

Immediate steps for bleeding in labor



Recognize the emergency and call for help

In a hospital or birth center, press the call bell or ask someone to summon the obstetric, midwifery, anesthesia, and neonatal teams immediately. If bleeding begins outside a clinical setting, call emergency services and state that the person is in labor or has recently given birth and is bleeding. Give the location, gestational age if known, whether the baby has been born, and whether the placenta has delivered.

Do not wait for bleeding to stop, and do not attempt to drive yourself if the bleeding is heavy, associated with faintness, severe pain, shortness of breath, or reduced alertness. While help is arriving, remain lying on the side or in a position advised by the emergency team. Keep the person warm, avoid food and drink if urgent anesthesia or surgery may be required, and preserve any pads or cloths used so clinicians can estimate blood loss. A support person can record when the bleeding started, whether clots or tissue were passed, and any medications or medical conditions that may affect clotting.

The phrase bleeding and hemorrhage during labor covers a broad range of situations. Visible blood loss may underestimate the true volume, particularly when blood is concealed behind the placenta, in the uterus, or on bedding. The

appearance of the blood alone cannot determine severity.

Perform rapid maternal and fetal assessment

Clinicians first assess airway, breathing, circulation, mental status, skin perfusion, and vital signs. Blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, and level of consciousness are repeated frequently because deterioration can be rapid. A fast pulse, falling blood pressure, pallor, cool skin, confusion, reduced urine output, or collapse may indicate significant circulatory compromise, although apparently normal vital signs do not exclude substantial blood loss.

At the same time, the team evaluates the abdomen and uterus, observes the bleeding, and examines the placenta and birth canal when appropriate. They may assess uterine tone, contraction pattern, abdominal tenderness, fetal position, cervical dilation, and signs of trauma. In labor, fetal heart-rate monitoring is generally used to detect evidence of reduced placental oxygen transfer. A concerning fetal heart-rate pattern may require urgent obstetric decision-making while maternal resuscitation continues.

Clinicians should establish an accurate baseline and track ongoing loss through quantitative blood loss assessment when available. This may involve weighing blood-soaked materials and measuring collected blood rather than relying only on visual estimates. Blood tests commonly include a complete blood count, blood group and crossmatch, coagulation studies, fibrinogen, and other tests guided by the clinical situation. Testing should not delay stabilization or definitive treatment.

Start immediate stabilization measures

For substantial or ongoing bleeding, the team activates the local obstetric hemorrhage protocol and assigns clear roles. Two large-bore intravenous cannulas are commonly placed to permit rapid blood sampling, fluid administration, medication delivery, and blood-product transfusion if required. An intraosseous route or other access may be considered when intravenous access is difficult and the situation is life-threatening.

Initial fluid resuscitation generally uses warmed isotonic crystalloids, such

as normal saline or a balanced crystalloid, while blood products are arranged when bleeding is severe or persistent. Excessive crystalloid administration can worsen dilutional coagulopathy and tissue swelling, so treatment is reassessed continuously. Red cells, plasma, platelets, cryoprecipitate, or fibrinogen replacement may be given according to the degree of hemorrhage, laboratory results, and local massive-transfusion guidance.

Supplemental oxygen may be provided when clinically indicated, with attention to airway protection and ventilation. The person should be kept warm using blankets, active warming devices, and warmed fluids where available; avoiding hypothermia supports coagulation and reduces physiologic stress. Continuous cardiac, blood-pressure, and oxygen-saturation monitoring is appropriate in significant hemorrhage, and a urinary catheter may be inserted to monitor urine output as a marker of organ perfusion.

These measures occur in parallel rather than as a sequence. The team should involve anesthesia, transfusion services, operating-room staff, senior obstetric clinicians, and neonatal personnel early when there is rapid blood loss, maternal instability, suspected placental separation, or fetal compromise.

Control bleeding after birth

When bleeding follows delivery, clinicians assess whether the uterus is contracting effectively. A soft, poorly contracted uterus suggests uterine atony, one of the common causes of postpartum hemorrhage. Uterine massage should begin promptly when postpartum hemorrhage is diagnosed, while the team evaluates the placenta, genital tract, and coagulation status. Massage can encourage contraction but should be performed by trained clinicians and does not replace urgent medical assessment.

Uterotonic medication may be administered according to the patient's clinical condition, contraindications, and local protocol. The choice and route depend on factors such as hypertension, asthma, cardiovascular disease, prior medications, and the response to initial treatment. Medication decisions belong to the treating team; patients and companions should not attempt to obtain or administer uterotonics independently.

Tranexamic acid may be included in the first-response bundle for postpartum

hemorrhage. It works by reducing fibrinolysis and is most beneficial when given promptly after bleeding is recognized, provided there is no contraindication. Its use, timing, and dosing must follow the clinician's assessment and applicable guidelines. Ongoing blood loss may require repair of a cervical, vaginal, or perineal laceration, removal of retained placental tissue, uterine balloon tamponade, interventional radiology, or surgery.

If bleeding continues despite initial measures, escalation can include examination under anesthesia, uterine compression or vascular procedures, laparotomy, and, in extreme circumstances, hysterectomy. These interventions are intended to control life-threatening hemorrhage. The specific choice depends on the cause, hemodynamic status, fertility goals where relevant, available expertise, and how quickly bleeding is progressing.

Consider causes before and during delivery

Before the baby is born, bleeding may reflect cervical change, but it may also signal placental abruption, placenta previa, vasa previa, uterine rupture, genital-tract trauma, or a coagulation disorder. Painful bleeding with a tense or tender uterus can raise concern for placental abruption, while painless bright-red bleeding may require evaluation for placenta previa or another placental source. These patterns are not diagnostic on their own, and digital vaginal examination may be unsafe until placenta previa has been excluded when clinically suspected.

During an assessment for placental abruption during labor, clinicians consider maternal symptoms, fetal monitoring, uterine activity, ultrasound findings when useful, and laboratory evidence of coagulopathy. Ultrasound can be helpful but does not exclude abruption. If maternal or fetal condition is deteriorating, delivery may need to be expedited by the safest available route.

After delivery, clinicians commonly organize causes into four broad categories: inadequate uterine contraction, retained placental tissue or abnormal placentation, trauma to the genital tract or uterus, and coagulation abnormalities. A contracted uterus with persistent bright bleeding may suggest laceration, whereas a retained placenta or uterine inversion requires specific urgent management. The team may also investigate concealed bleeding, particularly when pain, shock, or abdominal distension is out of proportion to

visible loss.

Understanding these categories helps explain why treatment can change quickly. The first response addresses circulation and contraction while examination, imaging, laboratory testing, and the condition of the mother and baby guide definitive care.

Continue observation, communication, and recovery support

Once bleeding is controlled, monitoring continues because recurrent hemorrhage is possible. Vital signs, uterine tone, vaginal loss, urine output, mental status, laboratory values, and response to treatment are followed at intervals determined by the clinical risk. Iron deficiency or anemia may require follow-up testing and clinician-directed treatment. The patient should receive clear information about what happened, the suspected cause, medications or procedures used, transfusions if any, and warning signs that require immediate reassessment.

Severe bleeding can be traumatic even when the physical outcome is good. Fear, intrusive memories, sleep disturbance, grief, or difficulty processing the birth are valid responses. A postnatal debrief with the maternity team can help clarify the timeline and answer questions. Psychological support, a primary-care review, or specialist perinatal mental-health care may be appropriate when distress persists or interferes with daily life.

Before discharge, ask who to contact day and night, which symptoms should prompt emergency care, whether follow-up blood tests are needed, and how the event affects future pregnancy planning. A history of postpartum hemorrhage or another bleeding complication should be documented and discussed with the obstetric team in a subsequent pregnancy. Preparation can include reviewing the birth setting, blood-group information, anemia prevention, placenta location, and an individualized delivery plan.