Worcestershire Acute Hospitals NHS Trust

Management of retained placenta

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Key Amendments

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INTRODUCTION

Retained placenta is diagnosed when the woman is unable to deliver the placenta by 30 minutes following active management of third stage and by one hour after physiological third stage of labour.

Retained Placenta complicates 1-2% of all deliveries and this incidence is much higher in preterm deliveries. In many cases retained placenta is associated with postpartum haemorrhage and can result in significant maternal morbidity and mortality.

The use of prophylactic oxytocics reduces the length of the third stage compared to physiological management, but there is no difference in the number who requires manual removal. There is a greater incidence of retained placenta when ergometrine is used compared to oxytocin 5 or 10 units alone.

Types of Retained Placenta

1. Trapped placenta - is when the placenta is detached/ separated but merely trapped behind a closed cervix.
2. Adherent Placenta - is when the placenta is adherent to the uterine wall (associated with previous caesarean section, uterine surgery).

Patients with prolonged third stage may have different clinical reasons for retained placenta and therefore may require different management.

MANAGEMENT OF RETAINED PLACENTA

The most important factor to determine management plan is presence or absence of active bleeding.

If the woman wishes a physiological third stage and there is no evidence of placental separation or a delivered placenta 60minutes after birth then a change to active management should be advised.

If a placenta has not delivered and there is no evidence of placental separation 20mins after delivery then prompt preparation should be made to treat for retained placenta

In the presence of active bleeding

- Insert 16G IV cannula and obtain bloods for FBC and Group & save.
- Monitor and record Pulse and Blood pressure, individualised according to clinical situation

- Inform Obstetric Registrar
- Inform on-call anaesthetist
- Insert urinary Foley's catheter
- Commence and continue oxytocin infusion 40 u/l 250mls/hour
- Unclamp cord at maternal end to allow blood to drain out if cord bloods not required.
- Middle grade obstetrician to perform vaginal examination to ascertain whether the placenta is already separate in which case it can be removed.
- Record blood loss and request cross match blood if clinically indicated. (Remember that persistent steady blood loss can result in an underestimate of a significant PPH).
- Urgently prepare and transfer patient to theatre for manual removal of placenta (MRP)

NB: There is no evidence that repeated bolus doses of oxytocics before placental delivery, assist in the delivery of adherent placenta. Repeated doses of uterotonics may result in contraction of uterine cervix resulting in difficult manual removal.

Home Delivery: If the placenta is retained after a home delivery or on the MLU, the woman should be transferred to hospital for further management and manual removal. If there is associated active bleeding usual protocol for PPH after home birth should be followed. Misoprostol 800microgram can be inserted PR while awaiting transfer to the hospital. Misoprostol is effective in the treatment of postpartum haemorrhage, but its uterotonic effect is slower in onset than the oxytocin (probably 30 to 60 minutes) and therefore it is likely to prevent later uterine relaxation than have much effect on the acute loss. It is especially useful in cases where oxytocin infusion is difficult to commence due to poor venous access. Misoprostol can cause pyrexia, nausea and vomiting and it is contraindicated in asthmatic and cardiac patients.

Manual Removal of Placenta (MRP)

- MRP should be performed by an experienced obstetrician.
- It should be performed in theatre under regional / general anaesthetic.
- Place gloved hand into uterus under aseptic technique with other hand on fundus to control it.
- Follow umbilical cord until you find lower edge of placenta.
- Gently push the hand between the placenta and the body of the uterus and ease placenta away with a sawing action (N.B. in cases of placenta accreta the placenta will not detach easily and use of excess force can result in life-threatening haemorrhage which may require hysterectomy) If part/ total of the placenta is morbidly adherent and cannot be separated leave it insitu and inform the obstetric consultant on-call who should attend and manage accordingly (See PPH guideline)
- When fully detached, explore the uterine cavity for damage and other pieces of placenta or membranes.
- Massage fundus with one hand whilst extracting placenta and membranes with hand in uterine cavity.

- Examine the placenta to be sure that it is complete.
- Inject oxytocin 5 units IV and continue oxytocin infusion (as mentioned above).
- Give single dose IV antibiotics – 1.2g co-amoxiclav unless otherwise indicated. If patient penicillin allergic give cefuroxime 1.5g IV and metronidazole 500mg IV. If patient known to be severely penicillin allergic i.e. anaphylaxis discuss with consultant microbiologist.
- Debrief the patient.

Complications of Manual Removal of Placenta

- PPH (See guideline)
- Infection/ puerperal sepsis (Maintain aseptic technique for MRP and give antibiotics.)
- Perforation of uterus (experienced obstetrician to perform MRP and explore the uterine cavity at the end of procedure.)
- Inverted uterus (See guideline)

In the absence of active bleeding

- Try breast feeding, nipple stimulation, emptying bladder and change of position – encourage upright position.
- Check pulse and blood pressure half hourly
- Do not leave unattended
- Regularly check for PV loss and any signs of placental separation
- Catheterise the bladder if not emptied recently
- Insert 16G IV cannula and obtain bloods for FBC and Group & save as risk of PPH.
- Inform Obstetric Registrar who will review when necessary for examination and assessment of need for MROP.
- **Trapped Placenta** can be treated by obtaining acute uterine relaxation - giving the woman glycerol trinitrate (GTN) - two 400mg puffs sublingually or a single dose of Terbutaline 250 microgram subcutaneously. Followed by delivery of the placenta by controlled cord traction

  NB: Beware of hypotension and PPH and administer prophylactic oxytocin infusion 40 u/l 250mls/hour afterwards.

NB: The administration of prophylactic oxytocin before placental delivery does not reduce the incidence of postpartum hemorrhage or third-stage duration, when compared with giving oxytocin after placental delivery. Early administration, however, does not increase the incidence of retained placenta

(Remember that persistent steady blood loss can result in an underestimate of a significant PPH).