POST PARTUM HAEMORRHAGE

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Ayurvedic Approach

- **Prasav Vyapad-**
- 1) Akal Prasav (Preterm / Post-term labour)
- 2) Anagat prasav (Failure to descend)
- 3) Garbh Sang (Obstructed labour)
- 4) Mudhgarbha (Abnormal presentation)
- 5) Aparasang (Retained placenta)

- **Sutika Vyadhi = Total 74**
- 1) Yonibhed
- 2) Yonikshat
- 3) Asrugdar
- 4) Raktpitta

__All these can correlate with PPH due to trauma or systemic illness

Sushrut mentioned remedy to control excessive bleeding

1) Sandhan - Kashay Ras Pradhan
2) Skandan - Sheet Dravya
3) Pachan - Bhasm
4) Dahan - Dahan karm for Contraction of Sira

These measures may helpful for Traumatic PPH.

Post Partum Haemorrhage

- Definition :-

- A) Quantitative – Blood loss in excess of 500 ml or more following birth of the baby.

- B) Qualitative / Clinical – Any amount of blood loss from or into the genital tract following birth of baby upto end of puerperium which adversely affects general condition of patient evidenced by rise in PR, Fall in BP.

INCIDENCE :- About 1 % amongst hospital deliveries

TYPES:

A)PRIMARY – Haemorrhage occurs within 24 hours following birth of baby

a. **Third Stage Haemorrhage** – occurs before expulsion of placenta

b. **True PPH** – Occurs subsequent to expulsion of placenta

B) SECONDARY – Occurs beyond 24 hours and within puerperium.

Usually occurs between 8th to 14th day of delivery.

CAUSES OF PRIMARY PPH

- WE CAN BROADLY DIVIDE IN FOLLWING

A. **ATONIC** - COMMONEST CAUSE (80%)

B. **TRAUMATIC** – LESS COMMON (20%)

C. **MIXED** – ATONIC + TRAUMATIC

D. **COAGULOPATHY**

ATONIC PPH

Uterine Contraction & Retraction is essential for control of Uterine bleeding.

Uterine muscles Fails to Contract & Retract

ATONIC PPH

Atonic PPH

- Grand Multipara
- Overdistension of Uterus – Polyhydramnios, Multiple Pregnancy, Macrosomic baby
- Malnutrition
- APH
- Prolonged labour
- Malformation of uterus
- Mismanaged third stage of labour
- Uterine fibroid
- Persistent uterine distension due to seperated placenta or placental bits

Contd…

- Constriction ring
- Precipitate labour
- Anesthesia – may due to depth of anesthesia or anesthetic agents like ether , halothane

Traumatic :-

- Trauma to genital tract (Cervix, Vagina, Perineum, Utrerus)
- Usually after manipulative delivery

Coagulopathy:

- Blood dyscrasias or blood coagulation disorder due to
  - Diminished procoagulants
  - Increased fibrinolytics
  - Sec. to Jaundice in preg, Pre-eclampsia, thrombocytopenic purpura

DIAGNOSIS

- Visible Blood Loss :
  - in majority cases vaginal bleeding is visible

- Concealed Blood Loss:
  - Rarely bleeding is concealed either inside uterovaginal canal , or in surrounding tissue leading to broad ligament haematoma, Vulvo-vaginal haematoma

Effect of blood loss depends on

a) Pre-delivery haemoglobin level

b) Degree of pregnancy induced hypovolaemia

c) Speed at which blood loss occurs

Diagnosis

- Visible blood loss
- Detoriating maternal condition may suspect concealed blood loss
- Atonic PPH – Uterus flabby
- Traumatic PPH – Uterus contracted,
- Maternal Condition : GC affected
  - Rise in Pulse rate
  - Fall in Blood pressure
  - Pallor
  - Altered sensorium

Complications of PPH

- **Immediate Sequele:**
- Increased Morbidity
- Shock
- Transfusion reaction
- Puerperal sepsis
- Failing lactation
- Pulmonary embolisam
- Thrombosis & Thrombophlebitis
- Death

Late Sequele

* Sheehans Syndrome
* Diabetes Insicpidus

Preventive Measures

- **Antenatal Measures :**

- Improve health status – Proper nutrition
- Haemoglobin level near by normal – Iron Supplement
- Blood grouping and cross match in all patients
- Plan delivery of high risk patients in tertiary centre to reduce morbidity and mortality rate

Preventive measures Cont.

- **Intranatal measures:**
  - Active management of third stage
  - Avoid Rapid delivery of baby
  - Examine placenta after delivery for intact membranes etc
  - Avoid pulling of cord
  - Exploration of utero-vaginal canal
  - Observe patient for atleast 2 hours postpartum
  - Continue oxytocin infusion for atleast 1 hour after delivery
  - Anesthesia – Prefer Local / Regional

Management

- A) Management of Third stage of bleeding
- B) Management of True PPH
    a) Atonic PPH
    b) Traumatic PPH

Third Stage Bleeding:

What is actual situation:

1) Placenta is not expelled out
2) Blood loss – may from placental site or Traumatic site

Principles of management:

1) To empty the uterus
2) Achieve Haemostasis
3) Replace the blood loss

1) **General management:**

- Ask for urgent help, Call assistant
- Catheterise bladder
- Start IV Fluid
- Arrange Blood Transfusion

2) **To empty the uterus :-**

- Remove retained placenta or placental bits, membranes manually

i. Placenta seperated – by Controlled cord traction

ii. Placenta not seperated – Manual Removal

3) **Placental Site bleeding:**

- Massage uterus to make it hard
- Administer uterotonics – Inj. Ergometrine 0.25mg OR
  Inj. Methargin 0.2 mg IV / IM

4) **Traumatic –**

- Explore Utero-vaginal canal under GA
- Suture

True PPH :

- **What is actual situation :**

1) Placenta is expelled
2) Blood Loss
3) Adverse effects of blood loss like hypovolaemia etc

- **Principles of Management :-**

1) Diagnose cause of bleeding
2) Control the bleeding
3) Resucitate patient, correct hypovolaemia etc

Atonic PPH – Step by step management

1) Step 1:

i) Massage Uterus to make it hard

ii) Inj. Oxytocin 10 Units in IV 500ml NS

iii) Inj. Methargin 0.2mg IV

iv) Examine Expelled placenta

2) Step 2:

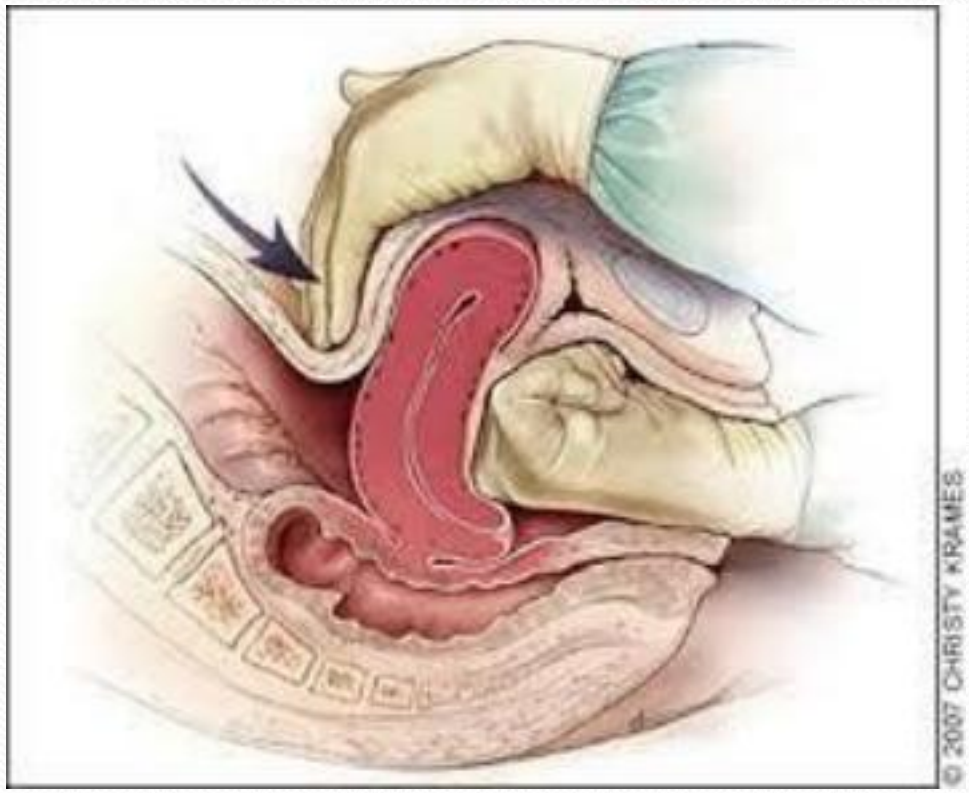
i) Explore Uterus under G.A.

ii) Simultaneously look for trauma to genital tract

iii)Inj. Carboprost 125-250mg Intramuscular / Intramyometrial

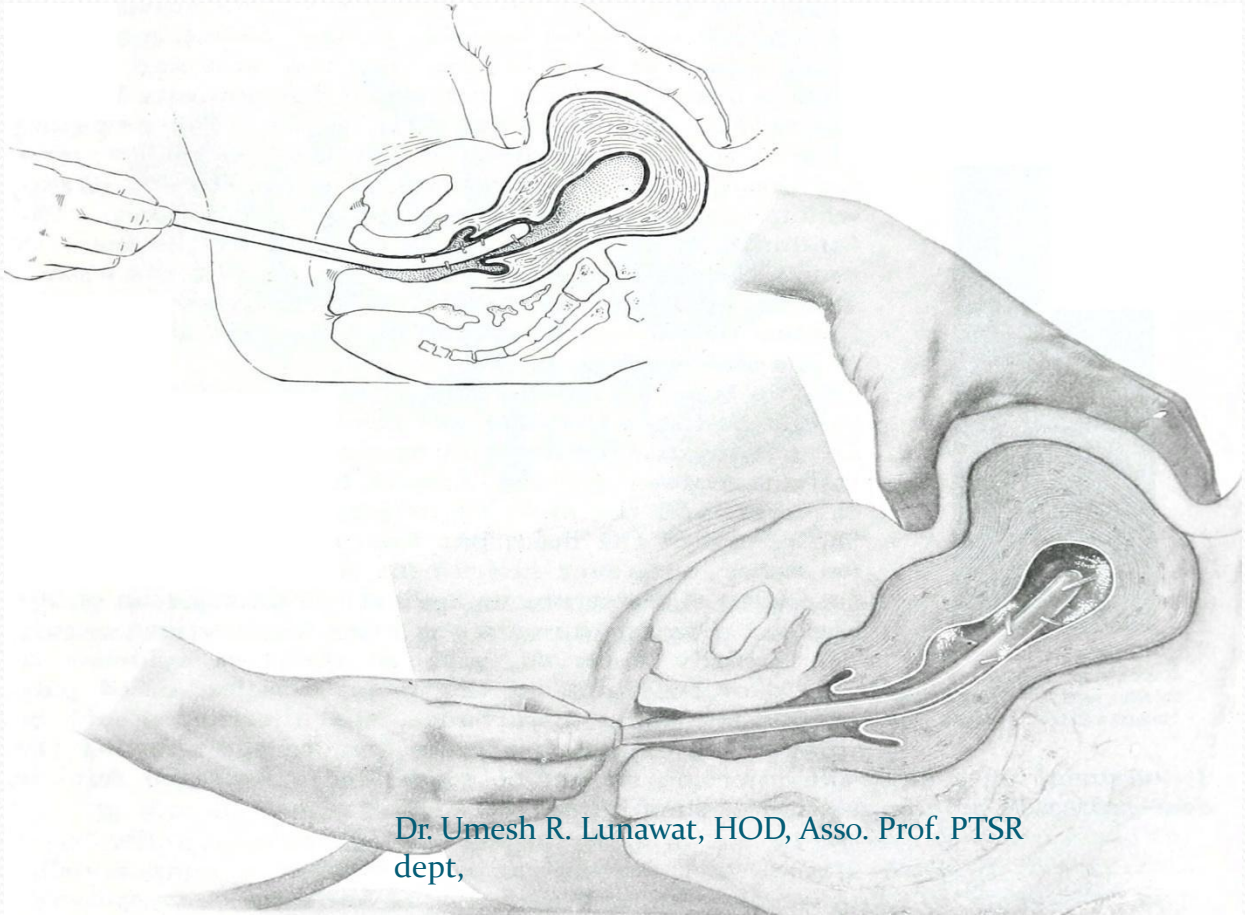
3) Step 3:- Bimanual Compression of uterus

- The uterus is firmly hold between two hands.
- Vaginal hand: fist of one hand in anterior fornix
- Abdominal hand: behind the uterus to make it anteverted



4) Step-4:- Hot Intrauterine Douche

- Hot water (47.8 C) + Antiseptic lotion
- Introduced in uterine cavity by douche nozzle & pipe
- Hot water stimulate uterus to attain its tone.



5) Step 5:- Tight Intra-uterine Packing

- Long strip of gauze (5 meter long , 8 cm wide) soaked in antiseptic lotion
- Uterus is packed with this gauze tightly
- Separate pack is used to fill up vagina
- Action – Stimulate uterine contraction
  Direct haemostatic pressure on uterine sinuses
- Pack Should be removed after 24 hours

6) Surgical Conservative Management:

i) Uterine artery ligation

ii) Internal iliac artery ligation

iii) Uterine Compression Suture

7) Hysterectomy

Traumatic PPH:

- Explore uterine cavity under G.A.
- Repair of the trauma site to achieve haemostasis

SECONDARY PPH :

- **CAUSES:**

1. Retained bits of cotyledon/Membranes – Commonest
2. Slough seperation over deep cervico-vagoinal laceration
3. Subinvolution of placental site
4. Sec. hemorrhage from CS wound usually occurs between 10-14 days.
5. Withdrawal bleeding following estrogen therapy for lactation suppression
6. Others : Cohorion-epithelioma, Carcinoma Cervix, Placental polyp, Infected fibroid, fibroid uterus, Puerpereal inversion of uterus

Diagnosis of Sec. PPH

- Varying amount of bright red blood loss may or may not preceded by bouts of warning haemorrhage.
- Evidence of Sepsis – Tachycardia , Fever, Foul smell vaginal discharge, subinvolution of uterus
- GC proportionate to blood loss
- Anemia

Management:

PRINCIPLES:

1) To assess the blood loss & replace lost blood
2) To find cause & steps to rectify the cause

MANAGEMENT:-

A) Slight bleeding with no apparent cause –

- careful watch for 24 hours
- bed rest

B) Brisk Bleeding with significant blood loss

- Resuscitative measures
- Blood transfusion
- Inj. Ergometrine 0.5 mg IM
- Antibiotics

C) Active Treatment as per Cause:

a) Retained bits – Explore uterus manually

- Gentle curettage using flushing curette
- Inj. Ergometrine 0.5mg IM

b) Sloughing wound of cervico-vaginal canal :

- Haemostatic sutures

c) Follwing C.S. :

- may require laparotomy

Ligation of internal iliac artery or may be hysteretomy may needed for above two conditions.

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