this & that

13

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.

Third Stage of Labour

& postpartum haemorrhage

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Prevention & management

Verified against ACOG · SMFM · RCOG/NICE · SOGC · WHO — October 2026

Third stage of labour & postpartum haemorrhage

At a glance: the numbers to remember

300 / 500 mL	1 g × 2	30 / 60 min	8 doses	>2 g/L
WHO 2025: start first response (≥300 mL + abnormal sign, or ≥500 mL)	TXA IV within 3 h; repeat after 30 min if bleeding	retained placenta: active / physiological third stage	carboprost 250 µg maximum (2 mg)	fibrinogen target in major PPH

Scope: third stage after vaginal and caesarean birth, primary and secondary PPH. Doses are for adults; check your formulary. Where societies disagree, each position carries the society name; follow your local protocol. Abbreviations are listed in Section 13.

01 Definitions

	ACOG	RCOG / NICE	WHO / FIGO 2025	SOGC
Primary PPH	≥1000 mL, or any loss with signs of hypovolaemia, within 24 h, any route	≥500 mL within 24 h; minor 500–1000, major >1000 (moderate 1001–2000, severe >2000)	Treat when ≥300 mL + abnormal sign, or ≥500 mL; measure objectively	Staged by measured loss: 500–1000 (CS 1000), 1000–1500, >1500
Abnormal signs	Hypovolaemia	Lower volumes matter if weight <60 kg	Pulse >100, SBP <100, DBP <60, shock index >1	—
Secondary PPH	24 h to 12 weeks	24 h to 12 weeks	—	—
Prolonged third stage	—	>30 min active, >60 min physiological (NICE)	—	Expedite if not delivered by 30 min

- Atony causes ≈80% of PPH; think tone, trauma, tissue, thrombin in every case.
- Pulse and BP hold until ≈30% of volume is lost (MBRRACE). Pre-eclampsia hides it further: a smaller circulating volume and a 'normal' BP that is really low (Williams).
- Visual estimates under-read. Weigh pads, swabs and drapes (1 g ≈ 1 mL) and use calibrated drapes (ACOG CO 794, WHO).

02 Risk assessment & prevention

IF	THEN
Every woman	• Assess PPH risk antenatally, on admission and after birth (AIM, NICE) • Antenatal: previous PPH >1000 mL, PAS, pre-eclampsia, Hb <85 g/L, BMI >35, grand multiparity, APH, overdistension, uterine anomaly, low-lying placenta • Intrapartum: induction or augmentation, long 1st or 2nd stage, sepsis, precipitate labour, OVD or CS, shoulder dystocia, SSRI/SNRI in last month (NICE)
Vaginal birth, active management	• **Oxytocin 10 IU IM** (or 5 IU slow IV over 3–5 min; NICE) straight after the birth, before cord clamping • WHO: oxytocin preferred; carbetocin 100 µg IM/IV or misoprostol 400–600 µg oral are alternatives • Clamp the cord after 1 min (not earlier unless the baby needs resuscitation), and within 5 min if using controlled cord traction • Controlled cord traction (Brandt–Andrews manoeuvre) only after oxytocin and signs of separation

IF	THEN
Risk factors for PPH, no hypertension	• **NICE/RCOG:** oxytocin 5 IU + ergometrine 500 µg IM (Syntometrine), with an antiemetic • **WHO 2025:** ergometrine and oxytocin-ergometrine are no longer recommended for prevention; oxytocin or carbetocin
Caesarean birth	• **NICE NG235:** carbetocin 100 µg slow IV (NG192 still says oxytocin 5 IU slow IV) • **SOGC:** carbetocin 100 µg IV over 30–60 s first-line at CS • **RCOG / ACOG:** oxytocin 5 IU slow IV, or IV infusion
Prophylactic TXA?	• **WHO 2025:** not recommended at vaginal or caesarean birth (judgement in selected high-risk women) • **ACOG:** not routine at CS. **RCOG 2016:** consider 0.5–1 g IV at CS for increased risk. **SOGC:** consider for high risk • Trials: TRAAP (vaginal) RR 0.83, NS; TRAAP2 (CS) less calculated loss, no clinical difference; MFMU 2023 (CS) no benefit, more infection; WOMAN-2 (anaemic) RR 1.05
Anaemia in pregnancy	Treat before birth; IV iron when oral fails or time is short (WHO 2025). A woman with Hb <85 g/L tolerates bleeding badly.
After oxytocin was given	No sustained uterine massage for prevention (WHO); check tone and loss every 15 min for the first hour or two.

03 Recognising PPH: measure, stage, escalate

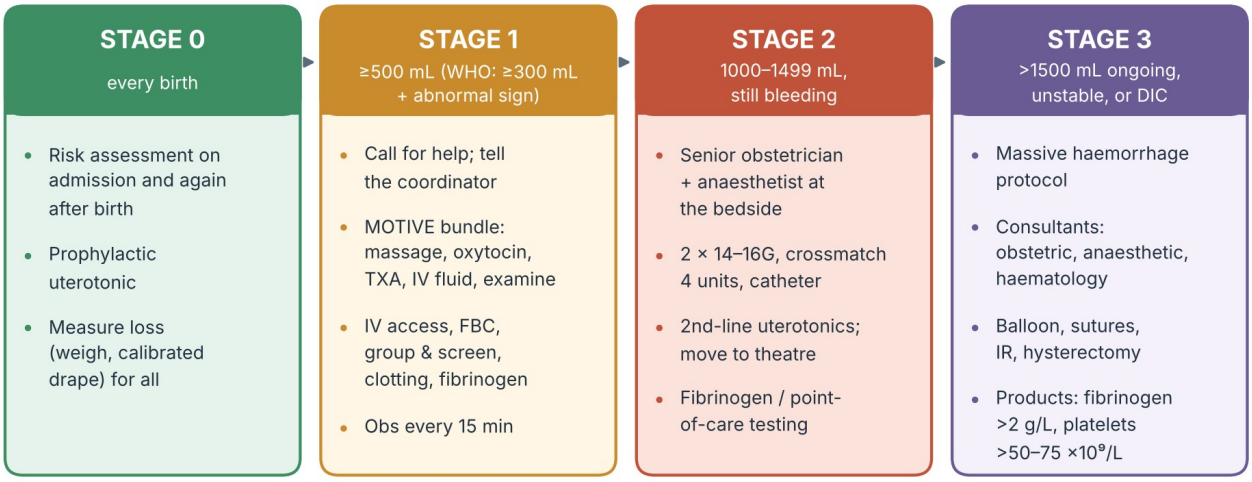


Figure 1. *Staged response by measured blood loss (stages adapted from OBS Cymru, CMQCC and SOGC; WHO trigger shown in stage 1).*

IF	THEN
Bleeding after birth	• Measure, do not guess: weigh pads and swabs, calibrated drape, suction volumes; keep a running total • Obs every 15 min (10 min in stage 2): pulse, BP, RR, SpO_2, temperature, urine output
Shock index (pulse ÷ systolic BP)	• **>1** (WHO) or **≥0.9** (FIGO): abnormal → act and escalate • ≥1.4: urgent intervention; ≥1.7: very high risk (El Ayadi)
Uterus rising, pain, tachycardia without visible blood	Concealed bleeding: clot in the uterus, broad ligament or vaginal haematoma, intra-abdominal bleeding. Examine, scan, theatre.

IF	THEN
Bradycardia with bleeding	Do not be reassured: vagal response to clot in the cervix or lower segment (Dewhurst). Examine.
Loss >1500 mL and continuing	Consultant obstetrician attends; formal incident review afterwards (RCOG).

04 First response

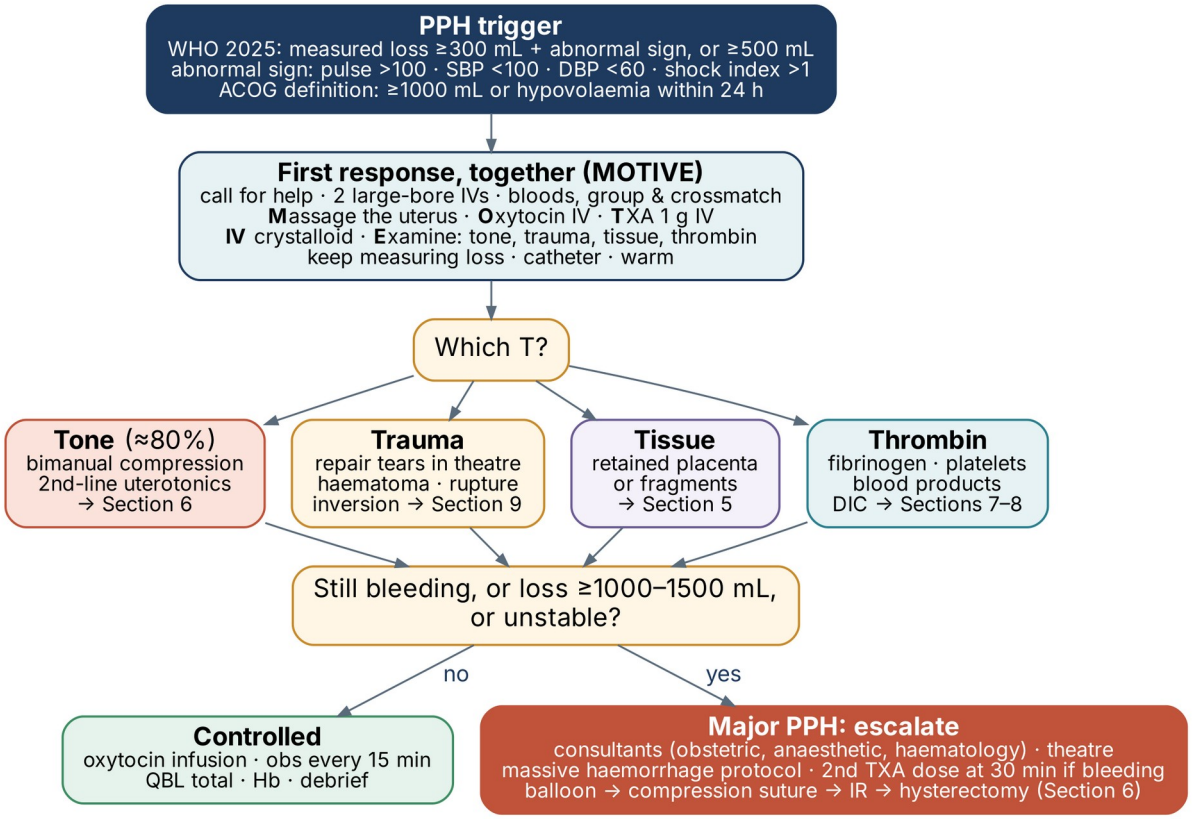


Figure 2. *PPH first response: one bundle, delivered together, then treat the cause.*

IF	THEN
PPH triggered	• **MOTIVE bundle together, not in sequence** (WHO 2025): Massage, Oxytocin, TXA, IV fluids, Examination, Escalation • E-MOTIVE (210,132 births): severe PPH, laparotomy or death 1.6% vs 4.3% (RR 0.40)
Access and bloods	2 × 14–16G; FBC, group and crossmatch 4 units, clotting, fibrinogen, point-of-care test if available; catheter for output. O_2 15 L/min (NICE).
Tranexamic acid	• **1 g IV over 10 min**, as soon as possible and within 3 h of birth; second 1 g if bleeding continues after 30 min or restarts within 24 h • WOMAN: death from bleeding RR 0.81; 0.69 if given within 3 h. No benefit after 3 h (WHO) • IV only: wrong-route (spinal) injection is dangerous (FDA 2025 boxed warning); store away from bupivacaine
Fluids while waiting for blood	• Warmed crystalloid; WHO prefers crystalloid to colloid • RCOG: up to 3.5 L clear fluid in total (≤2 L crystalloid, then ≤1.5 L colloid), no hydroxyethyl starch; then blood

IF	THEN
Placenta still in	Controlled cord traction if separated; otherwise manual removal in theatre (Section 5).

05 Retained placenta

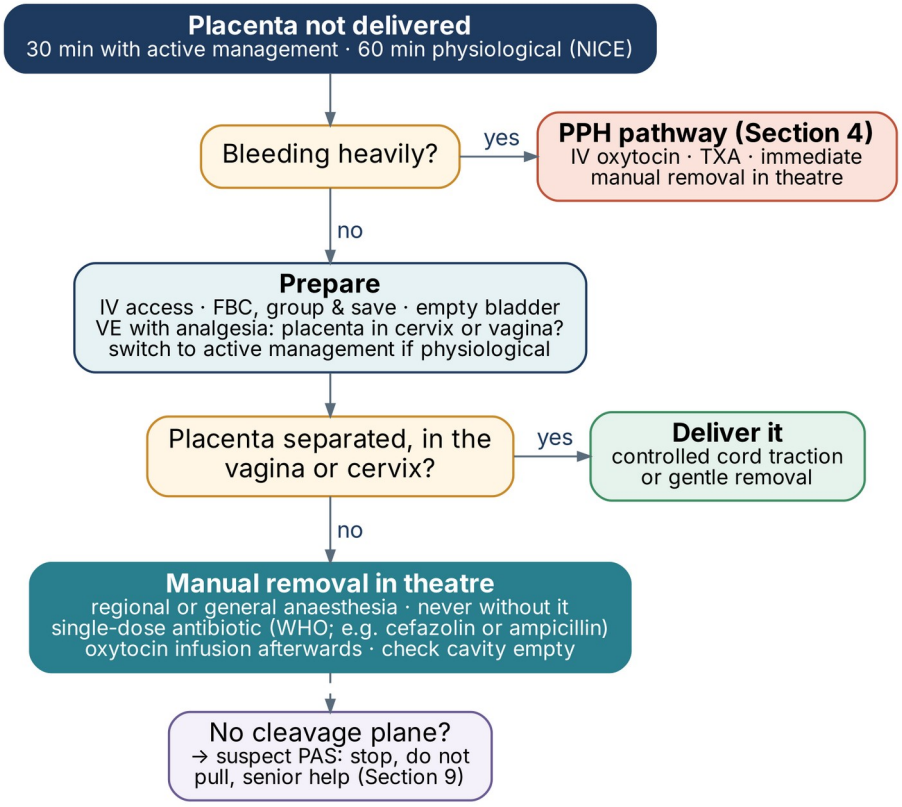


Figure 3. *Retained placenta: bleeding decides the urgency; manual removal only under anaesthesia.*

IF	THEN
Not delivered at 30 min (active) or 60 min (physiological)	• IV access, bloods; physiological → switch to active management (NICE) • VE with analgesia to see whether it lies in the cervix or vagina
No bleeding	• Do not give routine IV oxytocin to deliver it (NICE); WHO: uterotonic only if PPH • Do not inject oxytocin into the umbilical vein: no reduction in manual removal (Release trial, RR 0.98); WHO research only • Do not give GTN to relax the cervix: no benefit, more side effects (GOT-IT)
Manual removal	• In theatre with regional or general anaesthesia; never without (NICE) • Single-dose antibiotic, e.g. ampicillin or cefazolin (WHO recommends; ACOG: evidence neither supports nor refutes) • Oxytocin infusion afterwards; confirm cavity empty
No plane of cleavage	Suspect placenta accreta spectrum: stop, do not pull pieces off, call a senior; prepare for hysterectomy (Section 9).
Preterm birth	Placentas take longer to deliver at early gestation (90% by 21 min at 30 wk, 180 min at 20 wk; Williams). If not bleeding, allow more time.

06 Atony: uterotonics & refractory bleeding

Drug and class	Dose (treatment)	Repeat / max	Avoid if	Watch for
Oxytocin *Oxytocin receptor agonist*	5 IU slow IV (UK) or 10 IU IM; then 40 IU in 500 mL at 125 mL/h (UK) or 10–40 IU in 500–1000 mL (ACOG)	Bolus may be repeated once (RCOG)	—	Hypotension with rapid undiluted bolus; water retention with large volumes
Ergometrine (UK) / methylergonovine (US) *Ergot alkaloid*	Ergometrine 0.5 mg IM or slow IV (UK); methylergonovine 0.2 mg IM (US)	UK: do not repeat (NICE); US: every 2–4 h	Hypertension, pre-eclampsia, cardiac disease; HIV protease inhibitors	Severe hypertension, vomiting
Carboprost (Hemabate) *Prostaglandin F2α analogue*	250 µg deep IM (or intramyometrial at CS)	Every ≥15 min (US 15–90), max 8 doses = 2 mg	Asthma; caution cardiac, renal, liver disease, pulmonary hypertension	Bronchospasm, desaturation, diarrhoea, fever
Misoprostol *Prostaglandin E1 analogue*	800 µg SL (WHO, FIGO, RCOG); ACOG 600–1000 µg SL/PO/PR	Single dose	Already had 600 µg as prophylaxis (FIGO)	Shivering, pyrexia
Carbetocin *Long-acting oxytocin analogue*	Prevention only: 100 µg slow IV/IM	Do not repeat (NICE)	—	Not a treatment drug; not used in the US
Tranexamic acid *Antifibrinolytic*	1 g IV over 10 min within 3 h	Second 1 g after 30 min	Beyond 3 h; IV, never neuraxial	VTE (no excess in WOMAN)

Sequence in RCOG GTG 52: massage and empty bladder → oxytocin → ergometrine → oxytocin infusion → carboprost → misoprostol. Move on early, and give drugs from different classes; do not wait for each to fail fully.

IF	THEN
Drugs failing	**Bimanual compression** while the next drug is drawn up and the team moves to theatre.
Intrauterine balloon	• RCOG: first-line surgical step for atony; ≈85% success (Williams); WHO: only where surgery and blood are immediately available • Bakri: 300–500 mL; keep ≈12–24 h; antibiotics and catheter while in situ • Vacuum device (Jada): 94% control, median 3 min (PEARLE); 92.5% vaginal / 83.7% CS (RUBY registry)
Laparotomy	• Compression suture (B-Lynch): test by bimanual compression first; rapidly absorbable suture • Uterine or internal iliac ligation by an experienced surgeon; IR embolisation if stable (≈86% success) • Uterine packing with gauze: not recommended (WHO)
Still bleeding	**Hysterectomy sooner rather than later**, ideally with a second consultant (RCOG).
Temporising while help comes	Aortic compression (fist above the umbilicus, or direct at laparotomy); non-pneumatic anti-shock garment where available (WHO).

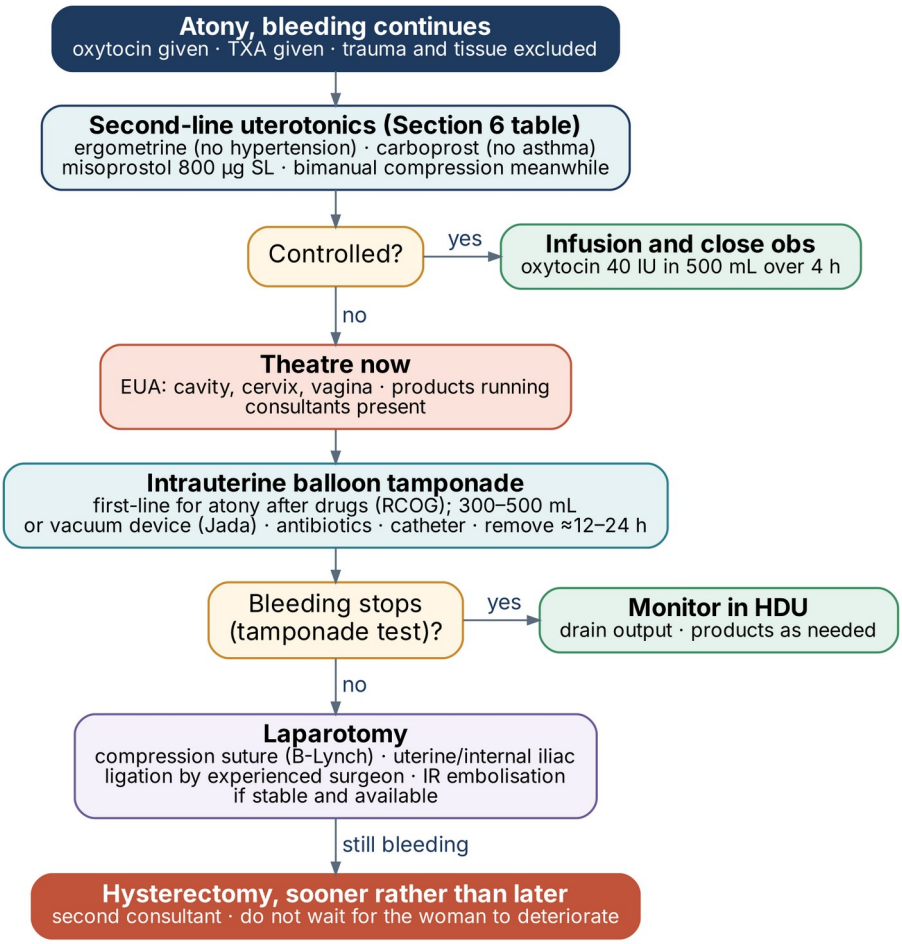


Figure 4. *Refractory atony: from drugs to theatre, tamponade, laparotomy and hysterectomy.*

07 Blood, clotting & massive haemorrhage

IF	THEN
Major PPH, still bleeding	• Activate massive haemorrhage protocol; emergency O RhD-negative, K-negative red cells until crossmatched • Cell salvage at caesarean or laparotomy (RCOG, RCOG 27a)
Targets (RCOG)	Hb >80 g/L · platelets >50 ×10⁹/L (transfuse at 75) · PT and APTT <1.5 × normal · fibrinogen >2 g/L
Fibrinogen	• Fibrinogen ≤2 g/L early in PPH predicts severe bleeding (PPV 100%; Charbit) • Cryoprecipitate 2 pools (raises fibrinogen ≈1 g/L) or fibrinogen concentrate guided by Clauss or FIBTEM (OBS Cymru)
No results yet, still bleeding	• FFP 12–15 mL/kg after 4 units of red cells (RCOG); early FFP in abruption or amniotic fluid embolism • After 8 units: 2 pools cryoprecipitate + 1 pool platelets • Ratios: SOGC 1:1:1 or 2:1:1; ACOG/SMFM (PAS) RBC:FFP:platelets 1:1:1 to 1:2:4
One normal clotting result	Do not withhold clotting products on a single test while bleeding continues (MBRRACE).
Throughout	Keep her warm; check ionised calcium, gases and lactate with each round of products (local MHP).

IF	THEN
Jehovah's Witness	Discuss acceptable products antenatally; cell salvage is often acceptable; involve senior staff early (Dewhurst).

08 Disseminated intravascular coagulation (DIC)

- **Two different problems.** Losing and replacing blood dilutes clotting factors (dilutional coagulopathy). DIC is systemic activation of clotting that uses up fibrinogen and platelets (consumptive coagulopathy). Both can occur together in massive PPH (Williams).
- In abruption and amniotic fluid embolism, DIC comes early and out of proportion to the visible loss: replace products early (SOGC).
- **Fibrinogen is the most useful single test.** It is 3.5–6.5 g/L at term, so a value of 2–3 g/L that is normal outside pregnancy is already low.

Suspect it

IF	THEN
Trigger present	• **Abruption:** the leading cause, about half of obstetric DIC; worst with fetal death (Erez 2014, ISTH registry 2026) • **Amniotic fluid embolism:** DIC in up to 83% (SMFM) • **Massive PPH**, especially atony at caesarean • **HELLP:** DIC in 21% (Sibai); **AFLP:** 80%, with low synthesis as well (Nelson 2014) • **Sepsis:** group A streptococcus, Staphylococcus aureus, clostridia; septic abortion (Williams) • **Retained dead fetus:** about 10% within 4 weeks of fetal death, rising after (RCOG GTG 55)
Bleeding where it should not	• Oozing from cannula and venepuncture sites, wounds, catheter; gum or nose bleeding • Petechiae under the BP cuff or tourniquet (Dewhurst, Williams) • Generalised ooze at surgery: 'the ultimate bioassay' (Williams)

Pertinent labs

Test	Normal at term	Points to DIC	Pitfall
Clauss fibrinogen	3.5–6.5 g/L	≤2 g/L at PPH onset: PPV 100% for severe PPH (Charbit); <1.5 g/L clinically important (Williams)	Falls fast: repeat; do not rely on one value
Platelets	Gestational fall; ≈7% <150 ×10⁹/L	Low or falling; <50 ×10⁹/L severe	Pre-eclampsia also impairs platelet function
PT, APTT	Barely change in pregnancy	PT 0.5–1.5 s above control already counts (Erez); >1.5 × normal: give FFP	A result inside the lab range may still be abnormal
D-dimer, FDP	High; most >0.5 mg/L in the third trimester	Very high, but not specific	Do not use alone to diagnose or exclude DIC
Blood film	—	Schistocytes (fragmented red cells)	Also seen in HELLP, TTP and HUS
ROTEM FIBTEM A5	—	OBS Cymru: ≤11 mm ≈ Clauss 2 g/L; ≤8 mm with the newer Sigma cartridges	Know which cartridge your unit uses
Bedside clot test	Firm clot that retracts in a plain glass tube	Soft clot that fails to retract (Williams)	Use while waiting for the lab, not instead of it

Also send: FBC, group and crossmatch, LFTs, LDH, creatinine, glucose, gases with lactate and ionised calcium.

Pregnancy DIC score (Erez 2014)

Component	0 points	Points
PT difference (patient − control)	<0.5 s	0.5–1 s = 5 · 1–1.5 s = 12 · >1.5 s = 25
Platelets (×10⁹/L)	>185	100–185 = 1 · 50–100 = 2 · <50 = 1
Fibrinogen (g/L)	>4.5	4–4.5 = 1 · 3–4 = 6 · <3 = 25

≥26 = DIC: sensitivity 88%, specificity 96%, LR+ 22 (single-centre, retrospective). Fibrinogen <3 g/L with a PT 0.5 s above control already scores 30. The ISTH overt DIC score (≥5) was built outside pregnancy and is not validated in it.

Is it DIC or something else?

Feature	DIC	HELLP	AFLP	TTP / HUS
Platelets	Low	Low	Low or normal	Very low in TTP (10–30 ×10⁹/L)
PT, APTT	Prolonged	Normal unless DIC or abruption	Prolonged (low synthesis)	Normal
Fibrinogen	Low	Normal	Low; stays low 4–5 days after birth	Normal
Haemolysis	May be present	Yes; LDH high	Mild	Marked; schistocytes
Key clue	A trigger (abruption, embolism, sepsis, PPH)	Hypertension; raised ALT/AST	Hypoglycaemia, raised ammonia and creatinine (Swansea criteria)	TTP: ADAMTS13 <10 IU/dL, neurology; HUS: kidney injury dominates

Adapted from BSH 2023 (TTP), Nelson 2014 (AFLP) and Williams.

Management

IF	THEN
DIC suspected	• **Treat the cause:** it is what switches DIC off (ISTH) • Abruption or fetal death: empty the uterus; DIC usually improves after, sometimes before (Obstetric EBG). Vaginal birth if the fetus has died and the woman is stable • Sepsis: antibiotics within 1 h and source control. HELLP or AFLP: deliver • Call a senior obstetrician, anaesthetist and haematologist
Bleeding	• Massive haemorrhage protocol; give products by results, and early in abruption and amniotic fluid embolism (SOGC) • **Fibrinogen >2 g/L** (RCOG GTG 52, SOGC): cryoprecipitate 2 pools, or fibrinogen concentrate (4 g raises it by ≈1 g/L) • **Platelets:** transfuse at 75, keep >50 ×10⁹/L (RCOG) • **FFP 12–15 mL/kg** if PT or APTT >1.5 × normal (RCOG); SOGC keeps INR <1.8 • Keep her warm, correct acidosis; ionised calcium abnormal <1.16 mmol/L, give calcium chloride (SOGC) • Repeat FBC, PT, APTT and Clauss fibrinogen (± FIBTEM) after each round of products
Tranexamic acid	• Bleeding obstetric DIC (PPH, abruption, embolism) is hyperfibrinolytic: give 1 g IV within 3 h (WHO, FIGO) • Avoid in DIC without bleeding, or with thrombosis or organ failure: fibrinolysis is protective there (ISTH, BSH)
Labs abnormal, not bleeding	Do not transfuse to correct numbers. Treat the cause and repeat the tests; correct before surgery or delivery if needed (BSH, ISTH).

IF	THEN
Regional anaesthesia	• Contraindicated in DIC (RCOG GTG 55) • Remove an epidural catheter only after platelets and clotting have recovered; SOAP counts removal as a neuraxial procedure
Not recommended	• Heparin in bleeding DIC; only where thrombosis predominates (ISTH) • Antithrombin concentrate (BSH); no RCTs of any haematological treatment in obstetric DIC (Cochrane) • rFVIIa: last resort, after surgery or IR are considered, with fibrinogen >1 g/L and near-normal pH and temperature (SOGC); discuss with haematology (RCOG GTG 47)
After the bleeding stops	• HDU or ICU care • Thromboprophylaxis once bleeding has stopped and clotting has recovered; with DIC, discuss timing with haematology (RCOG GTG 55)
Fetal death, labour delayed	Check platelets as soon as possible; test for DIC if labour is delayed beyond 48 h (RCOG GTG 55, 2024).

09 Trauma, inversion & placenta accreta

IF	THEN
Uterus firm, still bleeding	• Inspect cervix, vagina and perineum in good light; repair in theatre if access or analgesia is poor • Expanding vulvovaginal or broad ligament haematoma: evacuate, or IR
Uterine inversion (fundus not palpable, mass at introitus, shock out of proportion)	• Call for help; stop uterotonics; resuscitate; 2 large IVs • **Replace immediately** by pushing the fundus up along the vaginal axis (Johnson); leave the placenta attached until replaced • If the ring has clamped: terbutaline 250 µg SC, nitroglycerin 50–100 µg IV or $MgSO_4$ 4 g IV, or volatile GA (Williams) • Hydrostatic method (O'Sullivan) if manual fails; laparotomy: Huntington, then Haultain incision • Once replaced: oxytocin infusion, hand in the uterus until contracted
Known or suspected PAS	• Plan birth in a specialist MDT centre with ICU and blood bank • **Timing:** ACOG/SMFM 34+0–35+6 wk; RCOG 2026: 36+1–37+0 wk if stable (high probability of PAS) • At CS: do not separate the placenta; caesarean hysterectomy with placenta in situ; cell salvage

10 After PPH & secondary PPH

IF	THEN
Bleeding controlled	• Close (HDU-level) observation after major PPH; oxytocin infusion; fluid balance • Hb and iron: IV iron when oral iron cannot be used or rapid correction is needed (WHO); transfuse by symptoms, not a number • VTE prophylaxis once bleeding has stopped • Debrief the woman and the team; incident review if >1500 mL
Next pregnancy	Recurrence ≈10%; plan active management, IV access and a uterotonic plan in labour.

IF	THEN
Secondary PPH (24 h–12 weeks)	• Look for infection and retained tissue: swabs, FBC, CRP • Endometritis: clindamycin + gentamicin (RCOG) or local regimen • Ultrasound is unreliable for retained tissue; evacuation by an experienced surgeon (perforation risk) • Uterotonics and TXA if bleeding heavily

11 Do not

- Estimate blood loss by eye when you can weigh it.
- Give the bundle one step at a time and wait for each to fail.
- Give TXA more than 3 h after birth, or by any route other than IV.
- Give ergometrine in hypertension or pre-eclampsia, or carboprost in asthma.
- Give a rapid undiluted oxytocin bolus.
- Pull on the cord before the uterus has contracted and the placenta has separated.
- Attempt manual removal without anaesthesia, or pull a placenta that has no cleavage plane.
- Inject oxytocin into the umbilical vein or give GTN for a retained placenta.
- Withhold clotting products because of one normal test while bleeding continues.
- Site a spinal or epidural, or remove an epidural catheter, while DIC persists.
- Give heparin, or transfuse to correct numbers, in DIC that is not bleeding.
- Delay hysterectomy until the woman is moribund.

12 Where the guidelines differ

Topic	ACOG / SMFM	NICE / RCOG	WHO / FIGO 2025	SOGC
PPH definition	≥1000 mL or hypovolaemia	≥500 mL; major >1000 mL	Act at ≥300 mL + sign or ≥500 mL	Staged by measured loss
Prevention, vaginal	Oxytocin IM or IV infusion	Oxytocin 10 IU IM; Syntometrine if risk factors	Oxytocin; carbetocin or misoprostol; no ergometrine	Oxytocin 10 IU IM; IV if high risk
Prevention, CS	Oxytocin	NICE NG235 carbetocin; NG192 and RCOG oxytocin 5 IU	Oxytocin or carbetocin	Carbetocin 100 µg
Prophylactic TXA	Not routine at CS	RCOG: consider at CS if high risk	Not recommended	Consider if high risk
Treatment TXA	Consider when first-line drugs fail	1 g with uterotonics (NICE)	1 g within 3 h for all PPH	1 g, repeat once
Ergot dose	Methylergonovine 0.2 mg IM q2–4 h	Ergometrine 0.5 mg; do not repeat	Treatment only	Ergonovine 0.25 mg q2 h, max 5
Misoprostol (treatment)	600–1000 µg	800 µg SL	800 µg SL	Adjunct 200–400 µg
Antibiotic, manual removal	Neither supported nor refuted	Not addressed (NICE)	Recommended	—
Products in PPH / DIC	Fixed-ratio protocol (1:1:1)	Lab-guided: fibrinogen >2 g/L (GTG 52; GTG 47: >1.5), platelets >50, PT/APTT <1.5×	Replace fibrinogen early	Replace fibrinogen <2 g/L; INR <1.8
PAS delivery	34+0–35+6 wk	RCOG 2026: 36+1–37+0 wk	—	—

13 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACOG	American College of Obstetricians and Gynecologists	Hb	haemoglobin	PPH	postpartum haemorrhage
ADAMTS13	von Willebrand factor-cleaving protease	HDU	high-dependency unit	PPV	positive predictive value
AFLP	acute fatty liver of pregnancy	HELLP	haemolysis, elevated liver enzymes, low platelets	PR	per rectum
AIM	Alliance for Innovation on Maternal Health	HUS	haemolytic uraemic syndrome	PT	prothrombin time
ALT/AST	liver transaminases	ICM	International Confederation of Midwives	QBL	quantitative blood loss
APH	antepartum haemorrhage	ICU	intensive care unit	RANZCOG	Royal Aust. & NZ College of O&G
APTT	activated partial thromboplastin time	IM	intramuscular	RCOG	Royal College of Obstetricians and Gynaecologists
BMI	body mass index	INR	international normalised ratio	RCT	randomised controlled trial
BP	blood pressure	IR	interventional radiology	rFVIIa	recombinant activated factor VII
BSH	British Society for Haematology	ISTH	International Society on Thrombosis and Haemostasis	ROTEM	rotational thromboelastometry
CMQCC	California Maternal Quality Care Collaborative	IU	international units	RR	relative risk
CO	ACOG Committee Opinion	IV	intravenous	SBP	systolic blood pressure
CRP	C-reactive protein	LDH	lactate dehydrogenase	SC	subcutaneous
CS	caesarean section	LFTs	liver function tests	SL	sublingual
DBP	diastolic blood pressure	LR+	positive likelihood ratio	SMFM	Society for Maternal-Fetal Medicine
DIC	disseminated intravascular coagulation	MBRRACE	UK confidential maternal death enquiry	SNRI	serotonin–noradrenaline reuptake inhibitor
EUA	examination under anaesthesia	MDT	multidisciplinary team	SOAP	Society for Obstetric Anesthesia and Perinatology
FBC	full blood count	MFMU	NICHD Maternal-Fetal Medicine Units Network	SOGC	Society of Obstetricians and Gynaecologists of Canada
FDA	US Food and Drug Administration	MHP	massive haemorrhage protocol	SpO_2	oxygen saturation
FDP	fibrin degradation products	MOTIVE	massage, oxytocics, TXA, IV fluids, examination, escalation	SSRI	selective serotonin reuptake inhibitor
FFP	fresh frozen plasma	NICE	National Institute for Health and Care Excellence	TTP	thrombotic thrombocytopenic purpura
FIBTEM	ROTEM fibrinogen assay	NS	not significant	TXA	tranexamic acid
FIGO	Int. Federation of Gynecology and Obstetrics	OBS Cymru	Obstetric Bleeding Strategy for Wales	VE	vaginal examination
GA	general anaesthesia	OVD	operative vaginal delivery	VTE	venous thromboembolism
GTG	RCOG Green-top Guideline	PAS	placenta accreta spectrum	WHO	World Health Organization
GTN	glyceryl trinitrate	PO	by mouth		

14 Sources

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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.