

Retained Placenta Guideline

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		Extended whilst review is being undertaken - Obstetric Group	30.06.2022	08.07.2022	30.12.2022

Brief Summary of Document:	Safe care of women who experience a retained placenta through timely identification, management and treatment.
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Scope	Maternity wards throughout the Health Board and the home setting. Women 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.’
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To be read in conjunction with:	All Wales Postpartum Haemorrhage Guideline 618 – Placenta Praevia and Placenta Accreta Guideline
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Patient Information:	Include links to Patient Information Library
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Owning group	Obstetric Guideline Group
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Retained Placenta Guideline

Please check that this is the most up to date version of this written control document

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure that the printed version is the most recent

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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	04.06.2019

Glossary of terms

Term	Definition
PPH	Postpartum haemorrhage
MROP	Manual removal of placenta
AMU	Alongside Midwifery Unit
FMU	Freestanding Midwifery Unit

Keywords	Retained placenta, haemorrhage, third stage, postpartum
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Contents

1. AIM	5
2. OBJECTIVES	5
3. SCOPE	5
4. INTRODUCTION	5
5. DEFINITION	5
6. RISK FACTORS	5
7. KEY IMPLICATIONS	6
8. MANAGEMENT	6
9. THE '3 ES'	8
10. KEY PITFALLS.....	8
11. REFERENCES.....	8
12. APPENDIX A - BEFORE MROP CHECKLIST	9

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1. AIM

The aim of this guideline is to ensure the safe care of women who experience a retained placenta following birth of the baby.

2. OBJECTIVES

The aims of this guideline will be achieved by:

- Correctly identifying delayed separation and expulsion of the placenta after a vaginal birth
- Timely and correct management of retained placenta

3. SCOPE

Women who have a retained placenta in the hospital or home environment following an actively managed or physiological third stage of labour, during the second or third trimester. To be adhered to by obstetricians and midwives.

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.’

4. 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 0.5 and 3% depending on the care setting and on whether the delay is described as functional or pathological.

5. DEFINITION

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

5.1 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.

5.2 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.

6. RISK FACTORS

- Previous retained placenta
- Morbidly adherent placenta – placenta accreta/increta/percreta
- Preterm gestational age/preterm labour
- Use of ergometrine
- Uterine abnormalities/uterine scars (e.g. previous uterine surgery)
- Uterine atony
- Constriction ring or reforming cervix

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- Full bladder
- Inappropriate active management of the third stage of labour
- Following induction of labour
- Pre-eclampsia, stillbirth, small-for-gestational age (SGA) baby
- Velamentous cord insertion
- Maternal age \geq 30 years
- Delivery in a teaching hospital

7. KEY IMPLICATIONS

7.1 Maternal

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

7.2 Medicolegal

- Clinical negligence claims due to delay in removing the placenta or inappropriate management

8. MANAGEMENT

Follow flow chart below:

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Third Stage of Labour: Retained Placenta

Active Management

Physiological/Expectant Management

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

Placenta **NOT** expelled ≤30 mins in 3rd trimester

Placenta **NOT** expelled ≤60 mins in 3rd trimester

Administer oxytocic drug & revert to active management

Placenta retained in the Absence of Haemorrhage/ Maternal collapse

- AMU – transfer to LW
- FMU/homebirth – call 999 ambulance & inform LW

- Inform Obstetrician
- Empty the bladder
- **Consider** intra-umbilical vein oxytocin injection (30iu oxytocin in 20ml normal saline)*
- Secure IV access

Attempt to deliver the placenta
Always with sufficient analgesia and consent

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

Haemorrhage/ Maternal Collapse

- Follow OBSCYMRU PPH Pathway
- Transfer to Theatre

* *Nb. NICE (2014) does not recommend intra-umbilical vein oxytocin injection*

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9. 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

10. KEY PITFALLS

- Failure to identify the risk factors for retained placenta
- Failure to manage the third stage properly
- Failure to call for help/communicate clearly in an emergency/involve experienced clinicians
- Excessive or inappropriate handling of the uterus and the placenta leading to uterine inversion and retained placenta
- Failure to observe strict aseptic condition during MROP
- Failure to anticipate PPH
- Failure to recognise vaginal, cervical and uterine trauma after the procedure
- Failure to keep adequate records, including time keeping, and documentation of the events.

11. REFERENCES

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- NICE (2014) Intrapartum care for healthy women and babies
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- Weeks A (2018) Retained Placenta. UpToDate content <https://www.uptodate.com/contents/retained-placenta-after-vaginal-birth?csi=56168e51-81eb-4de4-a190-76f7153fade7&source=contentShare> accessed online

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12.APPENDIX A - BEFORE MROP CHECKLIST

MROP CHECKLIST	Yes	No	Date and time	Signature
• Inform Registrar/Staff Grade				
• Inform Obstetric Consultant				
• Cannula				
• FBC/G&S				
• Consent for MROP				
• Sufficient analgesia				
• Oxytocin infusion				
• Swabs/sharps check				
• Debrief				