OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Labour (third stage): Retained placenta

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this Disclaimer

Aim

To guide clinicians in the appropriate care of a woman experiencing a retained placenta.

Definitions

The definition of a prolonged third stage of labour and retained placenta is made according to the type of management used for the third stage of labour. From the time of birth of the neonate/s, if the placenta is not delivered within[1]:

- **Active management:** 30 minutes.
- **Physiological management:** 60 minutes.

Background

The incidence of retained placenta is approximately 2%. The risk for retained placenta may increase if uterine fibroids and/or uterine anomalies, such as bicornuate uterus[2] or septum are present. The placenta may also become retained if trapped in the cervix or lower uterine segment, and if the woman has a full bladder. Morbid adherence of the placenta includes placenta acreta, placenta increta and placenta percreta.[2] An adherent placenta is associated with absence of bleeding, and on examination the uterine fundus remains broad and high, the contractions may be weak or absent, and there is no lengthening of the umbilical cord.

Key points

1. In the presence of postpartum haemorrhage (PPH) the placenta must be delivered at once.
2. Avoid vigorous cord traction to prevent cord snapping or causing uterine inversion.
3. A full bladder may inhibit delivery of the placenta.
4. There are currently no randomised controlled trials to evaluate the effectiveness of prophylactic antibiotics to prevent endometritis after manual removal of the placenta.[3]

Procedure

1. **Notify the medical team and the midwifery co-ordinator of a suspected retained placenta if:**
    - The woman is bleeding, or
    - The placenta has not delivered within 30 minutes of the birth of the baby (active management), or
    - The placenta has not delivered within 60 minutes of the birth of the baby (physiological management), or
    - For CMP homebirths: in addition to notifying the above, an ambulance needs to be called as per the CMP section below.
2. **Bladder assessment**: Perform bladder catheterisation.
    - A full bladder may interfere with the descent and delivery of the placenta.
3. **Assess for placental separation.**

    If the placenta is separated:
    - Encourage maternal position changes.
    - Encourage maternal effort to deliver the placenta (though not whilst performing controlled cord traction).
    - Offer a vaginal examination to determine if the placenta is trapped in the cervix or lower segment.
    - Encourage breastfeeding or nipple stimulation.

    When these methods are unsuccessful an **experienced operator** may apply fundal pressure on the contracted uterus to push the placenta from the lower segment or vagina.
4. **Management if the placenta remains retained:**
    - Establish intravenous (IV) access with a 16 gauge cannula and commence an IV infusion of oxytocin 40IU in Hartmann's 500mL. Administer at a rate of 125mL/hour.
    - Collect blood for full blood picture and cross-matching.
    - Commence the woman fasting.

- Provide one on one midwifery care whilst placenta insitu. Perform frequent (15-30 minutely) vital signs, blood loss, fundal height and uterine tone).

5. **Manual removal of the placenta in theatre.**
    - Prepare the woman for manual removal of the placenta in theatre.
    - Note and document the time of placenta delivery in theatre.

Additional information

- A retained placenta increases the risk of PPH
- A significant amount of blood may be lost within an expanding uterus and/or in the vagina and not be seen externally
- An upright position may assist maternal effort in placental delivery
- Effective regional analgesia (or general analgesia) is required for manual removal of the placenta
- Ensure contemporaneous documentation

Community Midwifery Program (CMP)

In **addition** to the above procedure steps:

- **Oxytocic**- If the woman has elected for physiological third stage management and the placenta remains insitu 1 hour after the birth, the client must be offered an oxytocic:
    - Syntometrine® 1mL must be administered following consent as per Structured Administration Supply Arrangements (SASA): CMP Syntometrine SASA.
    - Commence active management with controlled cord traction (see WNHS clinical guideline Labour: Third Stage).
- **Contact** (in place of 'Procedure' point 1):
    - Call an ambulance and transfer into the supporting hospital. Where there is active bleeding or other emerging concerns, transfer via ambulance to closest maternity hospital. As per WNHS Clinical Guideline, O&G: Transfer from home to Hospital (VMS / MGP / CMP).
    - Consult with the supporting hospital, informing the Obstetrician and Midwifery Coordinator of immediate transfer in with a retained placenta.
- Insert a 2nd large bore cannula if practicable; commence 1 litre of CSL IVI following a verbal order.
- **Handover**- Complete an intrapartum clinical handover form and an intrapartum transfer form.
- For PPH in the home, refer to Primary PPH at Home- CMP guideline

If the placenta births at any time prior to leaving the house and: there is no PPH, the maternal observations are within normal limits and completeness of placenta and membranes is confirmed, consult with the supporting hospitals obstetrician or GP/obstetrician to discuss if transfer is still recommended.

References

1. National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies: CG190UK: NICE. 2017 (updated Dec 2022). Available from: https://www.nice.org.uk/guidance/cg190
2. Paterson-Brown S, Howell C, editors. Managing obstetric emergencies and trauma: The MOET course manual. Revised 3rd ed. Cambridge: Cambridge University Press; 2014.
3. Chongsomchai C, Lumbiganon P, Laopaiboon M. Prophylactic antibiotics for manual removal of retained placenta in vaginal birth. **Cochrane Database of Systematic Reviews**. 2014 (10). Available from: https://doi.org//10.1002/14651858.CD004904.pub3

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines:

Community Midwifery Program- Primary PPH at Home- CMP (access to WA Health employees through HealthPoint)

Obstetrics and Gynaecology:

- Postpartum Complications (PPH, uterine inversion) (access to WA Health employees through HealthPoint)
- Transfer from Home to Hospital (VMS / MGP / CMP)

Pharmacy: CMP Syntometrine SASA (available to WA Health employees through HealthPoint)

Keywords:	retained placenta, manual removal of placenta, third stage of labour, placenta not delivered, CMP		
Document owner:	Obstetrics and Gynaecology Directorate		
Author / Reviewer:	Head of Department, Obstetrics		
Date first issued:	May 2008(v1)		
Reviewed dates: (since Oct 2014)	Aug 2011(v2); Oct 2014(v3); (amended April 2016(v4); May 2016(v5); Dec 2022(v6)	Next review date:	Dec 2025
Approved by:	Head of Department Obstetrics KEMH	Date:	22/11/2022
Endorsed by:	Obstetrics and Gynaecology Directorate Management Committee	Date:	07/12/2022
NSQHS Standards (v2) applicable:	☒ 1: Clinical Governance ☐ 2: Partnering with Consumers ☐ 3: Preventing and Controlling Healthcare Associated Infection ☒ 4: Medication Safety	☐ 5: Comprehensive Care ☒ 6: Communicating for Safety ☐ 7: Blood Management ☒ 8: Recognising and Responding to Acute Deterioration	

Printed or personally saved electronic copies of this document are considered uncontrolled. Access the current version from WNHS HealthPoint.

Version history

Version number	Date	Summary
1	May 2008	First version. Previously known as B5.10.4 ‘Retained Placenta’ and ‘Care of a Woman with a Retained Placenta’
2-3	Aug 2011, Oct 2014	Routine reviews. Known as B5.10.4 ‘Management of a Retained Placenta’. Contact OGD Guideline Coordinator for previous versions.
4	April 2016	Amendment- new template, titled ‘Retained Placenta’. Infusion additive has been increased to 40IU in 500mL Hartmann’s solution.
5	May 2016	Amendment- oxytocin infusion rate amended
6	Dec 2022	• Provide one on one midwifery care whilst placenta insitu. Perform frequent observations (e.g. 15-30 minutely) vital signs, blood loss, fundal height, uterine tone. • Ensure contemporaneous documentation. • CMP section added, links to CMP SASAs- read section. CMP ‘Retained Placenta’ guideline withdrawn.

This document can be made available in alternative formats on request for a person with a disability.

www.nmhs.health.wa.gov.au