POUR ELLE

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18TH GENERAL MEMBERSHIP MEETING OF THE REPRODUCTIVE HEALTH SUPPLIES COALITION

Tranexamic Acid (TXA)

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Reproductive Health SUPPLIES COALITION

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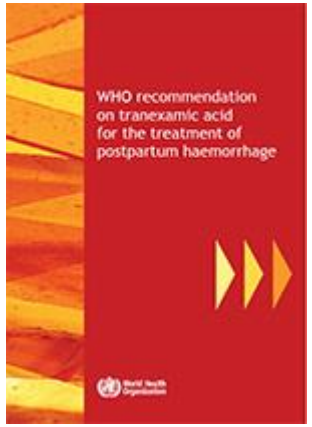
Tranexamic acid (TXA), anti-fibrinolytic agent; reduces bleeding by inhibiting the enzymes that breakdown clots



Included on WHO EML since 2012

World Health Organization Guidelines - 2017 (updated)

- Recommends early use of IV TXA within 3 hours of birth in addition to standard care for women with PPH following vaginal or caesarean birth *(should not be initiated more than 3 hours after birth).*
- TXA should be used in all cases of PPH, regardless of cause of bleeding.
- TXA should be administered at a fixed dose of 1 g in 10 mL (100 mg/mL) IV at 1 mL per minute (i.e., administered over 10 minutes), with a second dose of 1 g IV if bleeding continues after 30 minutes.
- TXA should be administered via an IV route only for treatment of PPH.

Research on other routes of TXA administration is a priority

Oral TXA Trial

Individual randomized double-blind placebo controlled trial

1950 mg* oral tranexamic acid

+

800 mcg sublingual misoprostol

vs.

Oral placebo

+

800 mcg sublingual misoprostol

Primary outcome: proportion of women with bleeding controlled with study regimens alone, without recourse to further treatment.

*Current recommended dose for TXAA to manage heavy bleeding during menses is 1300mg x 3 daily (3900mg daily). Max 5 d. 2000mg has been found to be safe in a previous study exploring the pharmacokinetics and bioavailability of TXA.

Pibrant et al. "Pharmacokinetics and bioavailability of tranexamic acid." Eur J Clin Pharmacol. 1981;20(1):65-72.

Treatment Outcomes

	Miso + Placebo N= 128	Miso + TXA N= 130
Bleeding controlled with treatment only - (no additional intervention)^	75 (59.4)	76 (58.5)
Bleeding controlled with treatment only - (no additional serious intervention)^ ^	101(78.9)	103 (79.2)

Additional Interventions

	Miso + Placebo	Miso + TXA
Additional uterotonics *(oxytocin, ergometrine, syntocinon, carbetocin, misoprostol)*	41 (32.0)	44 (33.8)
Additional TXA	15 (11.8)	17 (13.1)
Blood transfusion	13 (10.2)	12 (9.3)
Hysterectomy	1 (0.8)	0 (0)

What this means

- PPH causes extend beyond atony

- The addition of oral TXA does not seem to confer an advantage over misoprostol alone for treatment of PPH.

- Research supports IV TXA for women delivering in higher level facilities – viable addition to package of interventions for PPH management.

Continued need for simple options for PPH management beyond uterotonics for lower-level and community based births

Thank you! Any questions?

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