Pregnancy outcomes in women with, and carriers of, Inherited Bleeding Disorders (IBD) in a London Obstetric Unit with Haemophilia Comprehensive Care Centre

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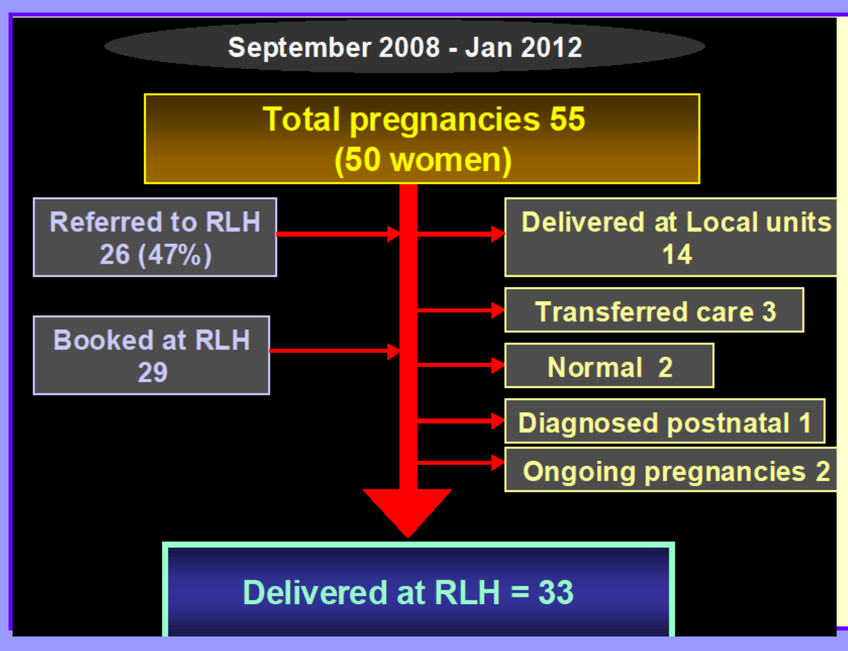
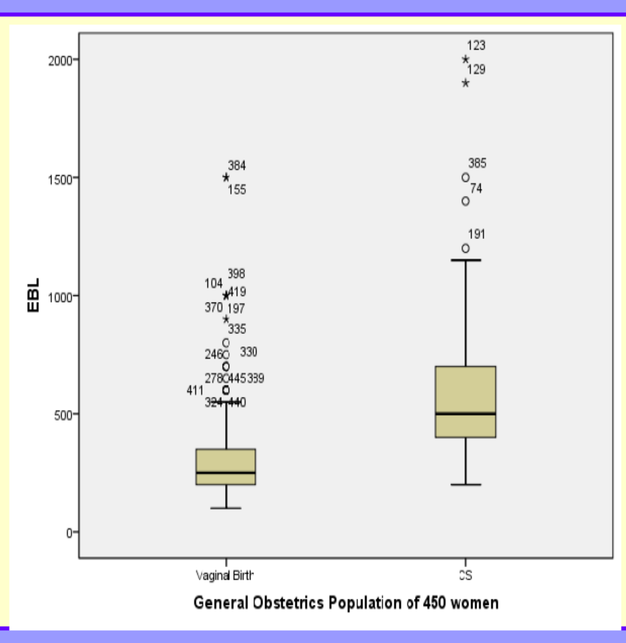
Objectives:

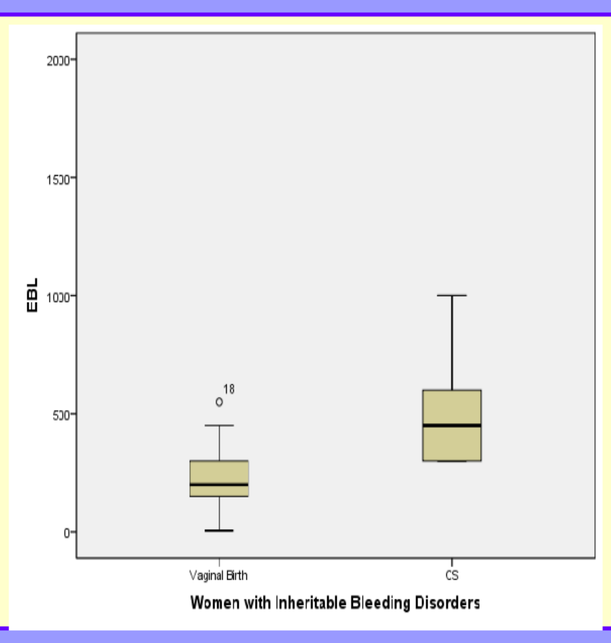
Previous studies have shown that women with Inherited Bleeding Disorders (IBD) have a higher risk of obstetric haemorrhage when compared to the general obstetric population. For example, it was reported that the incidence of primary and secondary postpartum haemorrhage (PPH) amongst haemophilia carriers were 22% and 11% respectively, while the incidence in the general obstetric population was 5-8% and 0.8% respectively.[1] We hypothesise that expert multidisciplinary approach to the care of pregnancies with IBD and carriers, with adherence to the national guidelines for the management of IBD in pregnancy (produced by the UK Haemophilia Centre Doctors' Organization), and the provision of individualised birth plans will result in a normal pregnancy outcome.

Methods:

Pregnancy outcomes were followed up for women with IBD, and carriers, who delivered at the Royal London Hospital Obstetric Unit with Haemophilia Comprehensive Care Centre from September 2008







Results:

There were 33 pregnancies including vonWillebrand's (vWD) type2 (8), Factor XI deficiency (6), Haemophilia A carriers (5), Haemophilia B carriers (3), Factor VII deficiency (3), platelet disorders (3), vWD type1 (3) and Factor XIII deficiency carriers (2). 21 women had peri-delivery haemostatic treatment. Primary postpartum haemorrhage (PPH) occurred in five women (15.2%) but none required blood transfusion. However, four out of five of these women had Caesarean sections. Secondary PPH occurred in one woman (3%).

In women with IBD or carriers, the average estimated blood loss (EBL) for those who had vaginal birth was 200ml (Interquartile range (IQR) 150-300ml) while average EBL for those who had Caesarean section (CS) was 450ml (IQR 300-700ml). This was not statistically significantly different from the control group (450 women without IBD), with average EBL of 250ml (IQR 200-350) for vaginal birth and 500ml (IQR 400-700) for CS respectively. None in the control group had secondary PPH.

Conclusions:

With the exception of one secondary PPH and one baby with spontaneous cephalhaematoma in a case with type2A vWD, our cohort had similar rates of primary PPH and neonatal outcomes as our control group.

The overall estimated blood loss (EBL) in women with IBD and carriers was higher than women without IBD, mainly because there were more Caesarean sections in women with IBD and carriers group. However subgroup analysis by mode of delivery showed that there was no significant difference in the EBL between the two groups.

We have shown that in pregnant women with IBD and carriers, normal pregnancy outcome can be achieved when managed via an expert multidisciplinary team.

References:

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