Worcestershire Acute Hospitals NHS Trust

Manual Removal of Placenta

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the management of retained placenta and the process of manual removal.

This guideline is for use by the following staff groups:

Midwifery and Obstetric staff facilitating birth and management of the third stage.

Lead Clinician(s)

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Approved by Medicines Safety Committee on:	13th December 2023
Review Date: This is the most current document and should be used until a revised version is in place	13th December 2026

Key amendments to this guideline

Date	Amendment	Approved by:
November 2023	Full Guideline Review and drug updates to reflect current process	MGM

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 60 minutes after physiological third stage of labour.

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. Can be complete or partial.

If woman has requested a physiological third stage of labour and placenta has not delivered or shown signs of separation 60 min after birth, advise woman to allow active management of the third stage.

Management of retained placenta

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 (20% of PPH) and can result in significant maternal morbidity and mortality. Therefore, If placenta has not delivered or has shown no signs of separation 20 min after administration of intramuscular 1 millilitre Syntometrine® or intramuscular 10 units oxytocin, with active management of the third stage prepare to treat promptly for retained placenta after 30 min.

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.

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

In the presence of active bleeding

- Notify delivery suite co-ordinator
- Insert 16G IV cannula and obtain bloods for FBC and Group & save.
- Monitor and record Pulse Respiratory rate and Blood pressure (frequency individualised according to clinical situation) and document MEOWS on Badger record.
- Inform Obstetric Registrar
- Inform on-call anaesthetist
- Insert urinary Foley's catheter

- Commence and continue oxytocin infusion 40units in 40millilitres Sodium Chloride at a rate of 10 millilitres/hour (this should **ONLY** be administered in the case of active haemorrhage and should be agreed with the senior obstetrician prior to administration).
- 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 oxytocic's 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 1000micrograms can be inserted PR while awaiting transfer to the hospital (see Patient Group Direction DA/WM/34). 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.

Manual Removal of Placenta (MROP)

- MRP should be performed by an experienced obstetrician.
- Written consent should be obtained
- It should be performed in theatre under regional / general anaesthetic.
- Use gauntlets to protect the operator
- 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 placenta accrete 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 Intravenous and continue oxytocin infusion (as mentioned above).
- Give single dose Intravenous antibiotics – 1.2 grams co-amoxiclav unless otherwise indicated. If patient penicillin allergic give cefuroxime 1.5 grams Intravenous and metronidazole 500 milligrams Intravenous. If patient known to be severely penicillin allergic i.e. anaphylaxis discuss with consultant microbiologist.
- Ensure woman and her partner are fully informed at all times.
- Debrief the patient. Inform woman of increased risk of placental retention in future pregnancy
- Ensure clear and accurate documentation, including the procedure and total estimated blood loss since delivery.

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 Respiratory rate, pulse and blood pressure half hourly and document on HDU WOW (MEOWS) chart.
- Do not leave unattended
- Regularly check for PV loss and any signs of placental separation
- Assist mother onto bed pan and encourage to empty bladder
- if unsuccessful 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.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Datix Themes and Trends	Governance Safety Report	Monthly	Governance Team	Maternity Governance Meeting	Monthly

References

National Institute for Health and Care Excellence. (2023). *NICE guideline [NG235] Intrapartum Care*. [Online]. NICE. Last Updated: September 2023. Available at: https://www.nice.org.uk/guidance/ng235

Contribution List

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This key document has been circulated to the following individuals for consultation;

Designation
All Maternity staff – Guidelines Newsletter
All Maternity Governance Team Members (meeting agenda)

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Guidelines Committee
Maternity Governance Meeting
Medicines Safety Committee