Signs and causes of retained placenta

What retained placenta means

After the baby is born, the uterus contracts and the placenta usually separates from the uterine wall. The detached placenta then passes through the cervix and vagina. This stage is commonly called the third stage of labour. A placenta may be considered retained when it has not been delivered within the time expected by the maternity team, or when examination shows that a fragment or membrane remains after an apparently complete delivery.

The precise time threshold depends on how the third stage is managed and on the clinical circumstances. In active management, medication and controlled cord traction may be used to support placental delivery; in physiological management, the process is allowed to progress with observation. A delay becomes more concerning when it is accompanied by heavy bleeding, maternal instability, an unusually soft uterus, or evidence that the placenta has not separated.

Retained tissue can be complete, meaning the whole placenta remains inside the uterus, or partial, meaning a lobe, cotyledon, or membrane has been left behind. A placenta that appears complete should still be inspected by the clinical team, because a small missing section may be difficult to identify

without careful examination.

Signs and symptoms to recognise

The most important sign is failure of the placenta to deliver within the expected time after birth. The birth team may observe that the usual signs of placental separation are absent, such as a change in the shape of the uterus, lengthening of the umbilical cord, or a small gush of blood. These signs are assessed clinically and are not reliable as a home diagnostic test.

Bleeding is a major warning sign. It may be continuous, increasing, or suddenly heavy, and it can lead to primary postpartum haemorrhage. The uterus may feel enlarged or boggy rather than firm because the retained placenta can interfere with effective contraction. However, substantial bleeding is not always present immediately. A placenta trapped behind a closing cervix may initially cause limited external bleeding, while blood accumulates inside the uterus.

When only a fragment remains, symptoms may develop later rather than in the delivery room. Possible features include persistent or unusually heavy postpartum bleeding, bleeding that becomes heavier after it had started to settle, passage of clots, lower abdominal or pelvic pain, fever, uterine tenderness, and an unpleasant-smelling vaginal discharge. These signs can have other causes, so they require examination rather than self-diagnosis.

Call emergency services or seek immediate hospital care for soaking pads rapidly, passing very large clots, faintness, confusion, severe weakness, shortness of breath, a racing heartbeat, cold or clammy skin, or severe abdominal pain. A person who has recently given birth may need urgent help even if the bleeding appears to lessen temporarily.

The three main causes

Uterine atony and failed separation: The uterus normally contracts after birth, helping the placenta separate and compressing blood vessels at the placental site. If the uterus does not contract effectively, known as uterine atony, separation may be delayed and bleeding may continue. Atony can also occur after the placenta has separated, so clinicians assess both placental delivery and uterine tone.

Abnormally adherent placenta: In some pregnancies, the placenta is attached unusually deeply or firmly to the uterine wall. This spectrum is commonly described as placenta accreta spectrum. The placenta may not separate normally, or attempts at separation may cause major haemorrhage. Previous caesarean birth or other uterine surgery can increase the likelihood of abnormal placental attachment, particularly when the placenta implants over or near a uterine scar. The degree of adherence varies, and not every person with a risk factor develops this condition.

Placenta trapped by cervical closure: The placenta may have separated from the uterine wall but become lodged in the uterus or lower uterine segment as the cervix begins to close. In this situation, the placenta cannot pass normally through the cervix. Bleeding may be concealed or less obvious initially, which is why the overall clinical picture and maternal observations matter more than visible blood alone.

Retained membranes or a small placental fragment can represent incomplete delivery rather than one of these complete mechanisms. The remaining tissue may prevent the uterus from contracting well and may contribute to delayed bleeding or infection.

Risk factors and associated conditions

Retained placenta can occur without an identifiable risk factor, but several circumstances are associated with greater likelihood. These include a previous retained placenta, previous uterine surgery such as caesarean birth or surgical treatment inside the uterus, placenta accreta spectrum or other placental implantation abnormalities, and a history of postpartum haemorrhage.

Other reported associations include preterm birth, prolonged or difficult labour, induced labour, uterine fibroids, multiple pregnancy, high parity, and conditions in which the uterus is overdistended. Some medications used during labour may influence uterine tone, although the clinical significance depends on the overall situation and medication exposure. Infection or inflammation involving the membranes or uterus may also be relevant.

These factors are not a prediction that retained placenta will happen. They

help the maternity team plan observation, ensure that blood-loss monitoring is careful, and arrange appropriate expertise if placental separation becomes difficult. People with known placenta accreta spectrum or a strong history of severe bleeding may need birth planning in a hospital with access to obstetric, anaesthetic, transfusion, and surgical services.

How clinicians assess the problem

Assessment begins with the person’s condition: blood pressure, pulse, breathing, temperature, level of alertness, pain, and estimated blood loss. The clinician examines the abdomen to assess uterine size and tone and may inspect the delivered placenta and membranes for missing lobes or fragments. Vaginal examination may be needed to determine whether the placenta is present in the birth canal or trapped behind the cervix.

The team considers whether the placenta has separated, whether bleeding is coming from the placental site or another birth-related injury, and whether uterine atony or clot retention is contributing. Blood tests may measure haemoglobin and assess clotting, particularly when bleeding is significant. Ultrasound can sometimes help identify intrauterine tissue, but it is interpreted alongside the examination because blood clots and normal postpartum findings can complicate imaging.

In a stable person, clinicians may use observation, medication to support uterine contraction, or other measures according to the circumstances and local protocol. If bleeding is heavy, the priority is simultaneous resuscitation and control of the source. Treatment decisions depend on the suspected cause, the extent of bleeding, whether the placenta is abnormally adherent, and the person’s preferences where time and safety allow.

Treatment, complications, and follow-up

Management may include intravenous access and fluids, medication that promotes uterine contraction, bladder emptying, and carefully controlled procedures to deliver the placenta. Manual removal of the placenta is performed by a trained clinician in an appropriate setting, usually with analgesia or anaesthesia and measures to reduce infection risk. If abnormal adherence is suspected, forceful separation can be dangerous, and specialist obstetric management is required.

Severe bleeding may require blood products, procedures to control haemorrhage, or surgery. The appropriate intervention is determined by the cause and by how the person responds to initial treatment. Retained tissue identified after discharge may be managed with medication, a planned procedure, or observation in selected circumstances, but this decision must be made by a healthcare professional.

Potential complications include primary postpartum haemorrhage, anaemia, infection of the uterine lining, delayed recovery, and rarely serious shock or the need for major surgery. Infection may present with fever, worsening pelvic pain, uterine tenderness, or foul-smelling discharge. Follow-up should address bleeding, temperature, pain, emotional wellbeing, and any laboratory results. A difficult birth or emergency intervention can be psychologically upsetting; discussing the birth with the maternity team and accessing perinatal mental health support may be valuable.

Anyone who is worried about bleeding or symptoms after birth should contact the maternity unit, obstetric service, midwife, or emergency service that supports them. Retained placenta risks and management vary substantially between individuals, so general information cannot replace an examination.