

**MATERNAL MORTALITY DUE TO HAEMORRHAGE**

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**SUMMARY**

Modern improvement in the maternity service and the advances in the field of medicine has resulted in a significant reduction in the maternal mortality rates. However Haemorrhage remains one of the major cause of death, even in well equipped hospitals. They are hence worth examining in detail to provide guidelines for all engaged in providing maternity care.

The present study has shown a gradual decline in the rates of maternal mortalities due to different causes of haemorrhage, but the incidence of preventable factors like post-partum haemorrhage has not materially changed. We are still loosing about one case each out of 100 cases of placenta praevia and abruptio placentae. More energetic treatment of antepartum haemorrhage along with anticipation and prophylaxis of postpartum haemorrhage will help to further reduce maternal mortality. Thus the avoidable factors can be reduced to the irreducible minimum.

Maternity health care is a multidimensional subject. The effectivity or otherwise of maternity health care is reflected in the figures of maternal and perinatal mortality rates.

The maternal mortality in the developing countries including India is about 10 times higher than in the developed countries (Rao, 1975). Despite many advances in the field of medicine and better availability of facilities, haemorrhage is one of the three prime killers in our country, as it is all over the world. Maternal death rates due to haemorrhage have been reported to range between 15 - 33.5% by different workers (Roychowdhury 1976, Hcera & Dasgupta, 1973).

A study of maternal mortalities due to haemorrhage was carried out at the Nowrosjee Wadia Maternity Hospital, Parcl, from the year 1976 to 1990. During this period there were 132 maternal deaths and 1,30,600 births, giving a maternal mortality rate of 101.1/1,00,000 births. It is much lower than an MMR of 9.94/1,00,000 quoted by Lopez et al (1986) in Bombay. The difference can be explained on the basis of class of population catered to and the registration status. Our registration status is over 90%. In our series, haemorrhage accounted for 52 deaths (39.81/1,00,000 births).

For the purpose of convenience the data was divided in three groups of five years each. Table - I shows the deaths due to haemorrhage.

It can be seen from the above table that the

TABLE - I

Maternal Mortalities Due to Haemorrhage

	1976 - 80	1981 - 85	1986 - 90
Total births	40394	44855	45351
Maternal deaths due to haemorrhage	31 (5%)	12 (34.3%)	9 (25.7%)
Maternal mortality Rate/100,000	76.74	26.75	19.84

maternal mortality rate due to haemorrhage has been gradually declining. What is also significant is the fact that the figure of deaths due to haemorrhage as a proportion of total death is also decreasing. This has become possible because of better availability of transfusion facilities, earlier intervention in antepartum haemorrhage cases, and more liberal policy with blood transfusions.

Antepartum haemorrhage has overtaken postpartum haemorrhage as a leading cause. Table II shows us the different causes in maternal mortality due to haemorrhage.

We have been successful in arresting maternal mortalities due to Rupture Uterus and V. Mole. A less conservative policy in scarred uteri is partly because of increased safety of abdominal deliveries and partly due to the small family

norm. In our population a hospital delivery is almost universal, thereby avoiding rupture of uterus from prolonged obstructed labour. Anticipation of haemorrhage in cases of vesicular Mole has gone a long way to prevent mortalities. Antepartum haemorrhage still challenges us, and we can hardly change it's occurrence. But have we been successful in preventing the occurrence of postpartum haemorrhage? Table III attempts to answer this question.

It is clear from the table that incidences of placenta praevia and abruptio placentae have remained constant, which is logical. What emerges as a surprise is the fact that even though mortality of postpartum haemorrhage has declined, the incidence is more or less constant. Much can be done in order to decrease the incidence of postpartum haemorrhage. Routine

TABLE - II

Cause	1976 - 80	1981 - 85	1986 - 90
1. Placenta Praevia	3	2	3
2. Abrutio Placentae	7	2	3
3. PPH	13	5	3
4. Rupture Uterus	3	3	0
5. V. Mole	5	0	0
<b>Total</b>	<b>31</b>	<b>12</b>	<b>9</b>

TABLE - III

## Incidence and Percent Mortality in Relation to Cause of Haemorrhage

		1976 - 80	1981 - 85	1986 - 90
Placenta Praevia	Incidence	0.39%	0.45%	0.49%
	% Maternal mortality	1.25	0.97	1.1
Abruptio placentae	Incidence	0.33%	0.41%	0.38%
	% maternal mortality	5.22	1.06	1.41
Vesicular mole	Incidence	0.13%	0.17%	0.12%
	% Maternal mortality	9.09	0	0
PPH	Incidence	0.43%	0.43%	0.38%
	% Maternal mortality	7.42	2.59	1.74

active management of third stage using oxytocic agents, more energetic treatment of postpartum haemorrhage along with anticipation and prophylaxis of PPH will go a long way in reducing the incidence and the mortality associated with this obstetric emergency.

A significant proportion of deaths are contributed by DIC. A laboratory equipped with facilities for component therapy and personnel with the experience to handle this dire emergency will be immensely helpful. Antenatal screening and treatment of anaemia will make our patients better able to tolerate the extra blood loss, should it occur. Eradication of mortality due to

haemorrhage may be too idealistic, but curbing it is certainly within our view.

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