Guideline Developer(s)
American College of Obstetricians and Gynecologists

Date Released
2006 Oct (reaffirmed 2013)

Full Text Guideline
Postpartum hemorrhage. (mailto:sales@acog.org)

Evidence Supporting the Recommendations

- Type of Evidence Supporting the Recommendations
  The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

Implementation of the Guideline

- Description of Implementation Strategy
  An implementation strategy was not provided.

- Implementation Tools
  Audit Criteria/Indicators

Benefits/Harms of Implementing the Guideline Recommendations

- Potential Benefits
  Appropriate evaluation and management of women with postpartum hemorrhage

- Potential Harms
  - Undiluted rapid oxytocin IV infusion causes hypotension.
  - Care must be taken in performing curettage to avoid perforation of the uterus.

Rating Scheme for the Strength of the Recommendations

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.
Level B — Recommendations are based on limited or inconsistent scientific evidence.
Level C — Recommendations are based primarily on consensus and expert opinion.

Qualifying Statements

Qualifying Statements
These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Methodology

Methods Used to Collect/Select the Evidence
Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence
2006 Original Document
The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists’ own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1901 and June 2006. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

2013 Reaffirmation
The NCBI database was searched from 2006 to 2013. Committee members conducted a literature search with the assistance from the ACOG Resource Center staff who routinely perform the Practice Bulletin literature searches.

Number of Source Documents
Not stated

Methods Used to Assess the Quality and Strength of the Evidence
Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence
Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Methods Used to Analyze the Evidence
Systematic Review
Description of the Methods Used to Analyze the Evidence
Not stated

Methods Used to Formulate the Recommendations
Expert Consensus

Description of Methods Used to Formulate the Recommendations

2006 Original Document
Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician–gynecologists were used. See also the “Rating Scheme for the Strength of Recommendations” field regarding Grade C recommendations.

2013 Reaffirmation
The Committee on Practice Bulletins - Obstetrics met in October 2013 and reaffirmed this document. A committee member reviewed the document and new literature on the topic. The document was then reviewed by the committee and the committee agreed that it is current and accurate.

Cost Analysis
A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation
Internal Peer Review

Description of Method of Guideline Validation
Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician–gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

Identifying Information and Availability

Bibliographic Source(s)

Adaptation
Not applicable: The guideline was not adapted from another source.

Source(s) of Funding
American College of Obstetricians and Gynecologists (ACOG)

Guideline Committee
American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Obstetrics

Composition of Group That Authored the Guideline
Not stated

Financial Disclosures/Conflicts of Interest
Not stated

Guideline Status
This is the current release of the guideline.

The American College of Obstetricians and Gynecologists (ACOG) reaffirmed the currency of the guideline in 2013.

Guideline Availability
Electronic copies: None available
Availability of Companion Documents
Proposed performance measures are included in the original guideline document.

Patient Resources
None available

NGC Status
This NGC summary was completed by ECRI Institute on August 2, 2007. The information was verified by the guideline developer on September 10, 2007. This summary was updated by ECRI Institute on March 21, 2008 following the FDA advisory on Erythropoiesis Stimulating Agents. This summary was updated by ECRI Institute on August 15, 2008 following the U.S. Food and Drug Administration advisory on Erythropoiesis Stimulating Agents (ESAs). This summary was updated by ECRI Institute on April 1, 2010 following the U.S. Food and Drug Administration advisory on Erythropoiesis-Stimulating Agents (ESAs). The currency of the guideline was reaffirmed by the developer in 2008 and this summary was updated by ECRI Institute on November 30, 2011. The currency of the guideline was reaffirmed by the developer in 2013 and this summary was updated by ECRI Institute on March 7, 2014.

Copyright Statement
This NGC summary is based on the original guideline, which is subject to the guideline developer’s copyright restrictions.

Scope

Disease/Condition(s)
Postpartum hemorrhage

Guideline Category
Evaluation
Management
Treatment

Clinical Specialty
Emergency Medicine
Family Practice
Obstetrics and Gynecology

Intended Users
Physicians

Guideline Objective(s)
• To aid practitioners in making decisions about appropriate obstetric and gynecologic care
• To review the etiology, evaluation, and management of postpartum hemorrhage

Target Population
• Women during the first 24 hours after delivery (at risk for primary postpartum hemorrhage), especially those with:
  • Uterine atony
  • Retained placenta—especially placenta accreta
  • Defects in coagulation
  • Uterine inversion
• Women between 24 hours and 6–12 weeks after delivery (at risk for secondary postpartum hemorrhage), especially those with:
  • Subinvolution of placental site
  • Retained products of conception
  • Infection
Inherited coagulation defects
• Women with other risk factors for postpartum hemorrhage

**Interventions and Practices Considered**

**Evaluation/Management**

1. Multi-disciplinary approach with high clinical suspicion
2. Laboratory evaluation of lost blood
3. Testing for bleeding disorders among patients with menorrhagia
4. Medical management, including use of uterotonic agents
5. Exploratory laparotomy
6. Ultrasonography
7. Drainage of hematomas
8. Uterine compression or massage
9. Tamponade: packing of the uterine cavity, Foley catheter insertion, Sengstaken-Blakemore tube insertion, SOS Bakri tamponade balloon use
10. Surgical management, including uterine curettage and hysterectomy
11. Arterial ligation or embolization
12. Blood component therapy (donor or autologous): packed red cells, platelets, fresh frozen plasma, cryoprecipitate
13. Manual replacement of the uterine corpus
14. Antibiotics

**Poststabilization Management**

1. Prenatal vitamin and mineral capsules
2. Additional iron tablets
3. Erythropoietin

**Major Outcomes Considered**

• Time to cessation of bleeding
• Incidence of serious sequelae (adult respiratory distress syndrome, coagulopathy, shock, loss of fertility, and pituitary necrosis)
• Loss of fertility
• Mortality

**Recommendations**

**Major Recommendations**
The grades of evidence (I-III) and levels of recommendations (A-C) are defined at the end of the "Major Recommendations" field.

The following recommendations and conclusions are based primarily on consensus and expert opinion (Level C):

• Uterotonic agents should be the first-line treatment for postpartum hemorrhage due to uterine atony.
• Management may vary greatly among patients, depending on etiology and available treatment options, and often a multidisciplinary approach is required.
• When uterotonics fail following vaginal delivery, exploratory laparotomy is the next step.
• In the presence of conditions known to be associated with placenta accreta, the obstetric care provider must have a high clinical suspicion and take appropriate precautions.

**Definitions**

**Grades of Evidence**

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Levels of Recommendations

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

Clinical Algorithm(s)
None provided

Contraindications

Contraindications
- Relative contraindication for 15-methylprostaglandin F$_{2a}$ in patients with hepatic, renal, and cardiac disease. Diarrhea, fever, tachycardia can occur.
- Avoid methylergonovine if patient is hypertensive.
- Avoid 15-methylprostaglandin F$_{2a}$ in asthmatic patients.
- Avoid dinoprostone if patient is hypotensive. Fever is common.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need
Getting Better

IOM Domain
Effectiveness
Timeliness

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