

MANAGEMENT OF THE THIRD STAGE OF LABOUR TO PREVENT POSTPARTUM HEMORRHAGE

This International Joint Policy Statement was developed by the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO), and was reviewed and is endorsed by the Society of Obstetricians and Gynaecologists of Canada.

The International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) are key partners in global Safe Motherhood efforts to reduce maternal death and disability in the world. Their mission statements share a common commitment in promoting the health, human rights, and well-being of all women, most especially those at greatest risk for death and disability associated with childbearing. FIGO and ICM promote evidence-based, effective interventions that, when used properly with informed consent, can reduce the incidence of maternal mortality and morbidity in the world.

Severe bleeding is the single most important cause of maternal death worldwide. More than half of all maternal deaths occur within 24 hours of delivery, mostly from excessive bleeding. Every pregnant woman may face life-threatening blood loss at the time of delivery; women with anemia are particularly vulnerable since they may not tolerate even moderate amounts of blood loss. Every woman needs to be closely observed and, if needed, stabilized during the immediate postpartum period.

Upon review of the available evidence, FIGO and ICM agree that active management of the third stage of labour is proven to reduce the incidence of postpartum hemorrhage (PPH), the quantity of blood loss, and the use of blood transfusion.

Active management of the third stage of labour should be offered to women since it reduces the incidence of postpartum hemorrhage due to uterine atony.

Active management of the third stage of labour consists of interventions designed to facilitate the delivery of the placenta by increasing uterine contractions and to prevent PPH by averting uterine atony. The usual components include:

- administration of uterotonic agents
- controlled cord traction

Key Words

Postpartum hemorrhage, uterine atony, maternal mortality, oxytocin, misoprostol, ergometrine

- uterine massage after delivery of the placenta, as appropriate

Every attendant at birth needs to have the knowledge, skills, and critical judgment to carry out active management of the third stage of labour, as well as access to required supplies and equipment.

In this regard, national professional associations have an important and collaborative role to play in:

- advocacy for skilled care at birth
- dissemination of this statement to all members of the organization and facilitation of its implementation
- public education about the need for adequate prevention and treatment of postpartum hemorrhage
- publication of the statement in national midwifery, obstetric, and medical journals, newsletters, and Web sites
- addressing legislative and other barriers that impede the prevention and treatment of postpartum hemorrhage
- incorporation of active management of the third stage of labour in national standards and clinical guidelines, as appropriate
- incorporation of active management of the third stage into pre-service and in-service curricula for all skilled birth attendants
- working with national pharmaceutical regulatory agencies, policy makers, and donors to assure that adequate supplies of uterotonics and injection equipment are available

HOW TO USE UTEROTONIC AGENTS

1. Within one minute of the delivery of the baby, palpate the abdomen to rule out the presence of an additional baby or babies and give oxytocin 10 units intramuscularly (IM). Oxytocin is preferred over other uterotonic drugs because it is effective 2 to 3 minutes after injection, has minimal side effects, and can be used in all women.

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2. If oxytocin is not available, other uterotonics can be used, such as ergometrine 0.2 mg IM, Syntometrine (1 ampoule) IM, or misoprostol 400–600 µg orally. Oral administration of 600 µg misoprostol should be reserved for situations when safe administration and appropriate storage conditions for injectable oxytocin and ergot alkaloids are not possible.
3. Uterotonics require proper storage:
 - ergometrine: keep at 2–8°C and protect from light and freezing
 - misoprostol: keep at room temperature, in a closed container
 - oxytocin: keep at 15–30°C, protect from freezing
4. Counselling on the side effects of these drugs should be given.

Warning! Do not give ergometrine or Syntometrine (because it contains ergometrine) to women with preeclampsia, eclampsia, or high blood pressure.

HOW TO DO CONTROLLED CORD TRACTION

1. Clamp the cord close to the perineum (once pulsation stops in a healthy newborn) and hold in one hand.
2. Place the other hand just above the woman's pubic bone and stabilize the uterus by applying counter-pressure during controlled cord traction.
3. Keep slight tension on the cord and await a strong uterine contraction (2–3 minutes).
4. With the strong uterine contraction, encourage the mother to push and very gently pull downward on the cord to deliver the placenta. Continue to apply counter-pressure to the uterus.
5. If the placenta does not descend during 30–40 seconds of controlled cord traction, do not continue to pull on the cord:
 - gently hold the cord and wait until the uterus is well contracted again
 - with the next contraction, repeat controlled cord traction with counter-pressure

Never apply cord traction (pull) without applying counter traction (push) above the pubic bone on a well-contracted uterus.

6. As the placenta delivers, hold the placenta in two hands and gently turn it until the membranes are twisted. Slowly pull to complete the delivery.
7. If the membranes tear, gently examine the upper vagina and cervix wearing sterile/disinfected gloves and use a sponge forceps to remove any pieces of membrane that are present.
8. Look carefully at the placenta to be sure none of it is missing. If a portion of the maternal surface is missing or there are torn membranes with vessels, suspect retained placenta fragments and take appropriate action.¹

HOW TO DO UTERINE MASSAGE

1. Immediately massage the fundus of the uterus until the uterus is contracted.
2. Palpate for a contracted uterus every 15 minutes and repeat uterine massage as needed during the first 2 hours.
3. Ensure that the uterus does not become relaxed (soft) after uterine massage is stopped.

In all of the above actions, explain the procedures and actions to the woman and her family. Continue to provide support and reassurance throughout.

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REFERENCE

1. Department of Reproductive Health and Research, World Health Organization. Managing complications in pregnancy and childbirth: a guide for midwives and doctors. Geneva:WHO; 2000.