

Assessment of possible causes of obstetric bleeding in Uzbekistan's condition

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Abstract: This article summarizes our own analysis and literature data, which show the need to comply with the strategy for monitoring critical conditions, in particular obstetric hemorrhages - the need for an active response to the current situation in the medical institution, early detection and treatment of conditions in order to minimize their consequences, quality control and providing medical assistance to reduce mortality and morbidity, strict adherence to regional standards, protocols orders and orders.

Keywords: pregnancy, obstetric hemorrhage, action algorithm, oxytocin.

INTRODUCTION

Obstetric bleeding, as the cause of maternal morbidity and mortality, for a long period is one of the leading places in the world. According to the majority of experts, this pathology is among the five main causes of maternal mortality, annually taking away more than one hundred thousand lives. The insidiousness and impetuous nature of the development of this pathology is known to every practicing obstetrician-gynecologist, which makes it very important to treat the appearance of the slightest signs of bleeding, to take decisive measures in the event of the development of a complete clinical picture.

According to WHO, there are 14,000,000 postpartum haemorrhages per year in the world of which 120,000 to 14,000 are fatal (50% in the first 24 hours) and 20,000,000 result in maternal morbidity. According to the opinion of the researchers, the incidence of postpartum haemorrhage is approximately 6%, and severe postpartum haemorrhage - 1.86%, and in different countries this indicator varies greatly. In the United States, blood loss is 12% in the structure of maternal mortality, 73% of which are preventable, in the UK - the third place in the structure of maternal mortality, 53% - preventable, and in Africa - blood loss reaches 60% in the structure of maternal mortality, in

Russia -18% in the structure of maternal mortality. For countries of the former Soviet Union, a characteristic that worries specialists is the structure of the causes of maternal mortality, more typical for developing countries: it is dominated by direct causes, primarily bleeding (up to 22% according to 2006 data), preeclampsia and eclampsia (17%), sepsis (12.4%), etc. Indirect causes are only 21.5%. The literature and randomized studies suggest that the majority - up to 80% - of maternal deaths from direct causes are preventable with timely and properly provided care. First of all, this refers to maternal deaths from bleeding. Given that most of the causes of massive hemorrhage and hemorrhagic shock in obstetrics are preventable, it is extremely important to follow the protocol of emergency treatment for this category of patients,

since the time for all diagnostic and treatment activities is extremely limited.

MATERIALS AND METHODS

To analyze the possible causes of bleeding, we analyzed 21 stories of childbirth complicated by this pathology, which amounted to 2.3% of all births.

Of these, 4 cases (19.1%) were obstetric haemorrhages in pregnancy (premature detachment of the normally located placenta, 17 cases (80.1%) postpartum haemorrhages.) All bleeding occurred in the early postpartum period: 16 cases (76.2) after delivery through the natural birth canal, 3 cases (14.3%) after operation, cesarean section In assessing the risk factors for postpartum haemorrhage in this group of patients, 11 pregnant women (52.4%) had low risk when entering the hospital, the average risk was 6 pregnant (28.6%), high - 4 pregnant (19.0%).

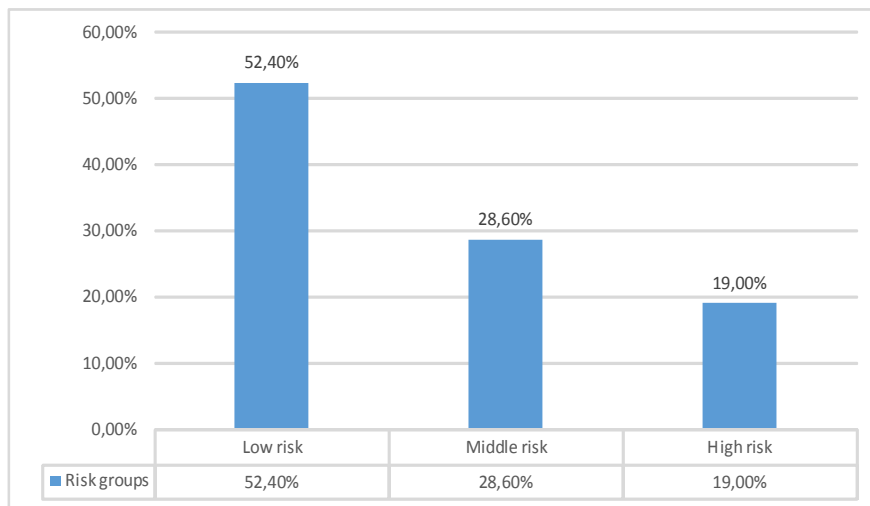


Fig.1 Risk groups for postpartum hemorrhage

RESULTS

At parity: primiparous made up 28.6% (6 patients), the recurrent - 71.4% (15 patients). Weighed obstetrical anamnesis (abortions, miscarriages with scraping of the uterine cavity, purulent-septic

complications after previous births) had 4 pregnancies, which was 19.05%, in the remaining patients the history was not burdened. Premature birth occurred in 2 cases - 9.52%, in all other cases all deliveries were urgent.

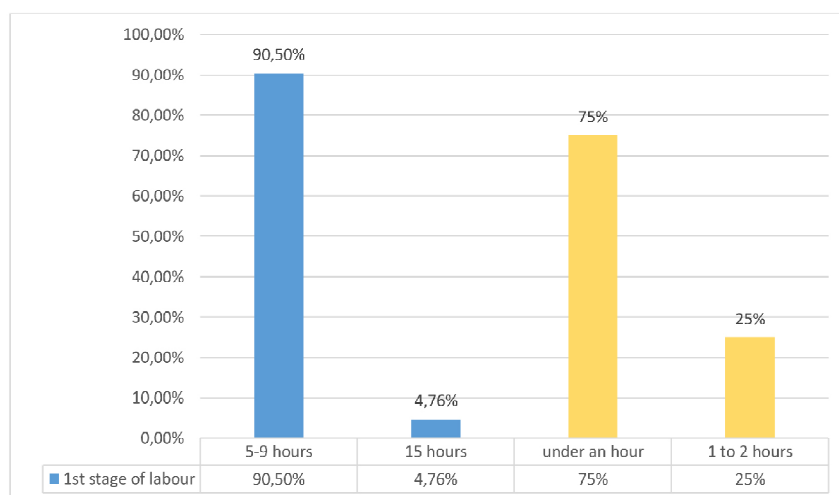
Induced labor in 4 cases (19.05%): in 1 case - prenatal rupture of membranes, in 2 cases - pre-eclampsia of mild degree, in 4 cases - gestation period more than 41 weeks. Of these, in 2 cases, the preparation of the cervix of the uterus with mesoprostol by intravaginal method (from 25 to 75 mg), induction of oxytocin in 2 cases. Of all the induced births, 9.52% of births were complicated by hemorrhage. Epidural anesthesia during labor was performed in 3 cases, which was 14.3%.

In 2 cases (9.52%), 1 the period of

labor was complicated by the secondary weakness of labor, rhytostimulation with oxytocin was carried out for 4 hours 30 minutes.

Analyzing the duration and the course of the generic act on the provided documentation, we obtained data that for the duration of the first birth period, 90.5% of the parturient women whose labor began spontaneously, was from 5 to 9 hours, in 1 case (4.76%) - 15 hours, 2 the period of childbirth was 75% less than 1 hour, in 25% - 1 to 2 hours.

Fig 2. Duration and course of the labour act:



The third stage of labor is the most dynamic, unpredictable and responsible, requiring maximum concentration from medical personnel. At first glance, this issue is well studied, because it is associated with the threat of bleeding and maternal mortality. However, practice shows that the maintenance of the third stage of childbirth remains an urgent issue, which is determined by the difficulties of practical implementation of the basic provisions of classical obstetrics.

The unresolved issues of the third period of labor caused the introduction of the concept of active management in

obstetric practice. Previously, it was believed that the risk of postpartum bleeding increases if the duration of the third period exceeds 30 minutes. Studies of recent years have shown that the optimal time for manual removal of the placenta for the prevention of postpartum hemorrhage is 18 min after the birth of the child. It was noted that the duration of the third period of labor for more than 10 minutes statistically significantly increases the risk of postpartum hemorrhage.

The WHO strategy is the only effective method of preventing postpartum

hemorrhages in the world is the active management of the III period of labor. It should be offered and recommended for all women.

With this tactic, the incidence of postpartum and early postpartum haemorrhage is 2.5-3 times lower. According to modern recommendations of Russian scientists, at present active tactics of conducting the third period of labor is recognized as the main method of preventing postpartum hemorrhage, and its main link is the use of uterotonics, among which the first-line drug is oxytocin. According to Radzinsky's data, V.E. [2011], the routine administration of oxytocin in the post-test period has become the "gold standard" for the prevention of postpartum haemorrhage. Studies conducted Chernukha EA. (2005) with the use of active labor management tactics show that the frequency of bleeding in this case is 1.6%.

The stage of active management of the third period of labor is a controlled traction for the umbilical cord, at which the blood loss and shortening of the third stage of labor decreases. In the opinion of Radzinsky V.E. (2011), supporters and opponents of controlled traction for the umbilical cord strictly equal. The use of controlled tractions for the umbilical cord reduces the risk of bleeding by 50% compared with expectant management, and when combined controlled traction with the administration of oxytocin, the risk of bleeding decreases by 66%. It was noted that the duration of the third period of labor for more than 10 minutes statistically significantly increases the risk of postpartum hemorrhage.

All the patients under study with postpartum hemorrhage had active

management of the 3rd stage of labor, with a duration of 5-10 minutes. This method, according to the clinical protocols of the Ministry of Health of the RK, was conducted with the informed consent of the mother in childbirth. For actively lead the third period of labor, the personnel assisting the woman in labor must have the necessary knowledge and skills - the technique of conducting it plays a special role in the effectiveness of controlled traction. If improperly conducted, it is the cause of formidable complications. The analysis showed that in 4 cases (22.2%) of the defect of the afterbirth, manual separation and isolation of the delayed parts of the afterbirth was carried out. Therefore, active management of the third period of labor and training of doctors and midwives with the knowledge and skills necessary for the prevention and treatment of obstetric hemorrhages can significantly reduce maternal mortality.

The amounts of bleeding recorded after delivery through the natural birth canal range from 600.0 to 1100.0 ml. Massive hemorrhages of more than 1200.0 were not. The volumes of bleeding registered after the operation by cesarean section were 1 case in the planned order - 1000.0 ml (50%), 1 case in emergency order - massive bleeding 1300.0 ml (50%). By the time of occurrence: 1 case - during the operation, 1 case - in the early postoperative period. Indications for surgery was a scar on the uterus after a previous operation by caesarean section. In 1 case, bleeding is intraoperatively stopped by applying a haemostatic suture to the uterine arteries by the O-Lery method, in 2 cases - conservative hemostasis by administration of oxytocin 30ED.

CONCLUSION

1. At all stages of pregnancy (and sometimes before its onset), it is necessary to identify risk factors for massive blood loss, both at the outpatient and inpatient level of care for pregnant women.

2. At the pre-hospital stage in a patient with a bleeding, the main activity is transportation to the nearest hospital with the possibility of surgical treatment. Providing venous access and carrying out infusion therapy, the introduction of antifibrinolytic drugs and vasopressors, warming and other measures should not extend the transportation time to the stage of surgical stop of bleeding. At the pre-hospital stage, if there is a hemorrhagic shock, the hospital should be notified in time, where the patient will be transported to prepare for surgical and conservative treatment.

3. When a hospital patient with bleeding (or suspected hemorrhage) arrives at a hospital inpatient, it is necessary to conduct clinical, laboratory and functional studies as quickly as possible to assess the severity of blood loss and determine the need for surgical treatment. In case of a serious condition of the patient - hemorrhagic shock, all studies are performed in the conditions of operating and intensive therapy.

4. In any situation, the time between the diagnosis of bleeding and the beginning of a surgical stop of bleeding should be minimized and this principle is very important to be carefully observed at both the prehospital and hospital stages of care (level of evidence: 1A). Operative treatment should be started in any conditions - hemorrhagic shock, DIC-syndrome, etc. and no circumstances can interfere with the surgical stop of bleeding.

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