Retained placenta risks and management

What retained placenta means

A retained placenta occurs when the placenta does not deliver within the expected interval after the baby is born. Many maternity units use approximately 30 minutes after birth as a practical threshold when the third stage is actively managed, although local protocols vary and some settings use a longer interval when bleeding is minimal and the parent is stable. The key issue is not the clock alone; it is the combination of time, bleeding, uterine tone, pain, vital signs, and signs of placental separation.

Clinicians often describe retained placenta in several overlapping patterns. In a trapped placenta, the placenta may have separated but remains inside the uterus or behind a closing cervix. In adherent placenta, separation is incomplete because the placenta remains attached to the uterine wall. A more serious spectrum is abnormal placental adherence, sometimes called placenta accreta spectrum, in which placental tissue invades too deeply into the uterine wall. That condition requires specialized planning and may not present like a routine retained placenta.

After birth, the uterus normally contracts strongly, reducing blood flow to the placental bed and helping the placenta shear away. If the placenta is not

delivered, open maternal blood vessels at the implantation site may continue to bleed. For this reason, placenta delivery after birth is monitored carefully even when the baby appears well and the immediate mood in the room is joyful.

Why retained placenta matters clinically

The most urgent risk is primary postpartum hemorrhage, which generally refers to excessive bleeding within the first 24 hours after birth. Retained placental tissue prevents the uterus from contracting down efficiently, and that impaired contraction can contribute to uterine atony after birth. Atony and retained tissue may coexist, making bleeding more difficult to control unless both are addressed.

Another concern is infection. Placental tissue left in the uterus can become a nidus for bacterial growth, particularly if manual procedures, prolonged rupture of membranes, or heavy bleeding have occurred. Infection may present later with fever, uterine tenderness, foul-smelling lochia, pelvic pain, or feeling acutely unwell. Even when the placenta is removed successfully, clinicians remain alert to endometritis and other postpartum infections.

Retained placental fragments can also contribute to delayed or secondary postpartum bleeding days to weeks after birth. A person may initially seem stable, then develop heavy bleeding, clots, persistent cramping, or subinvolution of the uterus. Ultrasound and clinical examination may be used to evaluate suspected retained products, but interpretation can be nuanced in the early postpartum uterus.

Beyond physical risk, retained placenta can be emotionally distressing. The experience may involve urgent staff movement, intravenous access, medication, operating-room transfer, anesthesia, or separation from the newborn. Compassionate explanations, consent whenever possible, and support for skin-to-skin contact or feeding after stabilization can make a meaningful difference.

Risk factors and prevention-minded planning

Retained placenta can occur without obvious warning, but several factors are associated with higher risk. Prior retained placenta is one of the more

clinically important historical clues. Other associations include preterm birth, induction or augmentation in some contexts, prolonged labor, previous uterine surgery, abnormal placentation, uterine anomalies, and a history of curettage or procedures that may affect the endometrium. Multiple pregnancy and stillbirth have also been discussed in obstetric literature as contexts in which third-stage complications may be more common.

Abnormal placentation deserves particular caution. Placenta previa, prior cesarean birth, and uterine surgery may increase concern for placenta accreta spectrum, especially when imaging has suggested low-lying or invasive placental tissue. In such cases, the risk is not only retained placenta but severe hemorrhage if an abnormally adherent placenta is forcibly removed. Delivery planning may involve a multidisciplinary team, blood bank readiness, anesthesia consultation, and surgical expertise.

Prevention is not always possible, but risk-aware care can reduce harm. Antenatal review of obstetric history, placental location on ultrasound, anemia management, and birth-site planning all matter. During the third stage, active management typically includes a uterotonic such as oxytocin and, when appropriate, controlled cord traction by a trained clinician. These measures are intended to support uterine contraction and reduce postpartum hemorrhage risk.

For a patient known to be at increased risk, practical planning may include discussing intravenous access, blood type and antibody status, availability of crossmatched blood if needed, and the threshold for moving from observation to intervention. This is not meant to create fear; it allows the team to respond quickly while preserving shared decision-making in labor whenever the situation allows.

Assessment when the placenta has not delivered

When placental delivery is delayed, clinicians assess both the parent’s stability and the likely mechanism. They monitor blood loss, pulse, blood pressure, uterine tone, level of pain, and signs of placental separation such as cord lengthening, a gush of blood, and change in uterine shape. The bladder may be emptied because a full bladder can interfere with uterine contraction and descent of the placenta.

Communication is important at this stage. A stable person with minimal bleeding may have time for a calm explanation of options, whereas active hemorrhage requires faster action. The team may start or increase intravenous fluids, administer uterotonics, check hemoglobin or coagulation studies if bleeding is significant, and prepare blood products if needed. Quantified blood loss, rather than visual estimation alone, can help guide escalation.

Clinicians also consider whether the placenta seems separated but trapped, or whether it appears adherent. Gentle controlled cord traction may be appropriate when there are signs of separation and the uterus is well contracted, but excessive traction can cause complications, including cord avulsion or uterine inversion. For that reason, traction should be performed only by trained professionals using standard technique.

If manual removal of the placenta is being considered, the care team usually reviews analgesia or anesthesia, infection prevention, hemorrhage readiness, and consent. In some cases, examination in an operating room is safer because it provides better pain control, lighting, sterility, and immediate access to surgical and transfusion support.

Management options and escalation

Management depends on bleeding, time elapsed, local protocol, and suspected cause. In a stable situation, non-surgical steps may be considered. These can include ensuring the uterus is contracting, administering uterotonic medication according to protocol, encouraging breastfeeding or nipple stimulation if appropriate, changing maternal position, and emptying the bladder. These measures aim to increase endogenous or administered oxytocin effect and support placental separation.

If the placenta remains undelivered or bleeding increases, manual removal is a common next step. During manual removal, a clinician inserts a hand through the vagina and cervix into the uterus, identifies the plane between placenta and uterine wall, and separates and removes the placenta. Adequate analgesia or anesthesia is essential because the procedure can be painful and invasive. After removal, the placenta is inspected for completeness, and the uterus is assessed for tone and ongoing bleeding.

Antibiotic prophylaxis may be used in many settings because manual intrauterine procedures can increase infection risk, although exact regimens vary by institution and patient factors. Uterotonics are often continued or repeated after removal to help the uterus contract. If bleeding persists, clinicians evaluate for the four broad causes of postpartum hemorrhage: tone, tissue, trauma, and thrombin. This means they assess uterine atony, retained tissue, genital tract lacerations or uterine rupture, and coagulation problems.

If abnormal adherence is suspected during attempted removal, forceful extraction may be dangerous. The clinician may stop and escalate to senior obstetric, anesthesia, interventional radiology, or surgical support depending on the setting. Rarely, severe hemorrhage or placenta accreta spectrum may require procedures such as uterine tamponade, arterial embolization, laparotomy, or hysterectomy. These possibilities are frightening, but they are usually considered only when less invasive measures are unsafe or insufficient to control bleeding.

Recovery, follow-up, and future pregnancies

After a retained placenta, recovery depends on blood loss, infection risk, anemia, pain, and the emotional experience of the birth. Monitoring may include vital signs, uterine firmness, lochia, urine output, hemoglobin testing, and assessment for dizziness or weakness. If significant hemorrhage occurred, iron therapy, transfusion, or additional follow-up may be discussed by the clinical team.

At home, postpartum bleeding should generally trend lighter over time, though brief increases can occur with activity or feeding-related uterine cramps. Urgent assessment is needed for soaking pads rapidly, passing large clots, fainting, chest pain, shortness of breath, fever, worsening abdominal pain, foul-smelling discharge, or a sudden return of heavy bleeding. These symptoms may indicate hemorrhage, infection, or retained placental tissue and should not be managed by self-treatment alone.

Emotional recovery is also valid medical care. Some people feel shaken, disappointed, or frightened after an unexpected manual procedure or hemorrhage. A postpartum debrief with the obstetric team can clarify what happened, whether

the placenta was complete, what treatments were used, and what the implications may be for future pregnancies.

For a later pregnancy, the history of retained placenta should be mentioned early in prenatal care. The clinician may review prior birth records, placental pathology if available, ultrasound findings, cesarean or uterine surgery history, and hemorrhage risk. Many people go on to have uncomplicated births, but advance awareness helps the team plan third-stage management, blood-loss monitoring, and rapid access to treatment if the problem recurs.