More than arterial embolisation

Post-partum haemorrhage is one of the most dreaded complications of pregnancy. In this issue, the use of arterial embolisation in managing post-partum haemorrhage in nine local patients is reported.[1] In all cases, the procedure successfully controlled the bleeding and no serious complications were found. The experience was comparable to what was reported from other centres. The report provides assurance for the applicability of this procedure in local settings.

One has to be cautious before endorsing embolisation as the management method for all cases of intractable primary post-partum haemorrhage, based on this paper alone. Other options of management should be considered before embolisation.[2] As mentioned by Tsang et al,[1] less invasive options including urological hydrostatic balloons had not been tried on their patients. Surgical compression sutures, and uterine and internal iliac artery ligation, may also be tried especially in cases that immediately follow Caesarean sections. In the presence of other options, the exact place of embolisation as a treatment method has yet to be defined.

The other issue is what constitutes intractable haemorrhage. In a previous report from the same obstetric unit,[3] seven hysterectomies were performed in 15 474 deliveries. Among the nine women described in the current report,[1] only one hysterectomy was performed. Unless there were other emergency obstetric hysterectomies performed in the same study period, embolisation was very successful in avoiding hysterectomy in patients suffering from post-partum haemorrhage. On the other hand, we may wonder why embolisation was needed by nine patients out of 9263 patients, a proportion that is much higher than in previous series. This cannot be explained without further information. It is, however, tempting to ask two questions: is there a genuine increase in the incidence of intractable post-partum haemorrhage? Or is one more ready to make a diagnosis of intractable post-partum haemorrhage in the presence of an apparently safe procedure? Although no serious complications were identified in the present series, we must remember that the number of cases reported was small and the duration of the follow-up was less than a year. It may be useful to collect more data through a multicentre audit.

It is also worrying to read about the prophylactic application of arterial embolisation, which was suggested in the management of patients suffering from placenta percreta.[4] We have managed a similar patient successfully without the need for this procedure.[5] Extending the indication for embolisation to prophylaxis would completely change the risk benefit ratio, and should not be undertaken lightly without good evidence or at least a good reason.

I have no doubt that arterial embolisation is an important addition to our armamentarium in the management of post-partum haemorrhage. However, it is important that we put arterial embolisation in the right place among the management options available, and not consider it as the panacea. Its use should be limited to therapeutic purpose for the time being. As timing is so important in the management of post-partum haemorrhage, the early on-site involvement of experienced staff is probably the only way to safeguard its proper application. In addition, every obstetric unit should lay down its own policy on the management of post-partum haemorrhage.[6] As specialists from other disciplines are also involved, for example, anaesthesiologists and interventional radiologists, their opinions should also be included when formulating the policy. Finally, disaster drills on this condition can also be run regularly to ensure that all staff are acquainted with the policy. The answer to post-partum haemorrhage is more than arterial embolisation.

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