Misoprostol for the treatment of postpartum haemorrhage in low resource settings

Joint statement

International Confederation of Midwives (ICM)

International Federation of Gynecology and Obstetrics (FIGO)

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The International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) have a long established common commitment towards upholding women's fundamental human right to health; reducing the global incidence of maternal mortality and morbidity and using evidence based interventions to do so.

This statement reßects the latest (2012) evidence base on the use of misoprostol for the treatment of postpartum haemorrhage (PPH) in low resource settings where intravenous oxytocin, the gold standard for treatment of PPH, is not available.

Background

Postpartum haemorrhage is the leading cause of maternal morbidity and mortality, but most cases of PPH can be effectively prevented and treated in virtually all settings where women deliver;

Investing in improved midwifery and obstetric services remains vital for reducing maternal morbidity and mortality. To meet the needs of the most underserved populations, access to life saving interventions in community settings must be prioritized.

Active management of the third stage of labour, with the administration of a uterotonic can reduce blood loss and reduce the incidence of PPH. Nonetheless, 6-16% of women who receive uterotonic prophylaxis [1] will still experience post-partum haemorrhage requiring prompt interventions.

When PPH occurs where the use of 40 IU IV oxytocin, the gold standard for PPH treatment, is not feasible (e.g. there is a lack of skilled attendants or refrigeration), 800 ! g sublingual misoprostol, a safe and effective drug with few contraindications or side effects, can be used to control blood loss.

FIGO and ICM have committed themselves to making increased access to misoprostol for the management of postpartum haemorrhage a reality, particularly in low resource settings where IV oxytocin remains largely unavailable or not feasible.

BeneÞts of misoprostol for the treatment of postpartum haemorrhage in low resource settings

- Safe, effective, easy to administer, transient side effects, cost effective, widely available and stable at room temperature
- Provides a safe and effective option for the treatment of PPH where currently IV oxytocin is not available and/or feasible

[1] Carroli G, Cuesta C, Abalos E, Gulmezoglu AM. Epidemiology of postpartum haemorrhage: a systematic review. Best Practice & Research Clinical Obstetrics and Gynaecology 2008; 22:999-1012.

Recommendations for treating PPH when 40 IU intravenous oxytocin is not immediately available[2]

Regimen	Single dose of misoprostol 800 !g sublingually is indicated for **treatment** of PPH when 40 IU IV infusion oxytocin is not immediately available (irrespective of the prophylactic measures).
Course of treatment	Once PPH is diagnosed, the treatment should be given immediately.
Repeat or consecutive doses	Since the known side effects of misoprostol appear to be dose related, repeat or consecutive doses of misoprostol may increase the incidence of side effects. If oxytocin is already being provided for treatment of PPH, evidence suggests that adjunct (simultaneous) use of misoprostol has no added benefit. There is insufficient information about the effect of two or more consecutive doses of misoprostol for treatment of PPH. In the absence of such information, repeat doses of misoprostol for PPH treatment are not recommended Other treatment options, such as bimanual compression or aortic compression, should be considered if one dose has not been effective.
Contraindications	History of allergy to misoprostol or other prostaglandin
Precautions	1. Caution is advised in instances where the woman may have already received misoprostol as prophylaxis for PPH prevention if an initial dose of misoprostol was associated with pyrexia or marked shivering. 2. After provision of uterotonics, the need for other steps to stop the bleeding should be explored, and causes of PPH other than uterine atony should be considered. 3. Small amounts of misoprostol or its active metabolite may appear in breast milk but no adverse effects on breast feeding infants have been reported.
Effects and side effects	

Call to action

As two leading international associations of healthcare professionals, ICM and FIGO have a pivotal role to play in ensuring that women, especially those most vulnerable to morbidity and mortality during childbirth due to a lack of a skilled attendant and a lack of access to oxytocin, have access to misoprostol.

In leading this effort, national obstetric and midwifery associations, particularly in countries where universal access to oxytocin is unreliable, are urged to undertake the following critical actions:

- Advocate for the incorporation of these international recommendations on the use of misoprostol in low resource settings for the treatment PPH into national clinical guidelines thereby improving maternal health care services and approaches