Retained Placenta
UHL Obstetric guideline

University Hospitals of Leicester NHS Trust

Trust ref:C42/2011

Contents

1. Introduction and Who Guideline applies to

These guidelines are for the use of all staff involved in the management of retained placenta. This includes midwifery, obstetric, anaesthetic, imaging and blood transfusion staff.

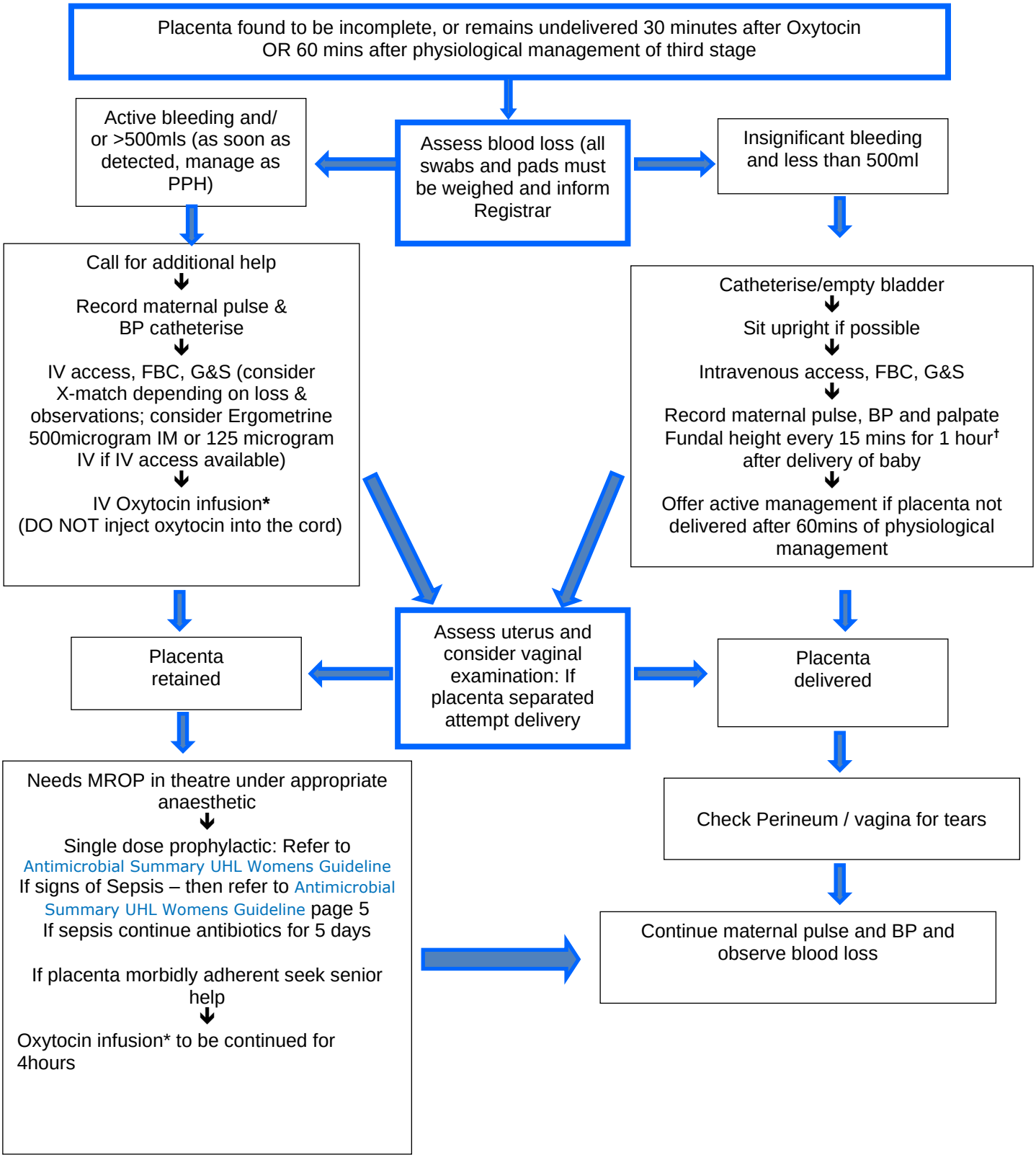
Definition:

Given the potential complications associated with retained placenta and in order to provide a consistent interpretation of the term "retained placenta" within UHL, the Working Party has arbitrarily agreed to the placenta being defined as "*retained*" if it cannot be delivered within 30 min of instigation of active management of the third stage OR 60 min with the physiological management of the third stage.

Related documents:

Enhanced Maternity Care UHL Obstetric Guideline
Declining Blood and Blood Products UHL Obstetric Guideline
Declining Blood and Blood Products UHL Policy
Patient Health Records - Documenting UHL Policy
Maternity Records Documentation UHL Obstetric Policy
Postpartum Haemorrhage UHL Obstetric Guideline
Blood Transfusion UHL Policy
Cardiopulmonary Resuscitation Policy UHL LLR Alliance LPT
Maternal Death UHL Obstetric Guideline
Last Offices Care of the Deceased UHL Policy

Algorithm for the Management of Retained Placenta



† In absence of haemorrhage expectant care should be considered as an alternative to anaesthesia and manual removal, with appropriate consideration to alternative strategies after 60 minutes.	Maximum delivery of baby to delivery of placenta interval:3hrs
	*40 International Units Oxytocin in 36ml 0.9% sodium chloride over 4 hours (10ml/10iu/hr)

2.1 Risk factors

- Previous retained placenta
- Previous injury or surgery to the uterus including caesarean section
- Preterm delivery
- Induction of labour
- Multiparity ≥5
- Instrumental delivery
- Maternal age greater than 35 years
- Congenital uterine anomaly
- Morbidly adherent placenta

2.2 Complications

- Postpartum hemorrhage (PPH)
- Shock (hypovolemic)
- Puerperal Sepsis
- Uterine inversion
- Sub-involution
- Hysterectomy

2.3 Management

The appropriate action is determined by the presence or absence of significant bleeding (see algorithm).

The absence of bleeding suggests that the placenta has either completely separated or not separated at all.

- If this is the case, it is advisable to await spontaneous separation for 1 hr after the birth of the baby, with the midwife recording observations every 15 min and remaining with the woman at all times.
- Waiting for 1 hr for spontaneous separation will almost halve the number of women requiring manual removal of the placenta.
- When a retained placenta has been diagnosed, oral omeprazole 40mg should be administered as soon as possible if appropriate as woman with retained placenta may require manual removal in theatre
- Intra-umbilical Oxytocin injection for the treatment of retained placenta **is not recommended** (Nardin et al 2012)
- Occasionally, the placenta may be separated but retained behind a partially closed cervix. However, there is currently insufficient evidence to recommend sublingual GTN spray in this circumstance (Abdel-Aleem et al, 2015)

2.4 Prevention

Prevention:

Prophylactic uterotonics should be routinely offered in the management of the third stage of labour to all women. The PPH risk assessment tool should be used to guide decisions regarding appropriate uterotonics (see Postpartum Haemorrhage UHL Obstetric Guideline).

Active management of the 3rd stage reduces risk of PPH compared to physiological management but there is no evidence that active management reduces the risk of a retained placenta (NICE intrapartum care guideline).

2.5 Maternal observations

Observations of maternal well-being, particularly blood loss, should be ongoing.

Commence a modified early warning score (MEOWS) chart and record maternal pulse, blood pressure and respiratory rate every 15 minutes. Record the total blood loss since delivery and where the total blood loss is greater than 500 mL and / or there is ongoing bleeding, a member of the Obstetric team (at least ST3 level) should be informed for an individualised plan of care.

Under no circumstances should the mother be left unattended by the midwife; if the baby requires medical support the emergency bell should be used to summon assistance.

Swabs, inco pads and sheets should be weighed for an accurate blood loss.

Placental assessment
The placenta should be examined to check it is complete as soon as possible after delivery.
• **Placenta incomplete:** Manage as per retained placenta algorithm
• **Membranes incomplete:** Document in case notes, inform mother and advise her to report any concerns about heavy or offensive vaginal bleeding, abdominal pain / tenderness, or flu-like symptoms / high temperature.

2.6 Location and type of anaesthetic

Manual removal of placenta must take place in the obstetric theatre under appropriate anaesthesia.

It is preferable to carry out this procedure under regional anaesthesia but a general anaesthetic may be necessary, for example if there is heavy bleeding or there are contraindications to regional anaesthesia. Appropriate liaison between the obstetric and anaesthetic staff is required.

2.7 Manual removal of placenta (MROP)

The procedure must be performed by a suitably trained obstetrician or under the supervision of a trained obstetrician.
Women requiring a manual removal of the placenta should be transferred to theatre in a timely manner. The Midwife Coordinator should be alerted if the placenta has not delivered by 30 minutes, with an obstetric team review and consideration for theatre at 45 minutes. The woman should be in theatre within 1 hour. The Consultant should be informed of any delays.

The bladder must be emptied prior to the procedure. An indwelling catheter should be inserted postoperatively until patient is ambulant if a regional block (epidural top-up or spinal) is used for MROP.

There must be a thorough check of the uterine cavity to ensure it is empty. Examination of the cervix, vagina and perineum must be undertaken to exclude significant tears / trauma which may need repair.

It is important to ensure the uterus is well contracted after removal of the placenta. Oxytocin infusion (40IU in 36ml 0.9% sodium chloride) should be commenced at the end of the procedure and run at 10iu/10ml per hour. If there is a significant constriction ring preventing the insertion of the examining hand into the uterus, careful consideration should be given to the use of uterine relaxants (tocolysis) to aid MROP. However, the oxytocin infusion regime must be started as soon as possible after that and continue in the post procedure to prevent PPH. Any PPH should be treated as per protocol (see guidelines on management of obstetric haemorrhage).

A single dose of prophylactic antibiotics should be administered (see Antimicrobial Summary UHL Womens Guideline).

2.8 Suspected Placenta Accreta Spectrum (PAS) or abnormally implanted placenta (AIP)

Women thought to be at risk of placenta accreta spectrum (PAS) would normally be investigated antenatally using appropriate modalities e.g. ultrasound and / or MRI and appropriate management plans put in place prior to delivery. If at MROP, in an unforeseen patient, the plane between placenta and uterus is not easily defined, consider PAS as a possibility. Clinically, placenta accreta is diagnosed when manual removal of the placenta is partially or totally impossible and no cleavage plane exists between part or the entire placenta and the uterus.

When this is suspected or diagnosed, the Senior Registrar and / or Consultant should be informed and they must be present to review the woman. **DO NOT** pull on placenta and cord. **DO NOT** continue attempts to deliver the placenta.

Blood should be cross-matched (if not already done), and other specialties e.g. interventional radiologists, critical care, haematology, vascular surgery may be required depending on the preferred treatment options of the Consultant. There are numerous management strategies for this scenario but the detailed management of this complication is outside the scope of this guideline.

2.9 Future pregnancy

Patients are advised to deliver in an obstetric unit if there has been a history of a retained placenta requiring MROP in a previous pregnancy.

Retained placenta is also a risk factor for PPH in any future pregnancy and therefore women should be advised to have active management of the third stage of labour in future pregnancies.

2.10 Management of retained products of conception post-partum (up to 6 weeks)

Women presenting with secondary postpartum haemorrhage should be managed with broad spectrum IV antibiotics for 24 hours (see Antimicrobial Summary UHL Womens Guideline), unless bleeding very heavily and then reviewed by a Consultant. If symptoms have settled and the uterus is well involuted, conservative management can be continued and no ultrasound is required. If symptoms have not settled and/or clinically there is a high suspicion of retained products, an ultrasound should be requested. Before arranging surgical evacuation of the uterus, the patient must be reviewed by the obstetric consultant.

Broad spectrum antibiotics should be given for 24 hours minimum prior to ERPOC unless the woman is bleeding heavily.

The procedure should be performed by a consultant or a senior trainee with the Consultant present. The procedure should be performed under ultrasound control. The procedure should either be performed on Delivery Suite (LRI and LGH) or theatre 17 at LRI.

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
MEOWS chart commenced and maternal observations recorded every 15 minutes IV access achieved	Audit	Obstetric delivery suite lead		

Bloods sent Blood loss recorded Delays for those requiring MROP documented in maternal health record Maximum time of delivery of placenta from birth of baby achieved within 3 hours Documentation of reason for delay exceeding the 3 hr time limit				

5. Supporting References

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6. Key Words

Retained placenta, PPH, Placenta accreta spectrum (PAS)

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review record	
Author: Original Working Party - Obstetricians and Midwives **Guideline Lead: A Richmond**	**Executive lead: Chief medical officer**

REVIEW RECORD

Date	Issue Number	Reviewed By	Description Of Changes (If Any)
September 2014	V2	As above	General update
June 2015	V2	L Matthews	NICE guidance changed re use of oxytocin into cord. Now not advised so algorithm amended accordingly
June 2016	V3	C Wiesender	Addition of process for management of RPOC up to 6 weeks postpartum
July 2017	V3	C Wiesender	Timescales for managing retained placenta added
July 2020	V4	Anna Collins	Risk factors updated. Ranitidine changed to omeprazole. PPH risk assessment to be used. Swabs, inco pads and sheets to be weighed for accurate blood loss.
January 2024	V5	Anna Richmond	Management updated, aligned with PPH guideline, antibiotics now not specified - advise to refer to antibiotics guidance