

**Postpartum haemorrhage: prevention**  
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**ABSTRACT**

**INTRODUCTION:** Loss of more than 500 ml of blood is usually caused by failure of the uterus to contract fully after delivery of the placenta, and occurs in over 10% of deliveries, with a 1% mortality rate worldwide. Other causes of postpartum haemorrhage include retained placental tissue, lacerations to the genital tract, and coagulation disorders. Uterine atony is more likely in women who have had a general anaesthetic or oxytocin, an overdistended uterus, a prolonged or precipitous labour, or who are of high parity.

**METHODS AND OUTCOMES:** We conducted a systematic review and aimed to answer the following clinical question: What are the effects of drug and of non-drug interventions to prevent primary postpartum haemorrhage? We searched: Medline, Embase, The Cochrane Library, and other important databases up to September 2007 (Clinical Evidence reviews are updated periodically, please check our website for the most up-to-date version of this review). We included harms alerts from relevant organisations such as the US Food and Drug Administration (FDA) and the UK Medicines and Healthcare products Regulatory Agency (MHRA).

**RESULTS:** We found 29 systematic reviews, RCTs, or observational studies that met our inclusion criteria. We performed a GRADE evaluation of the quality of evidence for interventions.

**CONCLUSIONS:** In this systematic review we present information relating to the effectiveness and safety of the following interventions: active management of the third stage of labour, carboprost injection, controlled cord traction, ergot compounds (ergometrine/methylergotamine), immediate breastfeeding, misoprostol (oral, rectal, sublingual, or vaginal), oxytocin plus ergometrine combinations, oxytocin, prostaglandin E2 compounds, and uterine massage.