Introduction
Post Partum hemorrhage is one of the important cause of maternal mortality in Bangladesh and in other industrialized and non industrialized countries.¹ No doubt prevention of PPH and active treatment of PPH could bring down the maternal mortality rate (MMR).

One of the primary objective of management of 3rd stage of labour is prevention of PPH, this approach may be active or expectant.² Active treatment involves oxytocic therapy at the delivery of anterior shoulder or shortly after delivery of the baby, early cord clamping and placental separation. On the other hand expectant treatment means, nothing is done, Placenta is allowed to deliver spontaneously by maternal effect and sometimes by gravity.³ Active management is associated with significant about 40% reduction of PPH.

Injectable prostaglandin may be superior to oxytotic in decreasing blood loss but safety data’s are still inadequate to recommend. Misoprostol El analogue has been reported for prevention of PPH. Oral misoprostol is effective but associated with shivering and pyrexia.⁴ Who collaborate trial of misoprostol for management of 3rd stage labour showed much side effect with 600 ug but non with the dose of 400 ug. Rectal Misoprostol is well tolerated and effective to reduce PPH.

Bleeding from episiotomy may contribute to PPH. Restricted use of episotomy associated with less morbidity of penneal trauma and less blood loss.

Retained placenta may contribute maternal death from bleeding if left untreated, prompt manual removal of placenta under G.A is the treatment option. Other measures include-umbilical mjeclal of saline and oxytocic. Early sucking and nipple stimulation not shown to be effective to reduce PPH.⁵

Treatment of PPH
Nonsurgical methods involves, uterine massage, oxytocic, placental removal ascertaining of origin of bleeding. Immediate measure include compression of aorta against sacral promontary⁶ and bimanual compression of uterus.

Uterine contraction need to be stimulated by uterine massage and injection of oxytocic with or without ergometrin IV. as a bolus or in drip. If this method fails prostaglandin-12a 250 pg I.M.⁷ is recommended. Rectal misoprostol administration is promising.

Once medical treatment fails, prompt decision of surgery should be taken. Delay in decision may increase maternal mortality. Blood transfusion and early involvement of haematologist is very important. Under G.A uterus, vagina, fornisces and cervix need to be explored under good light. Any retained product of conception are removed manually or with ovum forcep. choice intrauterine packing and use of segstaken blaknone tube or folley’s catheter with a large bulb depends upon individual surgeon. But these methods are not systematically evaluated. If bleeding is due to rupture-repair or hysterectomy may be needed accordig to the case.

If no tear or trauma, Internal iliac artery ligation or stepwise ligation of uterine and ovarian arteries may be effective when these measures fails subtotal and total hysterectomy is the choice.

References
Review Article

3. Gyte GML Evaluation of the meta-analysis on the effects, on both mother and baby, of the various components of active management of the third stage of labour. Midwifery 1994; 10; 183-199.