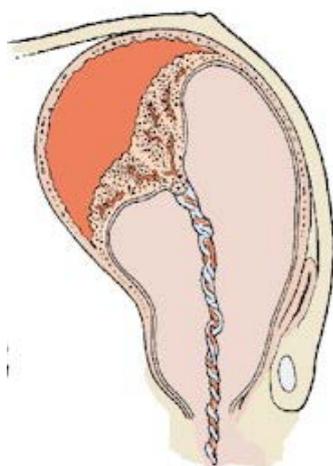


Manual removal of a retained placenta

This leaflet is for mothers with a retained placenta after giving birth. It explains who is available to help and advise you after the birth of your baby if the placenta does not come away normally and what may happen in your care. If you have any questions or concerns, please speak to your midwife or doctor.

In 97% of deliveries¹, the placenta (afterbirth) comes away easily from the inside of the uterus, once it contracts after the birth of the baby. In the UK, most women choose to have an 'actively managed' third stage of labour. This active management procedure includes injection of a drug (either Oxytocin alone or a compound of Oxytocin and ergometrine) into the mother's leg to speed up the natural process in which the placenta detaches from the wall of the uterus after the birth and is pushed out through the vagina^{2, 3}.



The picture shows a placenta with cord coming away from its attachment inside the uterus. The cord is passing through the cervix into the vagina

The third stage usually lasts between 30 and 60 minutes after the baby has been born. If the placenta has not been pushed out within that hour it is said to be 'retained' and help may be needed to remove it. A retained placenta may be due to:

- (i) the uterus not contracting well after the baby is born so that the placenta remains fully, or partially attached inside the uterus.
- (ii) the umbilical cord snapping.
- (iii) the placenta had attached abnormally deeply (placenta accreta, placenta increta or placenta percreta) and could not separate. These conditions are rare (less than 1 in 2500 pregnancies⁷) and are not discussed further in this leaflet.

Simple steps which midwives can offer to help separation of the placenta include:

- (i) ensuring that the mother's bladder is empty (if it is full, this tends to prevent the uterus from contracting down firmly);
- (ii) offering the baby the breast (as this releases oxytocin, which makes the uterus contract);
- (iii) massaging the top of the uterus through the abdominal wall (your tummy).

It is usual for there to be some bleeding from the mother's vagina after her baby has been born. If bleeding is brisk or continues at a steady rate, the midwife will call for a member of the obstetric team to assist her, and plan the next stage of care. This may happen before an hour passes, particularly if the midwife considers the bleeding to be heavy. The obstetrician may prescribe medication such as Syntometrine, given by injection, and also a Syntocinon infusion (given by a drip) to minimise blood loss. S/he may also call for a theatre team, as it is usual to offer to take the mother to theatre for a careful examination under anaesthetic if the placenta has not been delivered after an hour.

Theatre

When you go to theatre, the anaesthetist will visit you and discuss what type of anaesthetic is recommended: if you have had an effective epidural, this can be 'topped-up' and used, or the anaesthetist may recommend a spinal anaesthetic. With either of these, you will remain conscious but comfortable. Sometimes, a general anaesthetic is recommended, or requested by the mother.

Providing you are well enough you will be given the choice for your birthing partner and baby to accompany you to theatre. If a medical reason or emergency prevents this from happening, your baby will be given to your birthing partner to care for whilst you are in theatre.

In theatre, once the anaesthetist is satisfied that you are comfortable, the obstetrician will seek your permission to examine you vaginally. If the placenta is 'sitting in the cervix', it can be easily pulled down the vagina. If it is still up in the cavity of the uterus, the obstetrician will place their fingers inside the uterus to detach the placenta and remove it. Their other hand is placed firmly on your tummy to steady the top of the uterus whilst this manoeuvre is completed.

If you had any tears or an episiotomy, these will be stitched before you leave theatre.

It is normal for you to have a drip with oxytocin for about four hours after this procedure, and for you to be prescribed antibiotics. The first dose is given whilst you are in theatre.

References

1. Weeks AD; The retained placenta. Best Pract Res Clin Obstet Gynaecol. 2008 Sep 13. [abstract]
2. SAC Opinion paper 14, RCOG 2009
3. Prendiville WJP, Elbourne D, McDonald SJ. Active versus expectant management in the third stage of labour .The Cochrane Library; 2000.
4. National Collaborating Centre for Women's and Children's Health (NCCWCH). Intrapartum Care. Care of healthy women and their babies during childbirth. RCOG Press, London 2007.
5. RBH guidelines: Retained placenta GL904. Mark Selinger. 2006 - 2015
6. Bider D, Dulitzky M, Goldenberg M, et al. Intraumbilical vein injection of prostaglandin F2 alpha in retained placenta. Eur J Obstet Gynecol Reprod Biol 1996; 64:59.
7. Miller DA, Chollet JA, Goodwin TM. Clinical risk factors for placenta previa-placenta accreta. Am J Obstet Gynecol 1997; 177:210.

This document can be made available in other languages and formats upon request.

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