Standard Treatment Guidelines for Postpartum Haemorrhage (PPH)

1st Edition 2021

Carbetocin and Tranexamic Acid for the Management of PPH in Ghana

Special Note:
Special Note:
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High maternal mortality still remains a major concern for the Government of Ghana. Post-Partum Haemorrhage (PPH) is the leading cause of maternal mortality especially in low-income countries including Ghana, and the primary cause of nearly one quarter of all maternal deaths globally. PPH refers to excessive blood loss (the loss of more than 500 ml of blood) following childbirth. Oxytocin, a uterotonic which is the mainstay for PPH management over the years, is associated with extra resource requirements on the supply chain for refrigeration and cold chain management. Oxytocin has the associated risk of reduced efficacy when there are breaks in the cold chain management of the product with resultant negative effects on health outcomes specifically for maternal mortality.

With emerging evidence on the efficacy of heat-stable carbetocin and tranexamic acid as options for the management of PPH, the Ministry of Health (MOH) in collaboration with WACI (World AIDS Campaign International) Health has made recommendations regarding the listing of carbetocin and modification of tranexamic acid therapy in the Standard Treatment Guidelines (STG) and the Essential Medicines List (EML) 7th Edition 2017. These recommendations would inform associated actions in the health system including supply chain adjustments for the new product and training of health professionals.

Adherence to these guidelines is critical for achieving the set goals and objectives towards maternal mortality and achievements of the objectives of universal health coverage and sustainable development goals. These guidelines therefore form part of the STG and the EML 7th Edition 2017 as published by the MOH.

Kwaku Agyemang-Manu (MP)
Minister for Health
## Acknowledgements

### MOH/GHS Executives and Stakeholders

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<th>No.</th>
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<tr>
<td>1</td>
<td>Hon. Kwaku Agyeman-Manu</td>
<td>Minister for Health</td>
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<td>Hon. Tina Gifty Naa Ayele Mensah</td>
<td>Deputy Minister for Health</td>
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<td>Hon. Dr. Bernard Okoe Boye</td>
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<td>Dr. Bismark Attah-Adjepong</td>
<td>Director of Pharmaceutical Services, GHS</td>
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### Select National Medicines Selection Committee of Experts

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<td>Dr. Kwame Adu Bonsaffoh</td>
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<td>2</td>
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<td>University of Ghana Medical School (UGMS)</td>
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<td>Drug Policy Unit, Ministry of Health (MOH)</td>
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<td>Mr. Saviour Yevutsey</td>
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**Editorial Group and Reviewers**

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Comments should be sent to:
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Post-Partum Haemorrhage (PPH)

Post-partum haemorrhage may be primary or secondary. Primary postpartum haemorrhage refers to bleeding of more than 500 ml from the genital tract within the first twenty-four hours after vaginal delivery or more than 1000 ml after caesarean section or any amount of blood loss that results in haemodynamic compromise of the patient. It usually occurs before or immediately after delivery of the placenta.

Secondary post-partum haemorrhage is defined as excessive bleeding from the genital tract occurring from twenty-four hours to six weeks after delivery.

Postpartum haemorrhage becomes life threatening if the mother is already anaemic.

CAUSES

Primary PPH (The 4 T’s)

- **Tone**: Uterine atony (70-90% of cases)
- **Tissue**: Retained placenta (part of whole)
- **Trauma**: Genital tract trauma (laceration, uterine rupture)
- **Thrombin**: Clotting disorders (coagulopathy)

Note:
Secondary PPH is usually caused by infections and retained tissue.

SYMPTOMS

- Dizziness
- Palpitations
- Fatigue
- Thirst
- Lethargy
- Excessive or prolonged vaginal bleeding after delivery
**SIGNS**
- Active bleeding from the genital tract
- Mucosal pallor e.g. conjunctival
- Tachycardia (rapid and thready pulse)
- Blood pressure may be low or normal
- Deterioration of maternal levels of consciousness
- Flabby or poorly contracted uterus
- Tears in genital tract and/or perineum
- Retained placenta

**INVESTIGATIONS**
- Full Blood Count (FBC), sickling status
- Bedside clotting test
- Blood grouping and cross-matching
- Coagulation profile
- Kidney function test
- Ultrasound scan – recommended for secondary PPH

**TREATMENT**

*Treatment objectives*
- To identify the cause
- To stop bleeding as quickly as possible
- To replace blood volume
- To correct hypotension
- To correct resulting anaemia

*Non-pharmacological treatment*

**Prevention**
In all cases of deliveries, active management of the third stage of labour (AMTSL) should be offered.
The components of AMTSL are:
- Administration of a uterotonic immediately after the birth of the baby
- Controlled cord traction to deliver the placenta
- Massage the uterine fundus after the placenta is delivered
Note:
Delay clamping the cord for at least 1 – 3 minutes to reduce rates of anaemia in neonates.
Duration should not be longer than 30 seconds in preterm infants and cases of foetal distress.

Post-delivery interventions
- Immediately assess uterine tone to ensure a contracted uterus
- Palpate the uterus every 15 minutes for the first 2 hours
  - If there is atony, perform fundal massage and monitor more frequently
- Inspect perineum, vagina and cervix for tears and lacerations.
  - Repair any tears immediately under appropriate anaesthesia/analgesia with adequate lighting.
- Inspect placenta and membranes for completeness
  - If incomplete, consider examination under anaesthesia and curettage

Note:
Refer if facilities and/or expertise are not available.

Management of specific causes of PPH

Uterine Atony
- Establish intravenous access and perform investigations as stated above.
- Administer oxygen (by face mask or by nasal prongs)
- Administer crystalloids (R/L, N/S) in the ratio of 3 litres of crystalloid to 1 litre of estimated blood loss. This should be done until blood and blood products are available (see section on pharmacological management below)

Note:
Consider use of colloids in persistent hypotension in spite of initial resuscitation with crystalloids.
- Massage the uterus to stimulate contractions and expel clots
- Administer more uterotonics (See section on pharmacological management below)
• Insert an indwelling catheter to empty the bladder and also monitor urine output.
• If heavy bleeding persists, apply bimanual compression until further management decisions are made.
• Consider external aortic compression
• Examination under anaesthesia and insertion of a uterine balloon tamponade (Condom tamponade or uterine balloon tamponade)
• Anti-shock garments should be used especially in situations where patients have to be referred over long distances or there are expected delays.

Note:
Intrauterine packing is not recommended.

In the event of intractable bleeding refer to a facility where surgical intervention in theatre can be performed. Ensure the use of bimanual compression, abdominal aortic compression, uterine balloon tamponade or anti-shock garments is applied before and during referral.

Surgical options include:
• Compression sutures e.g. B-Lynch suture
• Uterine artery ligation
• Hypogastric artery ligation
• Hysterectomy (It may be lifesaving and the only option in critical situations)

Trauma
• In the presence of genital tract laceration, apply pressure and repair.
• Vaginal packing with gauze rolls lightly soaked in normal saline may be helpful in bruises that are not amenable to suturing without causing further damage. (Note the number of gauze rolls used and ensure they are documented and removed)
• If bleeding persists while the placenta is delivered and the uterus well contracted, consider ruptured uterus and broad ligament haematoma. These are life threatening emergencies that require urgent attention or referral.
Retention of all or part of placental tissue within the uterine cavity
• If the placenta is not delivered and bleeding continues, prepare for examination under anaesthesia and manual removal in delivery room or theatre (refer if expertise is not available)

Clotting Disorders
• In the presence of a well contracted uterus and where trauma and retained tissue have been excluded, consider investigating for coagulopathies:
  • Bed side clotting – normal range: 2 – 8 minutes.
  • Administer Tranexamic acid and blood products (fresh frozen plasma, cryoprecipitate and platelets concentrates) as required (see section on pharmacological treatment below)
• Ensure early referral if the facility does not have the capacity to provide effective management.
• Consider consultation with haematologists and intensive care physicians.

Pharmacological treatment

Prevention of PPH
1st Line Treatment
Evidence Rating: [A]
• Oxytocin, IM, 10 units stat.

Note:
Oxytocin should be stored between 2-8°C

2nd Line Treatment
Evidence Rating: [A]
• Carbetocin (heat-stable formulation), IV, 100 µg/ml slowly over 1 minute

Caution:
Carbetocin is contraindicated in hypertension in pregnancy and epilepsy.
Note:
Carbetocin is intended for single use administration only. No further doses of carbetocin should be administered for prevention of PPH. Heat stable carbetocin can be stored at room temperature.

Or
Evidence Rating: [B]
• Misoprostol, sublingual, 600 microgram within 1 minute of delivery

Treatment of PPH

A. If the uterus is poorly contracted (Atony)

1st Line Treatment
Evidence Rating: [A]
• Oxytocin, IM, 10 units stat.
  Then
• Oxytocin, IV, infusion, 20-40 units in 500 ml Dextrose saline or 0.9% Normal saline or Ringers Lactate administered over 4 hours.

Note:
Dose not to exceed 40 units

And
Evidence Rating: [A]
• Tranexamic acid, IV, Loading dose: 1 g in 10 mL (100 mg/mL) IV at 1 mL per minute (administered over 10 minutes)

  Then (if bleeding continues after 30 minutes or if bleeding restarts within 24 hours of completing the first dose);
• Tranexamic acid, IV, 1 g in 10 mL (100 mg/mL) IV at 1 mL per minute (administered over 8 hours in an IV infusion)

Note:
Tranexamic acid should be initiated within 3-hours after birth.
2nd Line Treatment  
Evidence Rating: [B]  
- Misoprostol, 600 microgram (sublingual or oral) stat if patient is conscious

Or  
3rd Line Treatment  
Evidence Rating: [B]  
- Ergometrine, IV, 250-500 microgram stat.

Caution:  
Ergometrine is contraindicated in eclampsia and severe hypertension.

Or  
Evidence Rating: [B]  
- Oxytocin-ergometrine, IM, (IV route is no longer recommended), Oxytocin 10 units and ergometrine 500 microgram stat.

Note:  
High rates of adverse effects (nausea, vomiting, and high blood pressure) occur in women treated with ergometrine.  
They should not be given to women with hypertension in pregnancy or heart disease.

Or  
Evidence Rating: [B]  
- Oxytocin and misoprostol, (oxytocin, IV, 10 units and misoprostol, , 600 micrograms (sublingual or oral) stat.

B. Hypovolaemia  
- Sodium Chloride 0.9% or Ringers lactate, IV, and blood transfusion as clinically indicated (See section on ‘management of hypovolaemic shock’)

C. Anaesthesia for manual removal of placenta  
1st Line Treatment  
- Ketamine, IM, 5-10 mg/kg stat.
• Ketamine, IV, 0.5-2 mg/kg stat.

**Note:**
Ketamine must be used only by trained health personnel. Provide antibiotic prophylaxis after manual removal of placenta or exploration of uterus or repair of genital tract lacerations.

And
• Midazolam, IV, 2-3 mg (max 5mg) to be administered 5-10 minutes before the procedure at a rate of 2mg/min

**Note:**
Midazolam should be administered before ketamine.

2nd Line Treatment
• Morphine, IV, 2.5 - 5 mg stat. as required (if no anaesthetist is available)
  Or
• Pethidine, IV slowly or IM, 1 mg/kg 6 - 8 hourly as required (max. 100 mg per dose)

And
• Midazolam, (as above).

Or
• Diazepam, slow IV, 5-10 mg 8 hourly as required (NOT more than 2.5 mg per minute)

**Note:**
Do not mix pethidine and diazepam/ midazolam in the same syringe. Monitor respiratory rate of patient closely. Stop drugs if respiratory rate is less than 12 per minute.

D. Secondary Postpartum Haemorrhage

**Note:**
Use pelvic ultrasound to rule out retained products of conception. Consider serum B-HCG to rule out gestational trophoblastic disease.
• Oxytocin, IV, 20-40 units in 500 ml Dextrose saline or 0.9% Normal saline or Ringers Lactate administered over 4 hours.  
  Or
• Ergometrine, IV/IM, 250-500 microgram stat.

**Note:**
Antibiotics are indicated in management of secondary PPH

**Treatment of endometritis**
  **Start with:**
• Clindamycin, IV, 600-900 mg 8 hourly  
  And
• Gentamicin, IV, 40-80 mg 8 hourly

  Or
• Amoxicillin + Clavulanic Acid, IV, 1 g 12 hourly  
  And
• Metronidazole, IV, 500 mg 8 hourly

  Or
• Ceftriaxone, IV, 1-2 g daily  
  And
• Metronidazole, IV, 500 mg 8 hourly

  Or
• Cefuroxime, IV, 750 mg 8 hourly  
  And
• Metronidazole, IV, 500 mg 8 hourly

**Continue with oral antibiotics:**
• Amoxicillin + clavulanic acid, oral, 625 mg 8 hourly or 1g, 12 hourly for 7 days  
  And
• Metronidazole, oral, 400 mg 8 hourly for 7 days
Or
- Amoxicillin + clavulanic acid, oral, 625mg 8 hourly or 1g, 12 hourly for 7 days
  And
- Secnidazole, oral, 2g stat.

Or
- Cefuroxime, oral, 500mg 12 hourly for 7 days

E. Antibiotic prophylaxis
- Amoxicillin + clavulanic acid, oral, 625mg 8 hourly or 1g, 12 hourly for 7 days
  And
- Metronidazole, oral, 400 mg 8 hourly for 7 days

Referral Criteria
Refer patients who do not respond to the treatments above to a specialist centre. Also refer promptly to a hospital with theatre and blood transfusion facilities for examination under anaesthesia and/or laparotomy if these are not immediately available.

Cases with the following may also be referred:
- Intractable bleeding
- Ruptured uterus and broad ligament haematoma
- Management of coagulopathies
FLOWCHART
**PROVISIONAL MEDICINES LIST FOR PREVENTION AND MANAGEMENT OF POST-PARTUM HAEMORRHAGE**

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