**WOMEN'S HEALTH AND PAEDIATRICS**

**MATERNITY UNIT**

# MANAGEMENT OF RETAINED PLACENTA

| Amendments | | | |
|---|---|---|---|
| **Version** | **Date** | **Comments** | **Approved by** |
| 1 | Dec 2018 | Whole document review and update | Women's Health Guidelines Group |
| 2 | Feb 2022 | Whole document review and update | Perinatal Governance Group |

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**In consultation with**: Perinatal Guidelines Group

**Ratified by:** Perinatal Guidelines Group

**Date ratified:** **February 2022**

**Next review date:** **February 2025** or if legislation, national guidance or lessons learnt indicate an earlier review

**Target audience:** All health professionals within the maternity services

**Equality impact assessment:** Perinatal Guidelines Group

**Comments on this document to:** Perinatal Guidelines Group

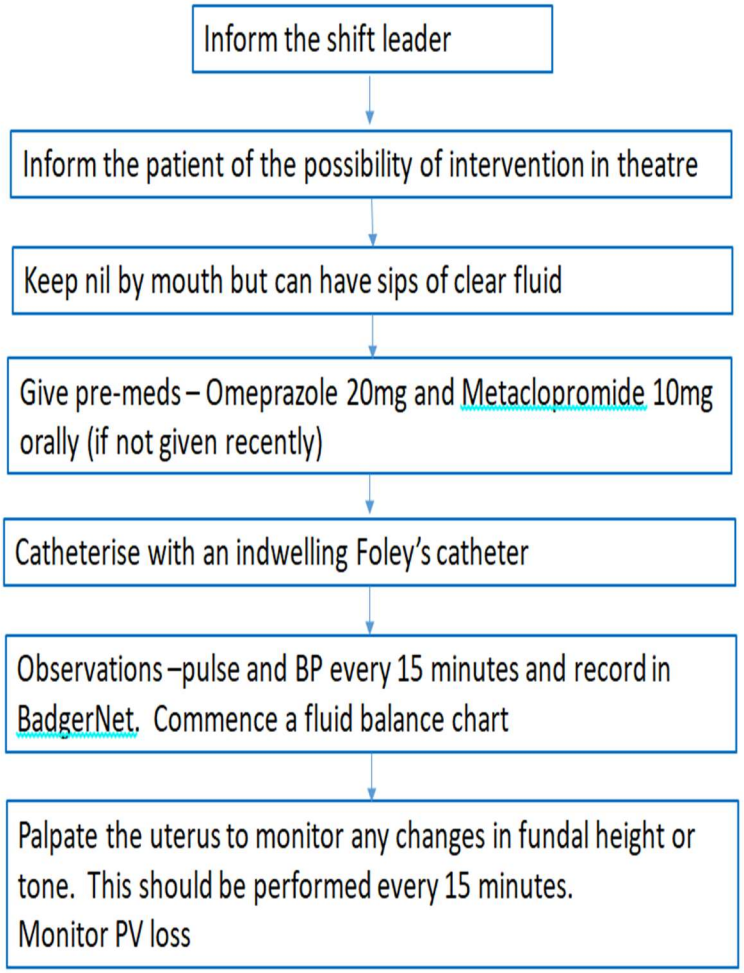
**Contents**



## Abbreviations

| | |
|---|---|
| BP | Blood pressure |
| FBC | Full blood count |
| G&S | Group and save |
| IV | Intravenous |
| MROP | Manual removal of placenta |
| PPH | Postpartum haemorrhage |

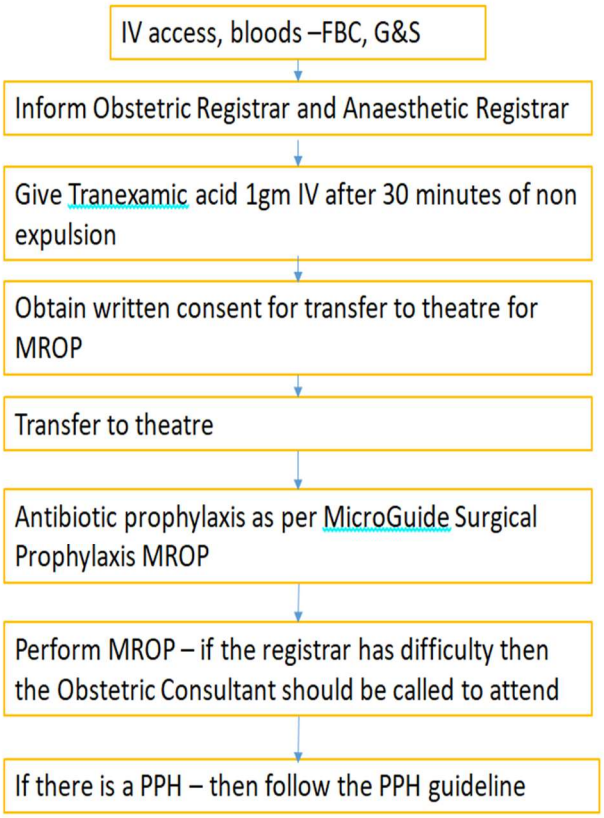
# Flow chart 1 - Initial Management of Retained Placenta in a stable patient




**Concern about the women's condition**

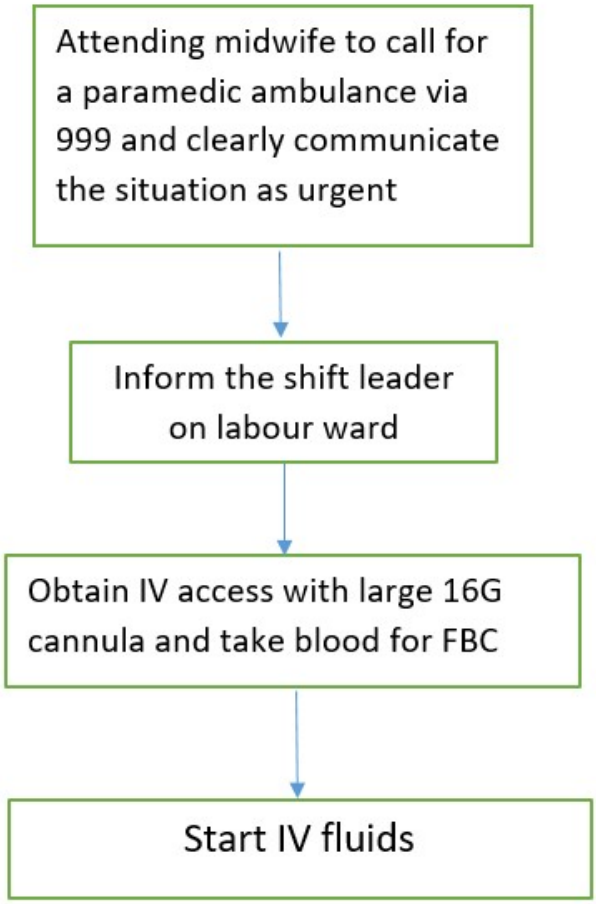
- **Offer vaginal examination**
- **Explain this may be painful and offer analgesia**
- **If there is inadequate analgesia then stop and address this immediately**

## Flow chart 2 – Subsequent Management Retained Placenta




Birth centre - arrange transfer to LW after 30 mins if placenta not delivered

**Flow chart 3- Management of retained placenta in the community**



# MANAGEMENT OF RETAINED PLACENTA

## 1.0 Introduction

Delayed placental separation and expulsion is a significant cause of maternal morbidity and associated with postpartum haemorrhage (PPH).

2-5 % of all deliveries are complicated with a delay in 3rd stage and 15-20% are complicated by postpartum haemorrhage.

## 2.0 Definition

The third stage of labour is diagnosed as being prolonged

- if not completed within 30 minutes of the birth of the baby with active management
- if not completed within 60 minutes with physiological management

## 3.0 Types of Retained Placenta

There are three types of retained placenta, in order of increasing morbidity

**●Trapped or incarcerated placenta**
The incarcerated or trapped placenta is simply a separated placenta that has detached completely from the uterus, but has not delivered spontaneously or with light cord traction because the cervix has begun to close

**●Placenta adherens**
The placenta is adherent to the uterine wall but is easily separated manually

**●Placenta accreta spectrum**
The placenta is pathologically invading the myometrium due to a defect in the decidua. It cannot be cleanly separated manually, although the placenta may still be removed vaginally if the abnormal area of attachment is small

## 4.0 Risk Factors

The following conditions are associated with retained placenta

- Previous retained placenta
- Preterm birth
- Other placentation disorder such as recurrent miscarriages, pre-eclampsia, fetal growth restriction, and stillbirth
- Previous caesarean section
- Previous uterine surgeries
- Labour and delivery interventions- such as induction of labour, augmentation of labour
- Mullerian abnormalities

## 5.0 Management

Retained placenta should be suspected if the placenta has not been delivered within 15 minutes of the baby's birth, where active management has been employed.

Initial Management- See Flow chart 1

Subsequent management after 30 mins – See Flow chart 2

Retained placenta in the community – see Flow Chart 3

### Other considerations:

- If the placenta is retained and there is a concurrent PPH follow the Guidelines for the Management of Obstetric Haemorrhage.
- If the placenta is not delivered within 1 hour of the birth of the baby- and physiological management was undertaken, a change from physiological management to active management should take place.
- For women with a second-trimester birth and no significant bleeding, the time period before manual extraction can be extended as the frequency of retained placenta is higher and the risk of hemorrhage is lower, but not waiting more than two hours due to the risk of infection.

### Morbidly Adherent placenta

- The on call/ labour ward consultant must be contacted and present in this situation
- If there is severe haemorrhage refer to "Obstetric Haemorrhage" guideline
- If Placenta is left in situ (a consultant decision) antibiotics should be prescribed with serial HCG's measurement arrangement and documented clear plan in the maternal records with subsequent follow up plan. Methotrexate adjuvant therapy should not be used (RCOG,

2018). Always consider the possibility of a morbidly adherent placenta if there is difficulty in removing the placenta in theatre

## 6.0 Following a Manual removal of Placenta

- Intravenous (IV) antibiotics, single dose in theatre – see Microguide Surgical prophylaxis, unless further course advised by the attending doctor.
- Ensure the placenta and the membranes are checked for completeness.
- Record the total amount of blood loss following delivery of the placenta including the vaginal loss after delivery of the baby.
- The woman will need an indwelling catheter after the procedure if performed under regional anaesthesia (Follow the bladder care as per guideline).
- If uterine atony occurs, follow the "Obstetric Haemorrhage" guideline.
- Woman should be transferred to the Observation bay for 2-4 hours as a minimum.

## References

1. Intrapartum care for healthy women and babies. Clinical guideline [CG190] Published: 03 December 2014. Updated 21 February 2017. https://www.nice.org.uk/guidance/cg190
2. Prolonged third stage of labor: morbidity and risk factors. Combs CA, Laros RK. Jr *Obstet Gynecol* 1991; 77: 863– 7.
3. Risk factors for retained placenta. Coviello EM, Grantz KL, Huang CC, Kelly TE, Landy HJ. *Am J Obstet Gynecol* 2015; 213: 864.e1– 11.
4. The incidence and risk factors for retained placenta after vaginal delivery – a single center experience. Ashwal E, Melamed N, Hiersch L, Wiznitzer A, Yogev Y, Peled Y. *J Matern-Fetal Neonat Med* 2014; 27: 1897– 900.
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**PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE**

| | |
|---|---|
| Policy/Guidelines Name: | Retained Placenta: Management of |
| Name of Person completing form: | |
| Date: | /08/2021 |
| Author(s) | Women's Health Guideline group |
| Name of author or sponsor to attend ratifying committee when policy/guideline is discussed | |
| Date of final draft | August 2021 |
| Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? | Yes |
| By whom: | |
| Is this a new or revised policy/guideline? | Revised |
| Describe the development process used to generate this policy/guideline. | |
| Perinatal Governance Group, Labour Ward Forum, Obs & Gynae Consultants, Supervisors of Midwives | |
| Who is the policy/guideline primarily for? | |
| Staff working within maternity services | |
| Is this policy/guideline relevant across the Trust or in limited areas? | |
| Maternity Services | |
| How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline? | |
| Intranet, newsletters, educational half day, training sessions | |
| Describe the process by which adherence to this policy/guideline will be monitored. | |
| See *monitoring section of policy* | |
| Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline? | |
| See *reference section of policy* | |
| What (other) information sources have been used to produce this policy/guideline? | |
| See *reference section of policy* | |
| Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation? | |
| No impact | |
| Other than the authors, which other groups or individuals have been given a draft for comment | |

| |
|---|
| All obstetric Consultants, Perinatal Governance Group, Supervisors of midwives |
| Which groups or individuals submitted written or verbal comments on earlier drafts? |
| Any comments received considered by Perinatal Governance Group |
| Who considered those comments and to what extent have they been incorporated into the final draft? |
| All comments considered |
| Have financial implications been considered? |
| Yes |