NEWSLETTER

November 2010

woman
World Maternal Antifibrinolytic Trial

THE GLOBAL COLLABORATIVE NETWORK IS GROWING

OVER 500 WOMEN RANDOMISED

OUR COLLABORATION WILL MAKE A DIFFERENCE TO MATERNAL LIVES

Some enthusiastic views from participating hospitals below

Federal Medical Centre Katsina, NIGERIA, team with PI Babasola Okusanya

I have been involved in local and national interventions to reduce maternal deaths in Nigeria, so when the opportunity for an international collaboration for the assessment of an intervention – TXA in the treatment of PPH (WOMAN trial) – came, I grabbed it!

Following the collaborators meeting at Ibadan, all doctors and midwives at our labour ward were trained over a two week period. Since the first woman was recruited at Katsina in April 2010, we have been recruiting all the way. Everyone in the team – six doctors and four midwives – has made this happen. An open, unassuming supervision of the trial team has been the secret of the team's success. PPH is the leading cause of maternal death in Nigeria and therefore all hands need be on deck for the WOMAN trial, **so come and join the Nigerian WOMAN trial train!** *Babasola Okusanya, FMC Katsina, Nigeria* – **TOP RECRUITING TEAM!**

Trial team of Hôpital Laquintinie de Douala, CAMEROON, with PI Tschélé Mésack Tchana second from right.

We are very pleased to top the list of recruiters in Cameroon. It is a great sign of motivation and encouragement for us. We are therefore inviting all health personnel around the world and especially in developing countries to join the WOMAN trial. It is a very exciting experience and we are very proud to contribute to the reduction of maternal mortality in our country through the proper management of PPH, which is the biggest killer. **Hope to see you in the trial very soon!**

Tchana Mésack, Principal investigator, Laquintinie Hospital Douala

Our experience with the WOMAN trial has been positive. Training meetings organised with doctors and midwives at our hospital, and at other hospitals where the trial will soon start, have helped us to re-evaluate the situation with PPH with regards to improving its early diagnosis and updating the protocol for its management.

PPH is the main cause of maternal mortality also in Albania; 40% of the maternal deaths in 1990-2004 were caused by obstetric bleeding. This led us and colleagues in other hospitals in Albania to be involved in this important clinical trial.

According to WHO the Maternal Mortality Ratio (MMR) in Albania in 2000 was nearly 50 per 100,000 live births. A lot remains to be done in order to achieve the Millennium Development Goal target in Albania – 9 per 100,000 live births.

Trial team at Obstetric Gynaecology University Hospital "K Gliozheni", with PI and ALBANIA NC Kastriot Dallaku second from left

We believe that besides the medical/surgical treatments, TXA may be a good option for immediate treatment of PPH. This is emphasised by the results of the CRASH-2 trial which showed that TXA reduces the risk of death due to bleeding in trauma patients. **Participation in the WOMAN trial is also a contribution to decrease the global maternal morbidity and mortality, so we invite other colleagues to join!**

Kastriot Dallaku, Albania National Coordinator

Trial team at BP Koirala Institute of Health Sciences, NEPAL, with PI Mohan Regmi in front in the middle

PPH is a life threatening condition and women in developing countries are particularly susceptible for the reasons that are well known to all of us. We have been using different modalities of treatment and also looking for new alternatives. New modalities of treatment should be explored and established if supported by evidence. **So, it is important that the WOMAN trial should be supported by all spheres, particularly by a developing country like Nepal, PPH being a major burden in maternal health.**

Mohan Regmi, Principal Investigator,
BP Koirala Institute of Health Sciences, Nepal

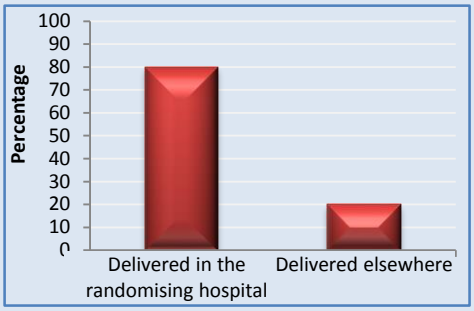
Collaborating to make a difference to maternal lives

31 sites recruiting in the above 4 countries

11 sites ready to start in Jamaica, Nepal, Nigeria, Pakistan, Zambia

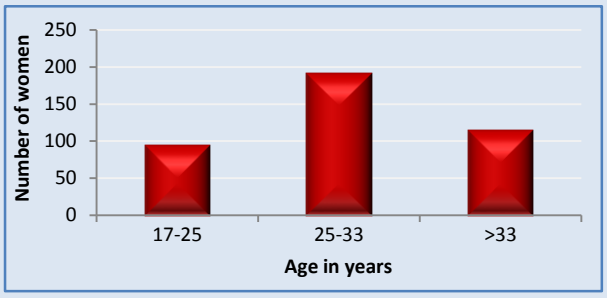
Sites in progress in Bangladesh, Botswana, Burkina Faso, Cameroon, Colombia, Ecuador, Ethiopia, Ghana, India, Kenya, Nigeria, Pakistan, Peru, Sudan, Tanzania, Thailand, Uganda, UK, Zimbabwe

DATA ALREADY COLLECTED SHOWS THE FOLLOWING DETAILS:



Blood	N (%)
Received transfusion	123 (58%)
Average (range) units RBC	2.5 (1 - 12)
Number (%) with 1 unit	65 (31%)
with 2-8 units	137 (66%)
with >8 units	6 (3%)
Average (range) units plasma	1.5 (1 - 3)
Average (range) other blood products	0

Procedure	n(%)
ANY intervention	93 (25%)
Hysterectomy	18 (5%)
Brace sutures of the uterus	3 (1%)
Arterial ligation / embolisation	8 (2%)
Laparotomy for other bleeding reasons	7 (2%)
Manual removal of placenta	53 (15%)
Intrauterine tamponade	24 (6.5%)



UTEROTONICS	N(%)
Oxytocin	353 (99%)
Ergometrine	207 (58%)
Misoprostol	167(47%)
Prostaglandins	2 (0.5%)

EVENT	TOTAL	%
Women who died	23	6.5
Women with Hysterectomy	18	5
Women who died after Hysterectomy	3	1
Overall event rate		10.5%

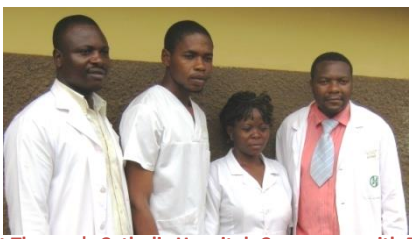
Remember to give the second dose if bleeding continues for 30 minutes, or stops and restarts within 24 hours.

Federal Medical Centre Azare, Nigeria, with PI Umar Ibraham

Federal Medical Centre Gusau, Nigeria, with PI Kamil Shoretire

Kumba District Hospital, Cameroon, with PI Etienne Asonganyi fourth from right

Regional Hospital Limbe, Cameroon, with PI Robert Tchounzou second from right



St Theresa's Catholic Hospital, Cameroon, with PI Mutsu Bumaha Venantius on the right.

University College Hospital Ibadan, Nigeria, with PI Oladapo Olayemi on the left

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