Medications and their dosage

Obsah článku

Oxytocin (Oxytocin®)

Initiation of treatment: 5 IU of oxytocin i.v. (administration time 1 minute) and 5-15 IU/hour in an infusion solution until bleeding stops.

Carbetocin (Duratocin®)

An alternative to an oxytocin infusion 100 µg i.v. (administration time 1 minute)

Methylergometrine

Initiation of treatment: 0.2 mg i.m. or slowly i.v., Further: After 15 minutes, repeat administration of 0.2 mg methylergometrine i.m. or 0.2 mg i.m. or slowly i.v. every 4 hours, not to exceed a dose of 1 mg (five doses of 0.2 mg).

Prostaglandiny F2α

In case the bleeding continues after administration of oxytocin, carbetocin, or ergometrine, if needed.

Dinoprostum (Enzaprost F®)

5 mg in a 500 ml infusion solution, Rate: 5 ml/min (= 300 ml/h) do not exceed 20 mg.
If there is no response, administer carboprost (Prostin 15M®)

Carboprost (Prostin 15M®)

Initiation of treatment: 0.25 mg i.m. or intramyometrically.
Further: As needed every 15 minutes (0.25 mg i.m.), not to exceed a dose of 2 mg (eight doses of 0.25 mg).

Misoprostol (Cytotec®)

400-600 µg sublingually, rectally, vaginally, or orally.
Repeat: After 15 min as needed, maximum dose 800 µg.

Tranexamic Acid (Exacyl®)

Initial dose: For life-threatening bleeding,
1 g i.v. within 10 minutes is recommended, the next dose depends on the clinical condition of the patient.
Total dose should not exceed 2 g/day.

Fibrinogen
Administration of fibrinogen is recommended during life-threatening bleeding when its concentration drops below 2 g/l i.v.
Initial dose: At least 4 g i.v. is recommended for life-threatening bleeding.

Recombinant activated factor rFVIIa (NovoSeven®)
Administration of rFVIIa is indicated for the treatment of severe obstetric hemorrhage if the use of uterotonics is not sufficient to achieve hemostasis - according to the appropriate scenario.
Initial dose: 90 µg/kg

Scenario 1
After vaginal delivery
For PPH after vaginal delivery, consider administration of rFVIIa after the use of first line non-invasive and invasive measures (uterotonics, TXA, intravenous fluids/blood/blood derivatives and fibrinogen, treatment of birth injuries, uterine cavity revision, uterine tamponade), if the patient is still bleeding laparotomy or uterine artery embolization.

Scenario 2
During caesarean section
For PPH during caesarean section, consider the use of rFVIIa after failure of first line surgical measures (uterine compression sutures, uterine vascular ligation, uterine tamponade),but before uterine artery embolization or hysterectomy.

Scenario 3
After caesarean section
After caesarean section, when the patient is in the ICU or PACU and the laparotomy has been closed and severe bleeding is evident, consider administration of rFVIIa (possibly in combination with uterine artery embolization), It is not advisable to postpone re-laparotomy in case of: severe intra-abdominal hemorrhage with a significant drop in hemoglobin and/or cardiovascular instability.

Scenario 4
Transport to a specialized workplace
In the event of transporting a PPH patient to a better equipped facility, rFVIIa can be administered to stabilize the patient and reduce the risk of worsening bleeding during transport. Administration of rFVIIa prior to transport should be considered based on the current clinical situation and the estimated time of transporting the patient to the center. However, the administration of rFVIIa may not be a reason to delay the patient‘s transport to a higher care center or the administration of uterotonic treatment and/or uterine tamponade.

Scenario 5
During Periparital Hysterectomy

If excessive bleeding occurs during (peripartum) hysterectomy due to PPH and hemostasis is difficult to achieve, consider administration of rFVIIa along with other standard measures

Medicines and Their Dosage