Lancashire Teaching Hospitals
NHS Foundation Trust

Information for patients and carers

Prevention and treatment of maternal blood loss around birth

Postpartum Haemorrhage (PPH)

What bleeding can I expect after my baby is born?

It is normal to bleed from your vagina after your baby is born. This blood mainly comes from the area in your womb (uterus) where the placenta was attached, but it may also come from any cuts and tears experienced during the birth.

Bleeding is usually heaviest and red or browny-red just after giving birth, it gradually becomes lighter in colour and flow over the next few hours. The bleeding will reduce further over the next few days. This vaginal bleeding is called lochia. Most women find that their flow of lochia is heaviest in the first 1 to 3 days after birth and gradually gets lighter over the following weeks. It will usually have stopped by the time your baby is 12 weeks old.

Blood clots are common, they are often the body's natural way of reducing blood loss from a cut or injury. They can also indicate infection or bits of placenta left inside your womb (uterus). Discuss any clots with your health care professional so that they can check that there is nothing to be concerned about.

It is important to reduce the chance of you getting an infection by washing your hands thoroughly before and after using the toilet. Change your maternity pads regularly.

Sometimes bleeding during or after birth is heavier than normal. This is called a Postpartum Haemorrhage (PPH)

What is a Postpartum Haemorrhage (PPH)?

PPH is heavy bleeding after birth. PPH can be primary or secondary:

- Primary PPH is when you lose 500ml or more of blood within the first 24 hours after the birth of your baby. Primary PPH can be

minor, where you lose 500–1000ml, or major, where you lose more than 1000ml.

- Secondary PPH occurs when you have abnormal or heavy vaginal bleeding between 24 hours and 12 weeks after the birth. Secondary PPH is often associated with infection, usually in the lining of your womb. Occasionally it may be associated with some placental tissue remaining in your womb after the birth. You should contact your midwife, the maternity triage team or GP if your bleeding is getting heavier, if your lochia has an offensive smell, or if you feel unwell. You may be given a course of antibiotics to treat an infection.

How could a PPH affect me?

Experiencing a PPH can cause you to be anaemic, this can make you feel weak and short of breath and can worsen the normal tiredness that all women feel after having a baby. This can make recovery and caring for your baby harder after giving birth.

If heavy bleeding does occur, it is important that it is recognised and treated very quickly so that a minor haemorrhage doesn't become a major haemorrhage, which can be life-threatening.

If your bleeding is heavy or continues after antibiotics, you may need to go to hospital for further tests. You may need antibiotics through a drip. Less commonly, you may need an operation to remove any small pieces of remaining placenta from your womb. You may need to stay in hospital for a few days.
Your baby can usually stay with you if you wish, and you can continue to breastfeed.

Who is at risk of primary PPH?

Most women who have a primary PPH have no identifiable reason for this. However, some women have an increased chance of experiencing a PPH, these reasons are listed in the below table.

-	Associated with an increased chance of Primary PPH
Before the birth	Known as placenta praevia – when the placenta is located lower down near the neck of the womb Suspected or proven placental abruption – when the placenta separates from the womb early Pregnant with twins or triplets Pre-eclampsia and/or high blood pressure Experienced a PPH in a previous pregnancy Having a BMI (body mass index) of more than 35 at booking Anaemia Fibroids Blood clotting problems Taking blood-thinning medication
In labour	Caesarean birth Induction of labour Delay in birth of your placenta (retained afterbirth) Perineal tear or episiotomy (a surgical cut to help birth) Forceps or ventouse birth Having a long labour (more than 12 hours) Having a large baby (more than 4kg or 9lb) Having your first baby if you are more than 40 years old Having a raised temperature (fever) during labour A general anaesthetic during birth

Your midwife or obstetrician will consider these factors with you during pregnancy and advise you on ways to reduce the chance of you

experiencing a PPH or recommend treatment at the time of giving birth. This may include treatment that is only available in a hospital setting.

It is important to remember that most women with these factors will not experience a haemorrhage after giving birth.

What can I do during pregnancy to reduce the chance of a PPH?

In some cases, steps can be taken to reduce the chance of having a PPH and to reduce the likelihood of needing a blood transfusion:

- During pregnancy, your body needs two to three times more iron than when it is not pregnant. Iron is important for your baby's growth and brain development. Iron is also needed to produce red blood cells which carry oxygen around your body, maintain a stable heart rate, blood viscosity and the body's blood clotting ability. Women with anaemia can tolerate a smaller volume of blood loss at birth before feeling unwell or needing a blood transfusion than women without anaemia

  The most common reason for developing anaemia during pregnancy is iron deficiency (not enough iron) but folic acid or vitamin B12 deficiencies can also contribute to anaemia. All pregnant women are offered screening for anaemia during pregnancy. If you are anaemic during pregnancy, it is important that you make dietary changes and take iron supplementation if advised by your healthcare professional If you are very anaemic during pregnancy or find it difficult to take tablets, alternative preparations may be advised, or iron can be given intravenously (through a drip)

- If any pre-existing factors for PPH are identified in the antenatal period, your healthcare professional will discuss these with you. Examples of this may include the offer of more scans to monitor the placenta or additional blood tests to monitor blood clotting levels. It is

important that you discuss your options and develop the plans for your care in labour jointly with your midwife or obstetrician

Treating major haemorrhage may include having a blood transfusion (see below). If this worries you, or if you do not wish to receive blood or other blood products, you should talk to your healthcare team. It is important that your wishes are known well in advance and that they are written clearly in your notes.

What can be done during birth to reduce the chance of a primary PPH?

Your third stage of labour begins once your baby is born and ends when you deliver the placenta (afterbirth). You can choose to have either a physiological (or natural) third stage or an actively managed third stage.

A physiological 3rd stage means that you wait for the placenta to be born naturally. After your baby's birth, your midwife will delay placing a clamp on the umbilical cord until it has stopped pulsating to allow oxygenated blood to pulse from the placenta to your baby. Your uterus will contract, and the placenta will separate from the wall of your uterus. The placenta will then drop down into your vagina, ready for you to push it out. Breastfeeding and skin-to-skin contact with your baby stimulates contractions and may help you achieve a physiological third stage. It may be easier to push your placenta out if you are in an upright position. Your baby's cord is usually clamped and cut after the placenta has been delivered, or when the cord has stopped pulsating. Your midwife will check the placenta and membranes to ensure they are complete and that no part has been left behind.

In an actively managed 3rd stage your midwife will give you an injection once your baby's shoulder emerges. After your baby is born cord clamping is delayed for at least one minute and up to five minutes to allow oxygenated blood to pulse from the placenta to your baby. The cord will be clamped and then cut. The injection causes your uterus to contract strongly so the placenta separates quickly. Once your uterus

contracts and there are signs that the placenta is ready to be born, your midwife will pull gently on the cord while pressing on your tummy above your pelvis to support your uterus while gently easing the placenta out of your vagina.

An actively managed 3rd stage can take around 10 minutes from the birth to complete. A physiological 3rd stage can vary in length but can take around an hour.

Active management of the third stage of labour is associated with a lower blood loss compared to physiological management of the third stage. The injection may occasionally increase feelings of headaches and nausea. Your midwife or obstetrician may advise you to have an actively managed third stage if you had any factors in the antenatal period or during the birth that may increase your chance of PPH. Changing from a physiological to an actively managed 3rd stage may be required if you start to bleed more heavily or if your physiological 3rd stage takes longer than one hour.

Whilst a physiological 3rd stage is not recommended at caesarean birth, it is possible to delay cord clamping for 1 to 5 minutes, providing that your baby does not require immediate resuscitation, and you are not bleeding heavily.

It is important that you talk to your midwife or obstetrician about your options for the 3rd stage of labour during the antenatal period so that you can develop an informed plan of care that is suitable for you.

What happens if I have a primary PPH?

Your midwife or obstetrician will tell you and your partner what is happening and why, they will take action to manage the blood loss whilst calling for additional clinical support. Other maternity team professionals including additional midwives, obstetricians, anaesthetic and support staff may attend your birth room in the event of a call for help from your midwife or obstetrician. The room can appear noisy and

bright, and it can happen quickly. This may be frightening for you and your birth partner. It is important that you speak to your healthcare team after this experience to ensure that you understand what happened and if there are any recommendations for future pregnancies. If you have any questions, this will be the opportunity to have them answered.

You may feel dizzy, light-headed, faint, or nauseous. In most cases (whether you are at home, in a midwifery-led unit or in hospital), heavy bleeding will settle with the simple measures listed below.

At the time of the PPH, the maternity team professionals attending you may:

- Massage your womb through your abdomen, and sometimes vaginally, to encourage it to contract
- Give a second injection into your thigh (or a first, if you did not have one at the time of the birth) to help your womb contract
- Put a catheter (tube) into your bladder to empty it, as this may help the womb contract
- Put a drip into your arm to give you some fluids after taking some blood for testing
- Check to make sure that all the placenta has come out. If there are any missing pieces still inside your womb, you may have to have them removed; this is usually done in an operating theatre under anaesthetic
- Examine you to see whether any stitches are required

Your blood pressure, temperature and pulse will be checked regularly. You can breastfeed if you wish.

What happens if I continue to bleed very heavily?

If heavy bleeding continues additional medications may be given to help stop the bleeding. You will be given oxygen via a facemask and a second drip for extra intravenous fluids. You may be given a blood transfusion or medication to help your blood to clot. If the bleeding

continues, you may be taken to the operating theatre to find the cause of the haemorrhage. You will need an anaesthetic for this. Your partner will be kept informed about how you are and what is happening, and your baby will be cared for.

There are several procedures your doctors might use to control the bleeding:

- A ‘balloon’ may be inserted into your womb to put pressure on the bleeding blood vessels. This is usually removed the following day
- An abdominal operation (laparotomy) may be performed to stop the bleeding
- Very occasionally, a hysterectomy (removal of the womb) is necessary to control the heavy bleeding
- In some situations, a procedure called uterine artery embolisation may be performed to help stop the bleeding

Once your bleeding is under control, you will either be transferred to the obstetric delivery suite or to an intensive care unit. You will be monitored closely until you are well enough to go to the postnatal ward.

How will I feel afterwards?

You may need a longer hospital stay. If tests show that you are very anaemic or if you are feeling faint, dizzy or light-headed, you may be offered a blood transfusion.

You can still breastfeed after a PPH and you can ask your healthcare team about extra support.

When you go home you may still be tired and anaemic, and you may need treatment with iron. It may take a few weeks before you make a full recovery. Your GP may offer you a blood test in 6–8 weeks’ time to check your blood count. You can help improve your iron levels by taking

iron tablets regularly and by eating a healthy diet including foods rich in iron (such as meat, pulses, eggs, and leafy green vegetables).

You may be offered daily blood-thinning injections and compression stockings to wear after the birth of your baby. This is because after a PPH you are at increased risk of developing blood clots in your legs or lungs. Your midwife will guide you and your birth partner how to do the injections yourself when you go home.

If you continue to feel upset or develop anxiety or depression after you go home, you should talk to your midwife, health visitor or GP.

What about future births?

If you have had a birth that was complicated by a primary PPH, there is an increased chance that you would experience a PPH in future births. Depending on the cause of the previous PPH you may be advised to take iron supplements in a future pregnancy to reduce the chance of becoming anaemic. You may be advised to have additional blood tests or preventative treatment for PPH at the point of giving birth. You should discuss your birth options with your healthcare team.

What happens if I have a secondary PPH?

Secondary PPH is often associated with infection in the uterus. Occasionally it may be due to some placental tissue remaining in your uterus. It usually occurs after you have left hospital. You should contact your midwife or GP if:

- Your bleeding is getting heavier
- If your lochia has an offensive smell or if you feel unwell

You may be given a course of antibiotics to treat an infection.

If the bleeding is heavy or continues, you may need to go to hospital for further tests. You may need antibiotics which will be given through a

drip. Less commonly, you may need an operation to remove any small pieces of remaining placenta from your womb. You may need to stay in hospital for a few days.

Your baby can stay with you if you wish, and you can continue to breastfeed.

Key points

- It is normal to bleed after you have a baby. Initially, bleeding can be quite heavy, but it will reduce with time. You may continue to bleed for several weeks after giving birth
- Women of increased chance of haemorrhage will be advised a specific course of management that can only be provided in the consultant-led delivery suite
- Sometimes bleeding is much heavier than normal, this is called postpartum haemorrhage (PPH). It is important to remember that many women will not experience a haemorrhage after giving birth. If bleeding is very heavy, it is important to act quickly
- In most cases, heavy bleeding will settle with simple measures
- Your healthcare professionals will keep you and your birth partner informed of what is happening at all times

Contact details

Should you wish to discuss this information further or would like advice please speak to your named midwife.

Sources of further information

www.lancsteachinghospitals.nhs.uk
www.nhs.uk
www.accessable.co.uk
www.patient.co.uk

Follow us on social media @lancshospitals

Lancashire Teaching Hospitals NHS Foundation Trust is not responsible for the content of external internet sites.

All our patient information leaflets are available on our website for patients to access and download:

www.lancsteachinghospitals.nhs.uk/patient-information-leaflets

Lancashire Teaching Hospitals is a smoke-free site. Smoking is not permitted anywhere on any of our premises, either inside or outside the buildings. Our staff will ask you about your smoking status when you come to hospital and will offer you support and advice about stopping smoking this will include Nicotine Replacement Therapy to help manage your symptoms of withdrawal and the opportunity to speak to a nurse or advisor from the specialist Tobacco and Alcohol Care Team.

If you want to stop smoking, you can also contact Smokefree Lancashire on Freephone **08081962638**

Please ask a member of staff if you would like help in understanding this information.
This information can be made available in large print, audio, Braille and in other languages.

Department: Maternity
Division: Women and Children
Production date: September 2024
Review date: September 2027
JR 1198 v1