

HAEMORRHAGE IN PREGNANCY

TANVIR JAMAL

*Department of Obstetrics and Gynaecology,
Postgraduate Medical Institute,
Lady Reading Hospital, Peshawar.*

SUMMARY

It is a one year retrospective study of the haemorrhage occurring in late pregnancy and postpartum period. Out of the total deliveries of 3266, in 1995, 234 cases were admitted with antepartum haemorrhage (APH) (0.70%) and 102 cases has postpartum haemorrhage (APH) (0.30%). Of the 234 cases with antepartum haemorrhage 185 (79%) cases delivered in hospital, while 49 (21%) had conservative treatment. Perinatal mortality rate was 303/1000 total births. Total maternal mortality in 1995 was 41, while mortality due to haemorrhage alone was 11(20.7%); all due to PPH with a MMR (maternal mortality rate), of 3.4/1000 births.

INTRODUCTION

Excessive bleeding remains a significant factor in the causation of maternal mortality. It is a leading cause of premature delivery and so of perinatal mortality.¹

Postpartum haemorrhage is the most common cause of excessive blood loss in pregnancy and mostly blood is transfused to replace blood loss after delivery.² Our women are already compromised by anemia, repeated pregnancies, pregnancy losses and intercurrent illnesses; they demonstrate serious deterioration following the blood loss of even less than the defined 500 ml. They many require blood transfusion with its added risk of transmission of hepatitis virus, human immuno deficiency virus infection and transfusion reactions.³

Antepartum haemorrhage is another serious and common complication of pregnancy.^{2,4} Antepartum haemorrhage may be due to obstetrical causes and non obstetrical causes. Obstetrical causes are more hazardous and most of the times result in excessive blood loss. The commonest is premature separation of placenta. Placenta previa is less common but still dangerous. Less

common causes of bleeding are circumvallate placenta, abnormalities of blood clotting mechanism and uterine rupture. Extrusion of cervical mucus (show) is the most common cause of vaginal bleeding before labour. It may be alarming for the patient but it never requires any medical intervention. Vasa previa is a rare cause of antepartum haemorrhage, in which fetal blood is lost; if suspected can be confirmed by presence of fetal haemoglobin in the blood lost.

MATERIAL AND METHODS

All the patients admitted and delivered in Gynae A unit from January 1, 1995 till December 31, 1995 were studied. It included their mode of admission whether emergency or booked, complaints on admission, provisional diagnosis, mode of delivery, whether abdominal or vaginal, fetal and maternal outcome, final diagnosis and condition of the mother and baby on discharge. Patients presenting with vaginal bleeding were separately, cause of bleeding, mode of delivery, fetal and maternal outcome noted. The aim of this study was to find out the overall incidence of haemorrhage in pregnancy, perinatal and maternal mortality and

TABLE - I
TOTAL DELIVERIES

Total deliveries.	3266	
Vaginal deliveries.	2675	83.9%
Caesareans Sections.	591	16.1%
C Sections due to APH.	127	21.5% of total C sections

TABLE - II
ETIOLOGICAL DISTRIBUTION

Placenta previa.	123	66.4%
Placental.	54	29.2%
Incidental.	5	2.7%
Ruptured Uterus.	3	1.7%

morbidity and a way to find out how we could reduce the effect of this disastrous complication of pregnancy.

RESULTS

Total admissions in Gynae A unit in the year 1995 were 11163. Out of these 4177 (36.5%) were obstetrical cases. The data of the year is given in a tabulated form (Table I). APH was responsible for the major portion of operative abdominal deliveries. It has been proven that operative abdominal delivery though much safer than before has much higher maternal morbidity than the vaginal delivery which is a natural process, though requires assistance in many places in the form of episiotomy, forceps and vacuum extraction.³ Total number of patients presenting with vaginal bleeding whether antenatally or postnatally, present on admission or resulted following delivery or some procedure was 336. Out of which 234 (70%) had antenatal bleeding, 185 (74.7%) delivered in hospital, while 49 (25.3) remained undelivered and had conservative treatment in the hospital. In addition out of 102 (30%) cases with post partum haemorrhage, 95 were admitted with PPH and 7 had hospital delivery.

APH

Total cases delivered in hospital were 185. Etiological distribution is shown in table-II.

Patients with placenta previa were further divided according to their grade from Type I-IV. This grading was done by examination in the theater under general anaesthetic. Ultra sound grading was not used here as most of the admissions were emergency admissions with heavy bleeding. Examination in the theater before proceeding to Caeserian Section is a routine.

127 Patients with APH had Caeserian section (68.5%), 121 Caeserian Section were for Placenta Previa (P.P), only 2 patients with type-I P.P had vaginal delivery while others were bleeding heavily so had abdominal delivery, 5 patients with placental abruption and heavy bleeding had Caeserian Section. One patient with incidental haemorrhage had Caeserian Section. Detail is given in Table IV.

Perinatal outcome is shows in Table V, total cases were 185.

There were 7 twins so total babies born were 192. 88(45.9%) were male while 104

TABLE - III
GRADES OF PLACENTA PREVIA

Type I	5	3.8%
Type II	34	27.9%
Type III	40	32.5%
Type IV	44	35.8%

TABLE - IV
CAESERIAN SECTION

	Total	C. Section	Percentage
P Previa	123	121	98.7%
Placental Abruption	54	5	9.3%
Incidental	5	1	20%

TABLE - V
PERINATAL OUTCOME

Etiology	Still Births	% Age	Premature	% Age
Placenta Previa	32	17.3	21	11.3
Placental Abruption	31	16.1	20	10.8
Incidental	1	0.52	3	1.56
Ruptured Uterus	3	1.56	0	0

(54.1%) were female. Perinatal mortality rate was 303/1000 total births. It is calculated from intrauterine deaths plus deaths occurring in the hospital or special care baby unit in the first week of life/1000 total births. While the patients who were allowed home in the first week, their perinatal outcome is not known. So actual perinatal mortality rate is probably much higher than the calculated rate. Prematurity was responsible for 70% of the perinatal mortality.

Postpartum haemorrhage.

Total cases reported were 102.4 had hospital delivery with retained placenta. 3 with vaginal delivery. 1 2 placentae were delivered manually, while in one, placental delivery was accomplished by Brandt' Andrew's technique. In one case patient had C. Section for prolonged labour and failure to progress. Placenta was found to be morbidly adherent so hysterectomy was done for PPH. In other³ cases C. Section was done for APH which proceeded to hyster-

ectomy for relaxed uterus. 95 cases for PPH had home delivery and had come to the unit with PPH. On the whole 94 patient had retained placenta while in 7 patients.

- 3 had relaxed Uterus
- 1 had Cervical Tear
- 1 had Cervical + Vaginal Tears
- 1 Had Cervical (Bilateral) + Vaginal + 2" Perineal Tears with retained placental pieces.
- 1 had Retained placental pieces + Vaginal Tears. Management of all the cases is given in table VI.

Total 7 patients had hysterectomy for haemorrhage; 6 had presented with APH. On laparotomy in 3 cases uterus was found to be ruptured while in 3 others, one was abruption Placenta one for type IPP and one for Type III PP. 2 were proceeded to hysterectomy for relaxed uterus and one for

TABLE - VI
MANAGEMENT

Manual Removal of Placenta	93	91.28%
Delivery of Placenta by B.A. Method	1	0.98%
Exploration of uterus + massage +Methergin		
+Syntocinon + Blood Transfusion.	1	0.98%
Repair of Tears Alone	1	0.98%
Exploration + Repair of Tears	2	1.86%
Hysterectomy	4	3.92%

TABLE - VII
INDICATIONS FOR HYSTERECTOMY

Ruptured	3	45%
Relaxed Uterus	3	45%
Morbidly adherent Placenta	1	10%
Total:-	7	100%

morbidly adherent placenta. One patient has C. Section for prolonged labour and ended up in hysterectomy for relaxed uterus. (Table VII)

11 patient died of haemorrhage, all due to postpartum haemorrhage A MMR of 3.4/1000 births.

DISCUSSION

Haemorrhage in pregnancy still constitute a major part of the gravest obstetrical emergencies. Antepartum haemorrhage often occurs without prior warning and within minutes a pregnant woman can become exsanguinated to the point of death.⁵ Perinatal mortality is also considerable. It is highest for placental obstruction.⁶ In our series was 303/1000 total births which is almost 30 times more than the international figure. In countries where health care is free and each and every pregnancy is looked after by a consultant unit in collaboration with the area mid wife and general practitioner. All pregnancies are well recorded and arrangements are made in advance if any problem is suspected to arise. Ultra sound at 16 weeks and if required again at 28 and 32 week is a routine practice, so placental localization is done and it makes diagnosis of placenta previa easier, before any bleeding episodes occurs, so steps are taken, to be more careful. Similarly post partum haemorrhages are and can be predicted⁷ before hand. There may be a previous history in most of the cases, history of scar in the uterus, large placenta,

over distended uterus etc. Ultra sound can show abnormally adherent placenta.⁸ If the pregnancy was cared by the obstetrician and delivery conducted in experienced hands, arrangements can be made before hand. Placenta can be delivered in time⁸ any tear stitched¹⁰ blood can be arranged beforehand. All this is only possible if 100% deliveries are supervised by a trained midwife, general practitioner or obstetrician's unit. As we have seen with us, out of 102 cases of PPH only 7 deliveries were conducted in hospital. While 95 had delivered at home without any trained supervisor and had come in emergency with PPH. All the maternal deaths recorded in our series were in postpartum haemorrhage and we needed to do quite a lot in obstetrics. First of all we need to educate the people. Importance of antenatal care is to be stressed, government need to change its policy about health and specially about women care, care of the mother and babies is to be made free and upto the standard. Healthy children will make healthy nation and it is only possible if the mothers are healthy and educated not those ending up in grand multigravidity, obstructed labour, Ruptured uterus, haemorrhage and death.

REFERENCES

1. Department of health Welsh office Scottish home and health department, department of health and social security, Northern Ireland, report on the Confidential enquiries into maternal deaths in the United Kingdom 1985-87 London, Her majesty stationery office 1991.
2. Fraser R, Watson R. Bleeding during the latter half of Pregnancy, effective care in pregnancy and childbirth. Oxford, Oxford University Press 1989.
3. Beazely JM. Complication of third stage of labour. Dewhurst's Textbook of obstetrics and Gynaecology for post graduates 4th edition, 409.

4. Scott JS. Ante partum haemorrhage, Dew-hurst's Text Book of obstetrics and Gynaecology for Post graduates, 4th edition 188.
5. Penna LK, Pearce JM. Placenta Previa, Progress in obstetrics and Gynaecology 11: 161.
6. Mark D. Pearlman and Judith E Tintanlli Evaluation and Treatment of the gravida and fetus following Trauma during pregnancy. Obstetrics and Gynaecology, clinics of South America. Critical Care in obstetrics, 1991; 317.
7. Martin L, Pernall MD. Third Trimester Haemorrhage obstetrics and Gynaecology diagnoses and Treatment, 1994; 7: 390.
8. Pasto ME, et al. Ultrasonic findings in placenta increata, Journal Ultrasound medicine May, 1983; 2: 155.
9. Peter S, Kepernick. Post partum haemorrhage, obstetrical and Gynaecological diagnoses and treatment 1994; 7: 575.
10. Guirgis RR, Kettle MJ, et al. Spontaneous rupture of a nulliparous uterus due to placenta percreata. J. of Obstetrics and Gynaecology 1989; 9: 216.