Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Retained Placenta Guideline

Guideline information

Guideline number: 658

Classification:
Clinical

Supersedes:
Previous Version

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
N/A

Version number:
2.0

Date of Equality Impact Assessment:
03/10/2023

Approval information

Approved by: Obstetric Written Control Document Group

Date of approval:
17/06/2022

Date made active:
04/10/2023

Review date:
17/06/2025
Extended by: Chair of Obstetric Guideline Group

Approved on:	28.05.2025	16.02.2026
Made Active:	29.05.2025	16.02.2026
Review Date:	28.11.2025	16.08.2026

Summary of document:
Safe care of women and birthing people who experience a retained placenta through timely identification, management and treatment.

Scope:
This guideline is applicable to maternity units throughout the Health Board and the home setting.

This guideline is applicable to women and birthing people who experience a retained placenta following an actively managed or physiological third stage of labour, in the second or third trimester.

The term “woman/women” in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.’

To be read in conjunction with:
All Wales Postpartum Haemorrhage Guideline
618 - Placenta Praevia and Placenta Accreta Guideline (opens in new tab)

Patient information:
Include links to Patient Information Library

Owning group:
Obstetric Guideline Group
17/06/2022

Executive Director job title:
Andrew Carruthers – Director of Operations

Reviews and updates:
1.0 – New Guideline
2.0 - Updated

Keywords
Retained Placenta, Haemorrhage, Third Stage, Postpartum

Glossary of terms
PPH – Postpartum Haemorrhage
MROP – Manual Removal of Placenta
AMU – Alongside Midwifery Unit
FMU – Freestanding Midwifery Unit

Contents

Guideline information....1
Approval information....1
Scope....4
Aim....4
Objectives....4
Introduction....4
Definition....4
Types of Retained Placenta....4
Pathogenesis – There are Four Phases in the Third Stage of Labour....4
Risk Factors....5
Causes....5
Key Complications....5
Management....6
Obstetric Speciality Trainee....6
Theatre Procedures....7
Second Trimester: Retained Placenta....7
The '3 ES'....7
Key Learning Points....7
References....8
Appendix 1 – Flowchart for the Management of Retained Placenta....9
Appendix 2 – Before MROP Checklist....10

Scope
This guideline is applicable to maternity units throughout the Health Board and the home setting.

This guideline is applicable to women and birthing people who experience a retained placenta following an actively managed or physiological third stage of labour, in the second or third trimester.

The term “woman/women” in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.’

Aim
The aim of this document is to:
- Ensure the safe care of women and birthing people who experience a retained placenta following birth of the baby in the second and third trimester of pregnancy

Objectives
The aim of this document will be achieved by the following objectives:
- Correctly identifying delayed separation and expulsion of the placenta after a vaginal birth
- Timely and correct management of retained placenta

Introduction
Delayed separation of the placenta during the third stage of labour is a potentially life-threatening event which can lead to haemorrhage.

It has a prevalence of between 1 and 3% depending on the care setting and on whether the delay is described as functional or pathological.

Definition
The most widely accepted definition is the retention of the placenta in utero for more than 30 minutes following an actively managed third stage. With a physiologically managed third stage 60 minutes can elapse before the diagnosis of retained placenta is made.

Types of Retained Placenta
- Detached – a separated placenta that has detached completely from the uterus but is retained inside the uterus
- Partially detached – the placenta has partially separated and is retained inside the uterus
  Non-detached – the placenta has not separated at all.

Pathogenesis – There are Four Phases in the Third Stage of Labour
- Latent phase – immediately after birth, all of the myometrium contracts except for the portion beneath the placenta
- Contraction phase – the retroplacental myometrium contracts
- Detachment phase – contraction of the retroplacental myometrium produces horizontal ‘shear’ stress on the maternal surface of the placenta, causing it to detach
- Expulsion phase – myometrial expulsions expel the placenta from the uterus.

Risk Factors

- Previously retained placenta
- Multiparity
- Maternal age > 35 years
- Induction of labour
- Preterm labour
- Placenta Previa / abnormally invasive placenta
- Uterine anomalies eg. Bicornuate uterus, fibroids
- Previous uterine surgery or instrumentation

Causes

- Full Bladder
- Constriction ring
- Morbidly adherent placenta
- Detached cord
- Uterine anomaly

Key Complications

- PPH
- Shock
- Sepsis
- Perforation
- Retained products
- Uterine inversion
- Trauma
- Rhesus-isoimmunisation
- Anaesthetic complications
- Severe maternal morbidity and death

Management

Active management	Conservative management
Routine use of uterotonic drugs	No routine use of uterotonic drugs
Deferred cord clamping and cutting	No cord clamping and cutting until pulsation has stopped
Placental delivery by controlled cord traction after signs of separation	Placental delivery by maternal effort
Risk of 14 in 1000 of a blood transfusion	Risk of 40 in 1000 of a blood transfusion

If the placenta is undelivered after 30 minutes of active management / 60 minutes of physiological management and patient stable with no significant bleeding

- Do not leave woman unattended
- Regular maternal observations : pulse, blood pressure, respiratory rate every 15minutes
- Position change to upright
- Empty the bladder. If cannot pass urine then catheterisation should be carried out
- Encourage breastfeeding or nipple stimulation
- Call Obstetric specialty trainee earlier if concerns regarding bleeding or becomes haemodynamically unstable
- Conservative management only: at 60minutes if placenta not delivered give Syntometrine (500 micrograms Ergometrine/5 IU Oxytocin) and wait a further 30 minutes if no active bleeding.

Obstetric Speciality Trainee

- Offer vaginal examination
- Examination in the room is appropriate with verbal consent and if signs of separation have occurred, **providing analgesia is adequate**. There should be a low threshold to abandon attempts and move woman to theatre if there is active bleeding or patient discomfort.
- Use of umbilical vein uterotonic drugs is no longer recommended
- Obtain informed consent for theatre
- Inform anaesthetist and theatre staff
- If there is a delay in transfer to theatre consider indwelling catheter and cross match

Consent should include:

- Risks of bleeding, infection, trauma to uterus or cervix, failure to remove all tissue, blood transfusion, repeat procedure, balloon insertion, laparotomy and hysterectomy.

Theatre Procedures

- Surgical pause and review of consent
- Ensure analgesia is functional
- Aseptic technique - clean and drape
- IV Antibiotic cover - 1.2g of co-amoxiclav OR clindamycin 600mg IV + gentamicin
- Empty bladder
- Stabilise fundus with non-dominant hand
- Gently insert hand through cervix and identify the placental plane
- If plane between placenta and uterus not easily defined consider placenta accreta and inform on call consultant. Do not pull on cord or placenta.
- Using the side of your hand and a sweeping motion sweep the placenta from the uterine wall
- Guard the fundus to avoid uterine inversion
- Grasp the uppermost portion of the placenta and aim to remove the whole placenta in one piece
- Check the cavity is empty - if in doubt call obstetric consultant on call
- Massage fundus
- Inspect for tears and repair as required
- IV Oxytocin infusion should commence (40iu of Oxytocin – 500ml of sodium chloride over 4hours if active bleeding has occurred)
- Document in notes and debrief patient when appropriate
- DATIX to be completed if PPH or other complications
- Completion of OBSCymru

Second Trimester: Retained Placenta

Conservative management may be considered for up to 180minutes in the absence of bleeding or shock. However, if no signs of separation have occurred within 60minutes then manual removal may be appropriate.

The '3 ES'

- Examine – for maternal trauma (genital tract trauma and PPH) and the general condition
- Explain – the events that took place, possible reasons, complications and future plan of care to the patient i.e. debrief
- Escalate – discuss at team meetings to identify learning points to continuously improve patient care

Key Learning Points

- Importance of identifying the risk factors for retained placenta
- Importance of managing the third stage in line with national guidance
- Importance of calling for help/communicate clearly in an emergency/involve experienced clinicians **EARLY ESCALATION**
- Importance of avoiding excessive or inappropriate handling of the uterus and the placenta leading to uterine inversion and retained placenta
- Importance of observing strict aseptic condition during MROP
- Importance of anticipating PPH
- Importance of recognising vaginal, cervical and uterine trauma after the procedure
- Importance of keeping adequate records, including time keeping, and documentation of the events.

References

Chandraharan E and Arulkumaran S (2013) Obstetric & Intrapartum Emergencies Cambridge UK

NICE (2017) Intrapartum care for healthy women and babies

PROMPT (2018) Course Manual, 3rd edition. Cambridge University Press, UK

Weeks A (2018) Retained Placenta. UpToDate content https://www.uptodate.com/contents/retainedplacenta-after-vaginal-birth?csi=56168e51-81eb-4de4-a190-76f7153fade7&source=contentShare (opens in new tab) accessed online

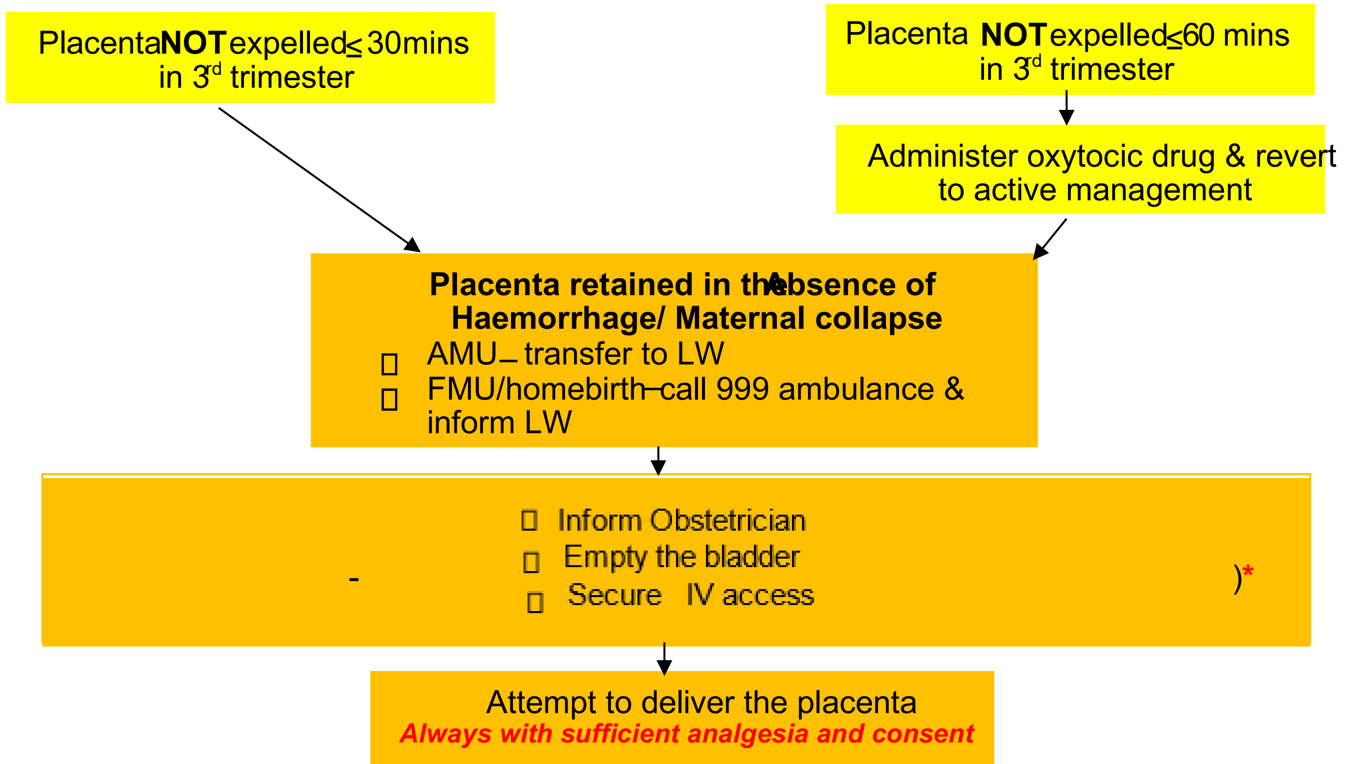
Perlman, N. C., & Carusi, D. A. (2019). Retained placenta after vaginal delivery: risk factors and management. International journal of women's health, 11, 527–534. https://doi.org/10.2147/IJWH.S218933 (opens in new tab)

Appendix 1 – Flowchart for the Management of Retained Placenta

Active Management

Physiological/Expectant Management

Timing to intervention period **ONLY** applies if the mother is not bleeding and is haemodynamically stable.



Placenta Trapped in Cervix

- Attempt CCT again
- Apply CCT with traction on the cord until the placenta is delivered.

Do not carry out uterine exploration or MROP without an anaesthetic

Placenta Adherent

- Expectant management for a maximum of 120 minutes following the birth of the baby (in the absence of bleeding)
- Transfer to theatre for MROP

Do not carry out uterine exploration or MROP without an anaesthetic

Appendix 2 – Before MROP Checklist

MROP CHECKLIST	Yes	No	Date and time	Signature
☐ Inform Speciality Obstetric Doctor (Registrar)				
☐ Inform Obstetric Consultant				
☐ Cannula				
☐ FBC/G&S				
☐ Consent for MROP				
☐ Sufficient analgesia				
☐ Oxytocin infusion				
☐ Swabs/sharps check				
☐ Debrief				