POST-PARTUM HAEMORRHAGE

PRESENTED BY:

FELICITY ADU-MILLS

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PREVENTION OF MATERNAL DEATH

GOALS:

To provide Gold Star Care to prevent death during Post-Partum Haemorrhage **(PPH)**

AIM:

•To emphasise the importance of early detection and response to PPH

•To create an awareness, sensitize and equip student midwives with the knowledge and confidence to prevent and manage excessive bleeding after birth.

WHAT IS POST-PARTUM HAEMORRHAGE?

There are 2 types of **PPH**

1. **PRIMARY PPH** – It is the loss of blood estimated to be 500mls, from the genital tract, within 24 hours of delivery. This is the commonest of obstetric haemorrhage

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- **SECONDARY=2 0PPH** – It is abnormal bleeding from the genital tract, from 24 hours after delivery until 6 weeks post-partum.

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- In simple words, PPH is excessive bleeding after child birth which is 500mls or any amount that compromises the well being of the mother.

CAUSES OF PPH

1. Uterine Atony: Commonest cause of about 70%
2. Retained tissue: placenta or fragments 10%
3. Trauma: Vulva or virginal lacerations. 19%
4. Thrombin 1%

PREDISPOSING FACTORS PPH

PREGNANCY RELATED FACTORS

- Ante partum haemorrhage
- Placenta praevia
- Multiple pregnancies
- Pre-eclampsia/ Pregnancy induced hypertension-> BP140/90mmHg
- Multi para
- Maternal Obesity
- Previous PPH

DELIVERY RELATED FACTORS

- Caesarean section
- Mismanagement of third stage
- Clotting disorder
- Instrumental delivery
- Prolong labour

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- Mediolateral episiotomy
- Retained placenta
- Big babies above 4 kg
- Infection – endometritis

EARLY DETECTION

During Pregnancy – Identify mothers with :-

- Anaemia – Treat with dietary advice and iron. Discuss possible blood transfusion

- Previous PPH and other predisposing factors and document for close observation during labour.

Post Partum:-,MANAGEMENT

- Prior to have an Agreed Protocols in place.

- Vital observations checked immediately after delivery and at regular intervals.

SIGNS AND SYMPTOMS OF PPH

- Visible bleeding
- Rising pulse rate
- Falling blood pressure
- Pallor
- Maternal collapse

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- Altered level of unconsciousness, may be restless or drowsy

- Enlarge uterus due to presence blood clots the uterus feels bogy (soft, distended lacks tone) on palpation. There may be no visible loss of blood.

ROLE OF THE NURSE MIDWIFE IN MANAGEMENT OF PPH

- Call for assistance
- Reassure mother and keep her calm
- Insert 2 cannulars ,one on each arm
- Send blood for X' matching, and FBC, U&E, Clotting screen, and FDPs
- Administer iv syntocinon infusion IM + Ergometrin IM or IV

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- Diagnose the cause of bleeding
- Check bladder – empty bladder by passing catheter. Full bladder will interfere with strong contraction.
- Continual assessment of the situation
- If laceration – repair speedily and adequately

ROLE OF THE MIDWIFE

- Massage uterus to stimulate contraction and expel clots.
- Examine the placenta and membranes
- Place woman in a semi-recumbent position
- Put baby to breast if possible to promote uterine contraction
- Monitoring observations, pulse, BP, ECG, and blood lost

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- Careful record keeping of observations, drugs, and fluid administered and keep all soiled linens and pads.
- Hourly urine output monitoring
- If bleeding persist prepare mother for theatre
- Maintain effective communication with mother and relatives

DANGERS TO BE AWARE OF

- Slow, steady trickling of blood after delivering
- Changing of shift
- Failure to add up total blood loss
- Frequent changes of bed sheets
- Woman may slowly sink into unconsciousness while the midwife complete her record keeping