Health & care information you can trust
The Information Standard Certified Member

Royal College of Obstetricians & Gynaecologists

Information for you

Published in December 2016

Heavy bleeding after birth (postpartum haemorrhage)

Who is this information for?

This information is for you if you wish to know about heavy bleeding after the birth of your baby. It may also be helpful if you are a partner, relative or friend of someone who is or who has been in this situation.

What bleeding can I expect after my baby is born?

It is normal to bleed from your vagina after you have a baby. 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 caused during the birth.

Bleeding is usually heaviest just after birth and gradually becomes less over the next few hours. The bleeding will reduce further over the next few days. The colour of the blood should change from bright red to brown over a few weeks. This vaginal bleeding is called the lochia and it will usually have stopped by the time your baby is 12 weeks old.

Sometimes bleeding during or after birth is heavier than normal.

What is a postpartum haemorrhage (PPH)?

Postpartum haemorrhage (PPH) is heavy bleeding after birth. PPH can be primary or secondary:

- **Primary PPH** is when you lose 500 ml (a pint) or more of blood within the first 24 hours after the birth of your baby. Primary PPH can be minor, where you lose 500–1000 ml (one or two pints), or major, where you lose more than 1000 ml (more than two pints).
- **Secondary PPH** occurs when you have abnormal or heavy vaginal bleeding between 24 hours and 12 weeks after the birth.

How could a PPH affect me?

If you lose a lot of blood, it can make you anaemic and worsen the normal tiredness that all women feel after having a baby. (See the entry for 'anaemia' in the 'Medical terms explained' section of the RCOG website: www.rcog.org.uk/en/patients/medical-terms.)

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

Who is at risk of primary PPH?

The table below shows the risk factors associated with primary PPH. Even if some apply to you, it is important to remember that most women with these risks factors will *not* experience a haemorrhage after giving birth.

In fact, most women who have a primary PPH have no identifiable risk factors. However, if you do have any of these risk factors you may be advised to have your baby in a hospital setting where there is access to blood transfusion if you need it.

	Risk factors for primary PPH
Before the birth	• known 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 • carrying twins or triplets • pre-eclampsia and/or high blood pressure • having had a PPH in a previous pregnancy • having a BMI (body mass index) of more than 35 • anaemia • fibroids • blood clotting problems • taking blood-thinning medication
In labour	• delivery by caesarean section • induction of labour • delay in delivery of your placenta (retained afterbirth) • perineal tear or episiotomy (a surgical cut to help delivery) • forceps or ventouse delivery • having a long labour (more than 12 hours) • having a large baby (more than 4 kg or 9 lb) • having your first baby if you are more than 40 years old • having a raised temperature (fever) during labour • needing a general anaesthetic during delivery

Often there is very little that you can do about these factors. However, in some cases, steps can be taken to reduce the risk of having a PPH and also to reduce the likelihood of needing a blood transfusion:

- If you are anaemic during pregnancy, taking iron supplements may reduce the likelihood of needing a blood transfusion. Some women may also be offered iron supplements if they are at risk of

anaemia. If you are very anaemic during pregnancy or find it difficult to take tablets, iron can be given intravenously (through a drip).

- If you have had a previous caesarean section and the placenta attaches itself to the area of the previous scar, leading to placenta accreta/percreta (also known as morbidly adherent placenta), it may not come away easily after birth. This condition is uncommon but it can cause major haemorrhage. If this is suspected on your ultrasound scan, you may be offered additional scans. Your healthcare team will discuss your options with you and make a plan for your care.

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?

If you have a vaginal birth, you should be offered an injection into your thigh just as the baby is born to help reduce blood loss. This injection helps the placenta to come away from the womb. Once your placenta has been delivered, you will be examined for any tears. If the tears are bleeding heavily, they will be stitched to reduce any further blood loss.

If you have a caesarean section, the same injection will be given and your placenta will be removed through the caesarean incision.

If you are known to be at high risk for PPH, you may be given additional medications to help reduce the amount you may bleed.

What happens if I have a primary PPH?

If you have had your baby at home or in a midwifery-led unit, your midwife will call for assistance and arrange your transfer to hospital.

If you give birth in hospital, your midwife will push the emergency bell to call other members of staff into the room to help. It can happen quickly and people rushing into the room may be frightening for you and your birth partner. Your midwife will tell you and your partner what is happening and why.

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

The midwife or doctor 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 warm fluids after taking some blood for testing
- check to make sure that all of 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 and you will stay on the labour ward until the bleeding has settled. You can breastfeed if you wish.

What happens if I continue to bleed very heavily?

If heavy bleeding continues and you have lost more than 1000 ml (two pints) of blood, a team of senior hospital staff will be involved in your care.

Medications may be given as an injection or via the back passage 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. This procedure is done by a specially trained radiologist (X-ray doctor). It involves injecting small particles via a thin tube (catheter) under X-ray guidance to block the blood supply to the womb.

Once your bleeding is under control, you will either be transferred back to the labour ward or you may be transferred to an intensive care or high-dependency 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). For more information, see the RCOG patient information *Healthy eating and vitamin supplements in pregnancy* (www.rcog.org.uk/en/patients/patient-leaflets/healthy-eating-and-vitamin-supplements-in-pregnancy).

You may be offered daily blood-thinning injections (heparin) and compression stockings to wear for 10 days 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 teach you and your birth partner how to do the injections yourself.

You and your birth partner may have found the experience distressing and it is often helpful to talk through the events. You will have the opportunity to discuss what has happened before you leave the hospital. You may be offered, or you can request, a further meeting with a senior member of the team who looked after you.

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. You can also find helpful contacts for support through the Maternal Mental Health Alliance: maternalmentalhealthalliance.org/contact/help.

What about future births?

If you have had a birth that was complicated by a primary PPH, there is an increased risk of PPH in future births. This is why you will be advised to have your baby in a consultant-led maternity unit. During pregnancy you may be advised to take iron supplements to reduce the chance of becoming anaemic. You should discuss your birth options with your healthcare team.

When you are in the hospital and in labour, you may have blood tests and a drip may be inserted into your arm so that fluids and medication can be given if needed. You will be offered medication to help the placenta come away and reduce the risk of a PPH.

What happens if I have a secondary PPH?

Secondary PPH is often associated with infection in the womb. Occasionally it may be associated with some placental tissue remaining in your womb. 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 usually 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 delivery.
- Women at high risk of haemorrhage will be advised to have their baby in a hospital setting.
- Sometimes bleeding is much heavier than normal and this is called postpartum haemorrhage (PPH). It is important to remember that the majority of women will *not* experience a haemorrhage after giving birth. If bleeding is very heavy, it is important to act quickly.
- In the majority of cases, heavy bleeding will settle with simple measures.
- Staff should keep you and your birth partner informed of what is happening at all times.
- Once you have recovered, you should be offered an opportunity to discuss what has happened and you can ask for further support from your healthcare team.

Further information

patient.info – 'Postpartum Haemorrhage': patient.info/doctor/postpartum-haemorrhage

netdoctor.co.uk – 'I suffered with postpartum haemorrhage': www.netdoctor.co.uk/ate/womenshealth/207160.html

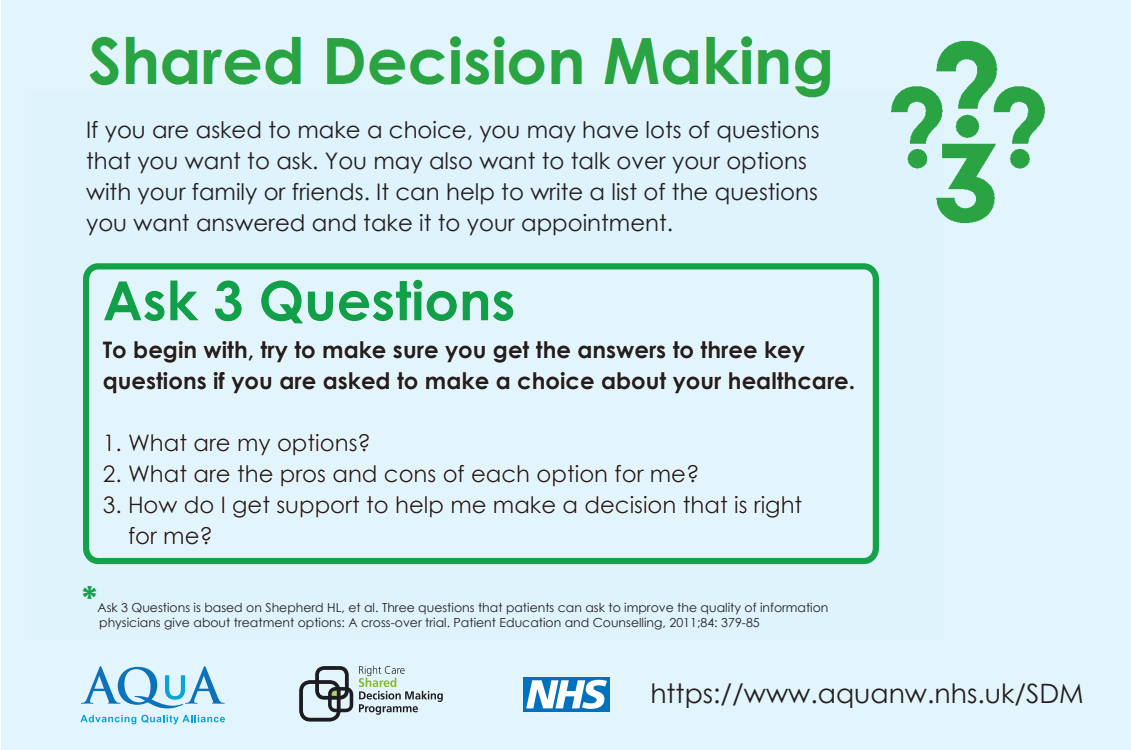
RCOG patient information *Blood transfusion, pregnancy and birth*: www.rcog.org.uk/en/patients/patient-leaflets/blood-transfusion-pregnancy-and-birth

RCOG patient information *A low-lying placenta (placenta praevia) after 20 weeks*: www.rcog.org.uk/en/patients/patient-leaflets/a-low-lying-placenta-after-20-weeks-placenta-praevia

Birth Trauma Association: www.birthtraumaassociation.org.uk

Maternal Mental Health Alliance: maternalmentalhealthalliance.org/contact/help

Making a choice



Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Guideline *Prevention and Management of Postpartum Haemorrhage*, which you can find online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg52.

This leaflet was reviewed before publication by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms.