (2014) Identified key issues from cases where women died:
- Failure to recognise PPH as an emergency
- Failure to act on signs & symptoms
- Failures with resuscitation and fluid replacement
- Lack of early senior multi-professional involvement
- Inadequate use and interpretation of MEOWS

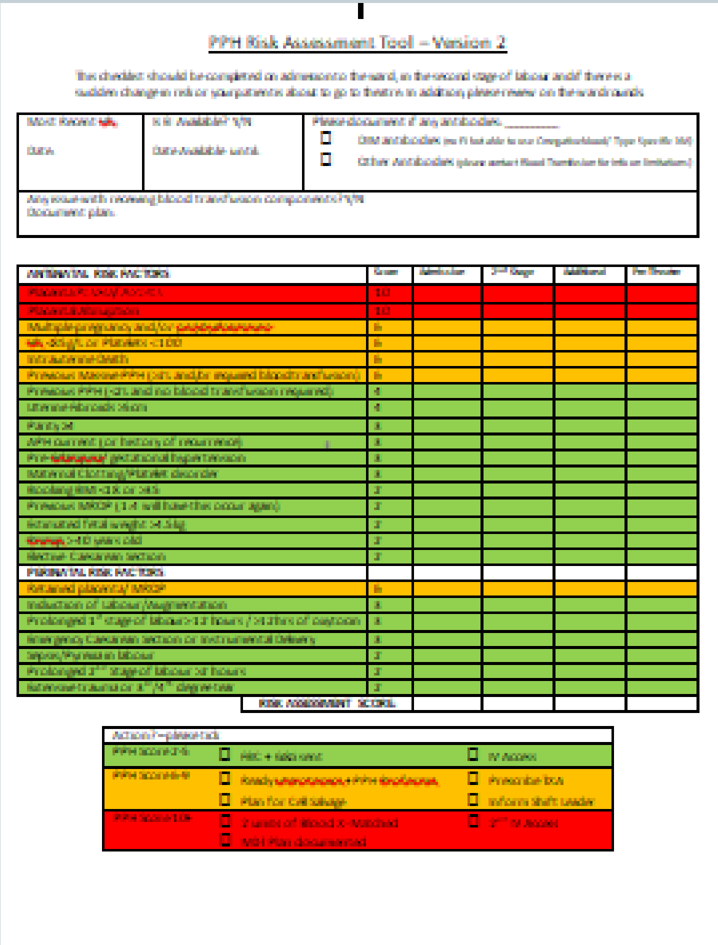
PPH-KEY ISSUES

- Prevention of PPH
- Early recognition of PPH
- Preparation to manage PPH
- Effective specific and timely management of PPH

PPH- Prevention

- **What antenatal risk factors do we take into consideration when risk assessing women?**
- Pre Eclampsia
- Previous Post Partum Haemorrhage (PPH)
- Multiple Pregnancy
- Previous Lower Segment Caesarean Section (LSCS)
- Primigravid Woman
- Multiparity (Para 4 or more)
- BMI greater than 35
- Maternal age greater than 40
- Placenta praevia
- Uterine fibroids or other uterine abnormalities
- Macrosomic baby (greater than 4.5 kg)
- Polyhydramnios
- Ethnic Influence: Asian and Hispanic descent
- Use of anticoagulants agents

- Fife version (UHD)



PPH Risk Assessment Tool – Version 2

This checklist should be completed on admission to the ward, in the second stage of labour and/if there is a sudden change in risk or your patient is about to go to theatre in addition please review on the ward rounds

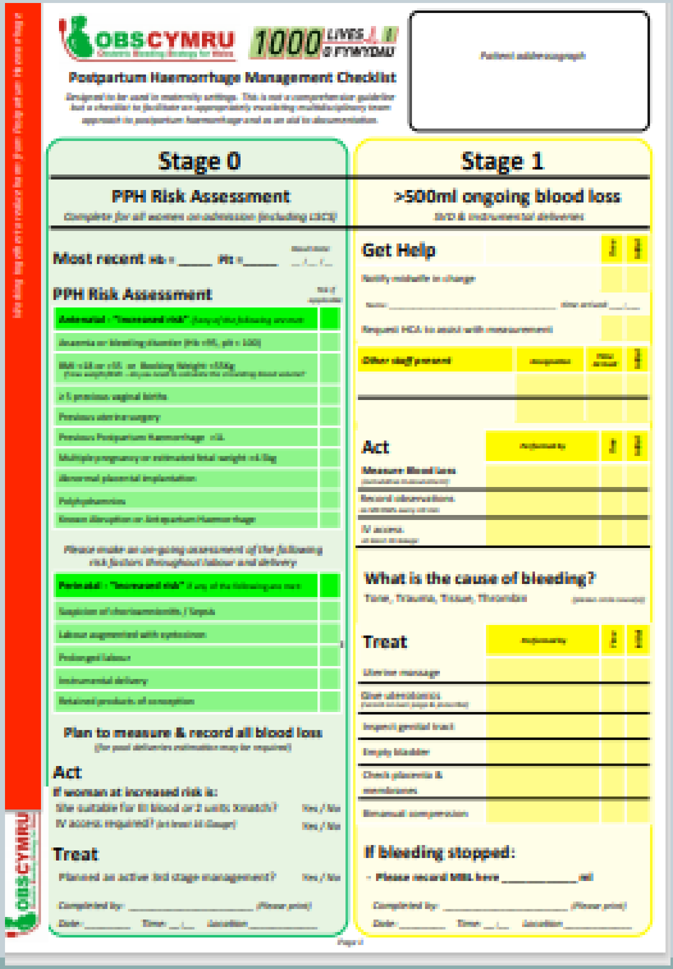
Most Recent Hb: Date:	X-M Available? Y/N Date Available until:	Please document if any antibodies: Other antibodies

Any issues with receiving blood transfusion components? Y/N Document plan:

ANTENATAL RISK FACTORS	Score	Admission	2nd Stage	Additional	Pre Theatre
Placenta Praevia/ Accreta	10				
Placental Abruption	10				
Multiple pregnancy and/or polyhydramnios	6				
Hb <85g/L or Platelets <100	6				
Intrauterine Death	6				
Previous Massive PPH (>2L and/or required blood transfusion)	6				
Previous PPH (<2L and no blood transfusion required)	4				
Uterine fibroids >5cm	4				
Parity ≥4	3				
APH current (or history of recurrent APH)	3				
Pre-eclampsia/ gestational hypertension	3				
Maternal Clotting/Platelet disorder	3				
Booking BMI <18 or >35	2				
Previous MROP (1:4 will have this occur again)	2				
Estimated Fetal weight >4.5kg	2				
Age >40 years old	2				
Elective Caesarean Section	2				
PERINATAL RISK FACTORS					
Retained placenta/ MROP	6				
Induction of Labour /Augmentation	3				
Prolonged 1st stage of labour >12 hours / >12hrs of oxytocin	3				
Emergency Caesarean Section or Instrumental Delivery	3				
Sepsis/Pyrexia in labour	2				
Prolonged 2nd stage of labour >3 hours	2				
Extensive trauma or 3rd/4th degree tear	2				
RISK ASSESSMENT SCORE					

Action? – please tick		
PPH Score 2-5	FBC + Gals sent	IV Access
PPH Score 6-9	Ready PPH	Prescribe TXA
	Plan for Cell salvage	Inform shift leader
PPH Score 10+	2 units of Blood X-Matched	2nd IV Access
	MDT Plan documented	

- Obs Cymru



OBS CYMRU 1000 LIVES

Postpartum Haemorrhage Management Checklist

Patient addressograph

Stage 0

PPH Risk Assessment

Complete for all women on admission (including LSCS)

Most recent Hb = ____ Plt = ____

PPH Risk Assessment

Antenatal - "Increased risk"

Anaemia or bleeding disorder

≥5 previous vaginal births

Previous uterine surgery

Previous Postpartum Haemorrhage

Multiple pregnancy or estimated fetal weight >4.5kg

Abnormal placental implantation

Polyhydramnios

Known abruption or Antepartum Haemorrhage

Perinatal - "Increased risk"

Suspicion of chorioamnionitis / Sepsis

Labour augmented with oxytocinon

Prolonged labour

Instrumental delivery

Retained products of conception

Plan to measure & record all blood loss

Act

If woman at increased risk is:

IV access required? Yes / No

Treat

Planned an active 3rd stage management? Yes / No

Completed by: ____ (Please print)

Date: ____ Time: ____ Location: ____

Stage 1

>500ml ongoing blood loss

SVD & instrumental deliveries

Get Help

Notify midwife in charge

Request HCA to assist with measurement

Other staff present

Act

Measure Blood Loss

Record observations

IV access

What is the cause of bleeding?

Tone, Trauma, Tissue, Thrombin

Treat

Uterine massage

Give uterotonics

Inspect genital tract

Empty bladder

Check placenta & membranes

Bimanual compression

If bleeding stopped:

- Please record MBL here ____ ml

Completed by: ____ (Please print)

Date: ____ Time: ____ Location: ____

Stage 2 >1000mL blood loss *OR* clinical concern (eg. Abruption or concealed bleeding) *OR* abnormal vital signs

Get Help

Act

Review causes

Tone / Trauma / Tissue / Thrombin

Treat

If bleeding stopped ensure PPH post-event checklist completed & Management plan written in notes

If bleeding ongoing transfer patient to theatre

Stage 3 >1500mL blood loss *OR* ongoing clinical concern

Act

Review causes

Tone / Trauma / Tissue / Thrombin

Treat

Once bleeding stopped ensure PPH post-event checklist completed & Management plan written in notes

Record of Uterotonics used

Blood & Blood products transfused

Measured cumulative blood loss

Total Measured Blood Loss = ________ ml

Record of further blood test results

PPH Post-event Checklist

PPH-Prevention

- **What Intrapartum risk factors do we take into consideration risk assessing women?**
- Precipitate or prolonged labour
- Intrapartum pyrexia
- Retained placenta
- Instrumental delivery
- Delivery by elective or emergency caesarean section
- Induction or augmentation of labour
- Perineal trauma (including episiotomy)
- Uterolytics- including magnesium, beta 2 agonists (GTN, inhalational anaesthetic agents excluding nitrous oxide)

PPH- Prevention

- Active 3rd stage management
- Syntometrine V's Syntocinon- thoughts?
- Syntometrine
  - Associated with increased risk of cerebral haemorrhage
  - Significant side effects
- Syntocinon
  - Slightly less effective at reducing initial blood loss
  - Not associated with post partum hypertension
  - Recommended by NICE (2014) Intrapartum guidelines

PPH- Prevention

- High risk cases
- Active 3rd stage management
- Early IV Access (In addition to admission for Induction of labour)
- Bloods- FBC, Clotting, G&S (Thinking about Cross-Match)

- **Anticipate Uterine Atony in high risk cases**
- Consider administration of longer acting Oxytocin (IV Infusion)
- Have in mind risk factors and cause of PPH in high risk women.

- Consider whether Tranexamic acid will be required
- Highlight high risk cases to whole MDT on ward rounds with consideration of cell salvage requirements

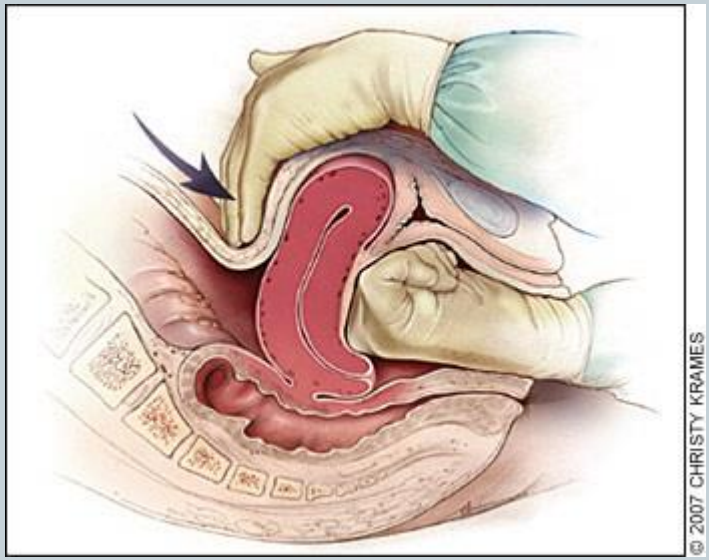
PPH- Recognition

- Early recognition
- Blood loss can be difficult to estimate
- Bleeding can be concealed in the uterus or abdominal cavity.
- **Ensure timely maternal observations are taken, recorded on MEOWS and escalated appropriately**
- Monitor and **document** fundal height postnatally
- If a woman reports to be feeling unwell- **ACT**

PPH- Initial management

- Wessex PPH Proforma/scribe sheet (Hand-outs)

- Call for Help
- Stop the Bleeding- Uterotonics
- Massage Uterus and Bi-Manual compression
- Perineal repair
- Assessment
- Monitoring/Cause/Transfusion
- Weighed Blood Loss
- Documentation



PPH- Initial management

- Fluid Replacement

IV Access

Rapid fluid resuscitation

Haemoglobin Assessment

Give Blood

Red blood cells- O Neg, Type specific, Full x-match and cell salvage

TEG ROTEM

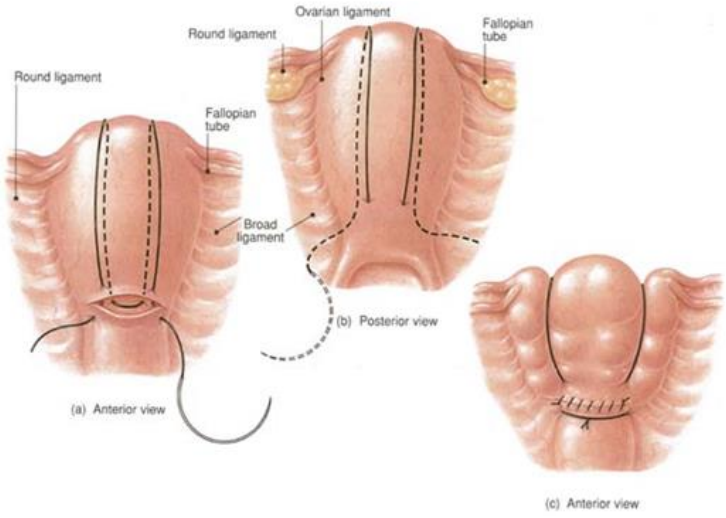
- TEG/ROTEM can be used to diagnose/ assess coagulopathies but can guide transfusion replacement
- Not only because coagulopathies are complex but also each unit given carries risk
- TEG- thromboelastography
- ROTEM- thromboelastogram
- Requires point of care machine and someone to interpret results
- Quicker than lab tests for coagulation

PPH- On-going management

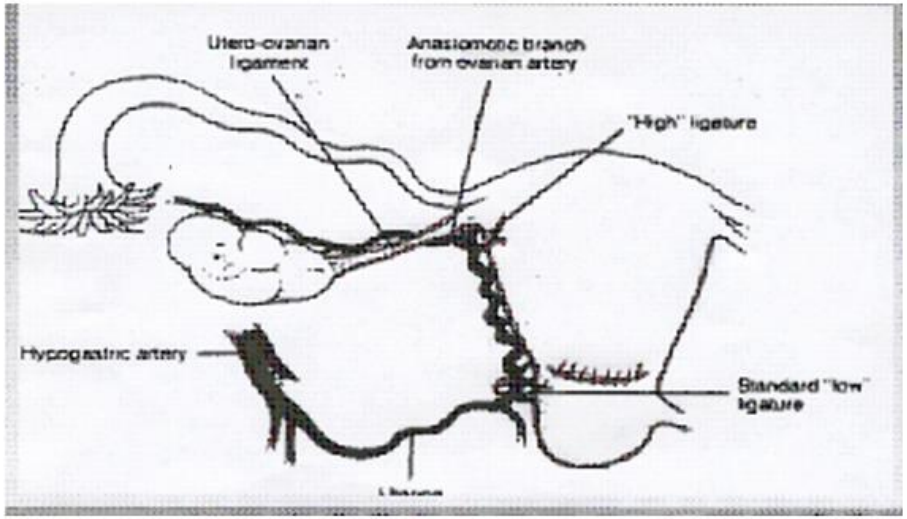
- Treat Cause and Early transfer to theatre
- Surgical approaches:

- EUA (Examination under anaesthetic)
- Manual removal
- Repair of trauma (Perineal, vaginal, cervical)
- B-Lynch Suture for uterine atony
- Uterine internal iliac vessel ligation
- Hysterectomy

B Lynch Suture/ Iliac artery ligation



Full thickness box sutures into upper segment body of uterus



Selective ligation of the uterine and tubo-ovarian arteries

PPH- On-going management

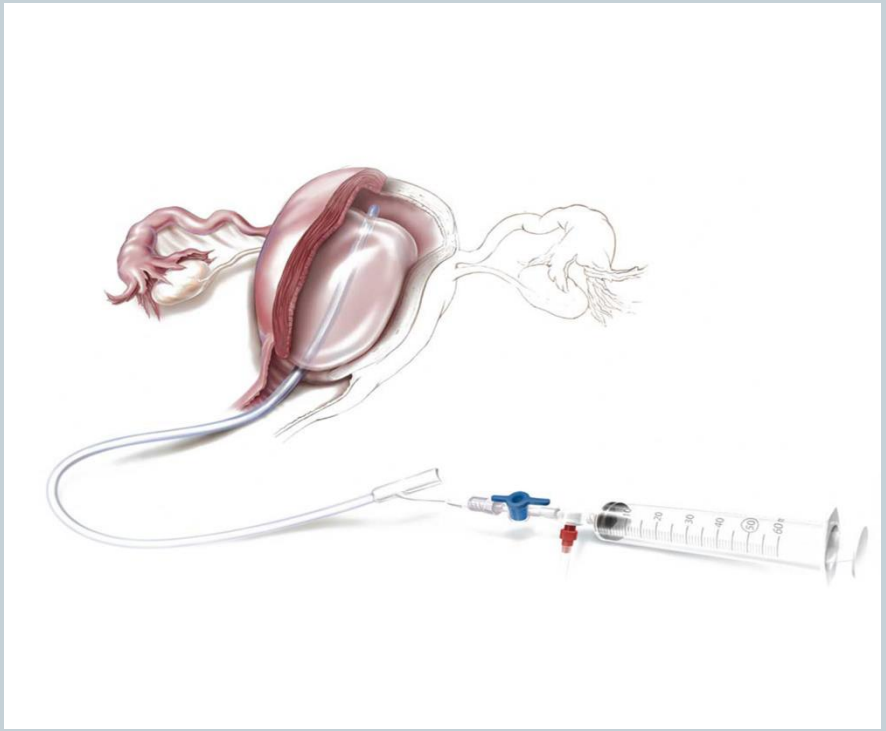
- Uterine Packing- REMEMBER DOCUMENTATION
- Packs being left in situ is a never event
- HSIB learning report 2021

- Surgeon responsibility:
- Say how many packs in situ

- Person removing responsibility
- Consent to remove
- Offer analgesia
- Clarify how many in situ and once removed document how many removed

BAKRI balloons

- Consider why useful:
- Work alongside oxytocin- oxytocin provides contraction and balloon causes pressure internally on any bleeding points
- Success rate of 65-90%
- Intended for use in primary PPH within 24 hours
- No clear evidence of how long a tamponade balloon should stay
- In place however in most cases 4-6hrs should be adequate to achieve haemostasis.



Debrief

- Debrief applies to both women (and birth partner) and staff
- Advise women they have had a PPH
- 1:10 women will a PPH in future deliveries
- Advise if additional measures- B lynch suture etc ligation that may affect future pregnancies
- Leaflets for women:
- Heavy bleeding after birth (postpartum haemorrhage) patient information leaflet (rcog.org.uk)

Summary

- Primary prevention of PPH
- Early recognition of PPH
- Preparation to manage PPH
- Effective specific and timely management of PPH
- Team working and multi-professional approach

Any questions?