

MATERNITY UNIT**GUIDELINE: MANAGEMENT OF RETAINED PLACENTA****SCOPE:** All midwives and obstetricians working in the maternity unit.**AUTHOR:** Core Midwife & Midwife Educator**PURPOSE:**

To provide guidance as to the appropriate and timely management of retained placenta in order to reduce the incidence of postpartum haemorrhage and its complications.

DEFINITIONS:***Up to date on line***

There is no consensus worldwide as to the length of the third stage after which a placenta should be termed "retained" and intervention initiated. The optimum time balances the risks of leaving the placenta in situ (haemorrhage, infection) and the risks of manual removal (haemorrhage, infection, uterine trauma) versus the likelihood that the placenta will spontaneously deliver with expectant management. The incidence of retained placenta occurs in 0.01 – 6.3% of vaginal deliveries and is an important cause of PPH. A retained or partially separated placenta interferes with normal uterine contraction, which leads to haemorrhage.

NICE guideline

Placenta is defined as retained when it has not been delivered within 30 minutes of birth when the third stage is actively managed, and 60 minutes when the third stage is physiologically managed, without signs of postpartum haemorrhage or maternal collapse.

For the purposes of this Hauora Tairāwhiti guideline, a retained placenta is when the placenta is not birthed within 30 minutes for active management and between 30 - 60 minutes for physiological management. If there are ANY deviations from the normal during 3rd stage management, obstetric assistance should be considered (Referral Guidelines).

GUIDELINE

If a placenta is left in situ, there is a high risk of postpartum haemorrhage (PPH) which may lead to maternal morbidity or mortality. Manual removal of the placenta is an invasive procedure with its own complications of haemorrhage, infection or genital tract trauma. Oxytocic administration followed by assisted delivery of the placenta, as in active management of the third stage, is recommended for all women. Expectant management has a two-fold increase in the incidence of postpartum haemorrhage and an increased risk for blood transfusion. That being said, if a woman is at low risk for PPH and requests physiologic management of the third stage, she should be supported in the absence of complications.

Common causes and risk factors for retained placenta include:**Possible causes:**

- Uterine Inertia
- Atonic uterus
- Full bladder
- Mismanaged third stage
- Abnormal uterus – e.g. Bicornuate shape
- Placenta accreta
- Constriction ring

Risk Factors:

- Low lying placenta
- History of APH in this pregnancy
- Placental abruption
- Previous uterine incision/surgery
- Previous retained placenta
- Fibroids
- Previous PPH
- Previous manual removal
- Early gestational age – early preterm gestational age is associated with a longer third stage, e.g. the earlier the gestation, potentially the longer the third stage
- Advanced maternal age
- High parity

Midwifery strategies to encourage placental birth

- Put baby to the breast
- Squatting position
- Ensure that the bladder is empty - if the woman is unable to void then catheterisation is required.

Management:

(Please note if the woman is bleeding and has a retained placenta, use this guideline in combination with the PPH guideline.)

During the management of the third stage of labour, if retained placenta is suspected:

- Perform an internal examination with informed consent from the woman. The placenta may be held in the vagina, or sitting in an open cervical os. Gentle traction may solve the problem.
- Do not be misled by an absence of heavy vaginal bleeding. A trapped placenta may cover the cervical os so blood cannot escape. The woman may be suffering very significant “hidden” blood loss into the uterine cavity.
- Vital signs should be recorded, remembering that a healthy woman can compensate for a large blood loss before a change in BP will be seen.
- Share your concerns with the woman.

- Call the obstetrician and give appropriate clinical information (use the SBARR communication tool).
- Have an intravenous line in place, bloods taken for CBC and Group & Hold, entonox and morphine sulphate for injection available for administration to the woman by the obstetrician as necessary.
- According to the obstetrician's findings, a manual removal in the Delivery Unit or removal in the operating theatre may be advisable. In either case, adequate pain relief must be available and administered, and the woman's informed consent must be obtained (verbal is sufficient if documented).

REMEMBER to keep full and comprehensive documentation. Use the following as a guide:

- o Times of events/actions
- o Those present giving assistance, names and designation
- o Ongoing maternal observations and ongoing EBL estimations
- o Medications, dosages and route given, times of administration, who ordered, checked and administered
- o Full explanation of management
- o Outcome including total estimated blood loss (EBL) and ongoing management plan
- o Medications/drugs used must be charted and signed for by those involved in their administration and prescribing at the end of the event
- o All this information should be legible, dated, timed and signed in the clinical notes

Women treated for a retained placenta must be observed for late sequelae, including infection and late post-partum bleeding.

Antibiotic prophylaxis to prevent endometritis after manual removal of placenta in vaginal birth is thought to be good practice, although there are no randomized controlled trials to evaluate its effectiveness.

If the woman suffers a PPH, then postnatal management according to the PPH guideline should be followed.

ASSOCIATED DOCUMENTS

Maternity unit guideline – Prevention and management of primary postpartum haemorrhage
Maternity unit guideline – Use and administration of Misoprostol

REFERENCES

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