On page 1:

- **Initial Steps**: Ensure 16G or 18G IV Access, Increase IV fluid (crystalloid without oxytocin), Insert indwelling urinary catheter, Fundal massage.

- **Medications**: Ensure appropriate medications given patient history, Increase oxytocin, additional uterotonic.

- **Blood Bank**: Confirm active type and screen and consider crossmatch of 2 units PRBCs.

- **Action**: Determine etiology and treat, Prepare OR, if clinically indicated (optimize visualization/examination).

On page 2:

- **Stage 1**: Blood loss > 1000 mL after delivery with normal vital signs and lab values. Vaginal delivery 500-999 mL should be treated as in Stage 1.

- **Oxytocin (Pitocin)**: 10-40 units per 500-1000 mL solution

- **Methylergonovine (Methergine)**: 0.2 milligrams IM (may repeat); Avoid with hypertension

- **15-methyl PGF2α (Hemabate, Carboprost)**: 250 micrograms IM (may repeat in q15 minutes, maximum 8 doses); Avoid with asthma; use with caution with hypertension

- **Misoprostol (Cytotec)**: 800-1000 micrograms PR, 600 micrograms PO or 800 micrograms SL

- **Tone (i.e., atony)**
- **Trauma (i.e., laceration)**
- **Tissue (i.e., retained products)**
- **Thrombin (i.e., coagulation dysfunction)**

- **Possible interventions**: Bakri balloon, Compression suture/B-Lynch suture, Uterine artery ligation, Hysterectomy

- **Stage 2**: Continued Bleeding (EBL up to 1500 mL OR ≥ 2 uterotonic) with normal vital signs and lab values (*two or more uterotonic in addition to routine oxytocin administration, or ≥ 2 administrations of the same uterotonic*)

- **Tranexamic Acid (TXA)**: 1 gram IV over 10 min (add 1 gram vial to 100 mL NS & give over 10 min; may be repeated once after 30 min)

- **Huddle and move to Stage 3 if continued blood loss and/or abnormal VS**

**Safe Motherhood Initiative**

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**STAGE 3: Continued Bleeding** (EBL > 1500mL OR > 2 RBCs given OR at risk for occult bleeding/ coagulopathy OR any patient with abnormal signs/labs/oliguria)

**INITIAL STEPS:**
- Mobilize additional help
- Move to OR
- Announce clinical status (vital signs, cumulative blood loss, etiology)
- Outline and communicate plan

**MEDICATIONS:**
- Continue Stage 1 medications; consider TXA
- Initiate Massive Transfusion Protocol (If clinical coagulopathy: add cryoprecipitate, consult for additional agents)

**ACTION:**
- Achieve hemostasis, intervention based on etiology
- Escalate interventions

**Oxytocin (Pitocin):**
10-40 units per 500-1000mL solution

**Methylergonovine (Methergine):**
0.2 milligrams IM (may repeat);
Avoid with hypertension

**15-methyl PGF\(_2\alpha\) (Hemabate, Carboprost):**
250 micrograms IM (may repeat in q15 minutes, maximum 8 doses);
Avoid with asthma;
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**Misoprostol (Cytotec):**
800-1000 micrograms PR
600 micrograms PO or 800 micrograms SL

**Tranexamic Acid (TXA):**
1 gram IV over 10 min (add 1 gram vial to 100mL NS & give over 10 min; may be repeated once after 30 min)

**Possible interventions:**
- Bakri balloon
- Compression suture/B-Lynch suture
- Uterine artery ligation
- Hysterectomy

**STAGE 4: Cardiovascular Collapse** (massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism)

**INITIAL STEP:**
- Mobilize additional resources

**MEDICATIONS:**
- ACLS

**BLOOD BANK:**
- Simultaneous aggressive massive transfusion

**ACTION:**
- Immediate surgical intervention to ensure hemostasis (hysterectomy)

**Post-Hemorrhage Management**
- Determine disposition of patient
- Debrief with the whole obstetric care team
- Debrief with patient and family
- Document

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