Treatment for retained placenta

What retained placenta means

After the baby is born, the placenta normally separates from the uterine wall and is expelled during the third stage of labour. Retained placenta generally refers to failure of placental delivery within the timeframe used by the local maternity protocol, commonly around 30 minutes with active management or longer with physiological management. The exact threshold may vary according to national guidance and the clinical circumstances.

The placenta may remain entirely attached, may be partly separated with tissue still inside the uterus, or may be trapped behind a closed cervix. A placenta that appears to have delivered should also be inspected, because a missing lobe or torn membranes can indicate retained placental tissue. Retained tissue can prevent effective uterine contraction and increase the risk of ongoing bleeding.

Assessment includes checking vaginal blood loss, pulse, blood pressure, temperature, uterine tone, abdominal symptoms, and the appearance of the placenta. Clinicians also consider risk factors such as previous retained placenta, previous uterine surgery, placenta accreta spectrum, preterm birth, and labour induction. Ultrasound is not always required for the initial decision, but it may be useful when retained tissue is suspected later or when

the diagnosis is uncertain.

Immediate assessment and stabilisation

Once retained placenta is suspected, the priority is simultaneous assessment and preparation for treatment. The maternity team evaluates whether the person is stable and whether bleeding is increasing. Intravenous access, blood tests, fluid management, and cross-matching may be arranged when haemorrhage is significant or considered likely. The uterus is assessed for atony, meaning inadequate contraction, and the bladder may be emptied because bladder distension can interfere with uterine contraction.

Urgency is determined by the whole clinical picture rather than by elapsed time alone. A stable patient with minimal bleeding may allow a short period for spontaneous separation while the team prepares definitive care. Heavy bleeding, a soft or enlarged uterus, falling blood pressure, tachycardia, pallor, dizziness, confusion, or collapse requires immediate postpartum haemorrhage management alongside efforts to remove the placenta.

Supportive communication matters during this stage. The clinician should explain what is happening, why treatment is recommended, and what analgesia or anaesthesia is available. A partner or support person can usually remain involved where clinically feasible, although emergency care may require rapid movement to a procedure area.

Initial measures to encourage delivery

In a stable situation, clinicians may use measures intended to support normal placental separation and uterine contraction. These can include encouraging breastfeeding or nipple stimulation, emptying the bladder, and administering a uterotonic such as oxytocin according to local protocol. Gentle observation for signs of separation is appropriate when there is no substantial haemorrhage.

Controlled cord traction may be used by a trained professional when the uterus is contracted and there are clinical signs that the placenta has separated. This involves supporting the uterus while applying carefully controlled traction to the cord. It should not be attempted by the patient or an untrained person, and forceful traction must be avoided because it can cause uterine

inversion or cord avulsion.

Some guidelines discuss oxytocin injected into the umbilical vein with saline as an option in selected circumstances, particularly where the placenta has not delivered and the patient is stable. Evidence and local practice vary, and this approach should not delay definitive treatment when there is significant bleeding or maternal deterioration. The broader evidence does not show a pharmacological treatment that reliably removes a placenta once retained placenta has been diagnosed.

Manual removal of the placenta

Manual removal is the main definitive treatment when the placenta remains undelivered. It is performed by an obstetrician, midwife with appropriate training and authorisation, or another qualified clinician, usually in an operating theatre or a setting equipped for anaesthesia, monitoring, haemorrhage control, and urgent surgery. The clinician inserts a gloved hand through the vagina and cervix, identifies the plane between placenta and uterine wall when possible, and separates and removes the placenta carefully.

Adequate analgesia or anaesthesia is important. Depending on urgency, available resources, and the patient’s condition, options may include regional anaesthesia, general anaesthesia, or intravenous analgesia and sedation. The choice is made by the anaesthesia and obstetric teams. Antibiotics are commonly given around manual removal because the procedure introduces a hand into the uterine cavity, although the exact regimen follows local policy and individual risk assessment.

After removal, the placenta is examined for completeness and the uterus is assessed for tone and ongoing bleeding. Uterotonics may be administered to help the uterus contract. The clinician also checks for genital tract trauma and considers whether ultrasound, suction evacuation, or another procedure is needed if tissue remains. Manual removal can be highly effective, but it carries risks including infection, uterine injury, anaesthetic complications, and haemorrhage, so the expected benefits and risks should be discussed whenever circumstances permit.

Treatment when postpartum haemorrhage occurs

Retained placenta and postpartum haemorrhage can occur together, and bleeding may continue until the placenta or retained tissue is removed. Management follows a coordinated haemorrhage protocol. The team may administer uterotonics, provide intravenous fluids, monitor vital signs closely, and give tranexamic acid when indicated under the local postpartum haemorrhage guideline. Blood products may be needed when blood loss is substantial or laboratory results show impaired oxygen-carrying capacity or coagulation.

If manual removal is unsuccessful, incomplete, or not appropriate because tissue is firmly adherent, suction evacuation may be considered. This is performed with appropriate anaesthesia and preparation for haemorrhage. Intrauterine balloon tamponade can be used in selected cases to apply pressure from inside the uterus when bleeding continues. It is a temporising or therapeutic measure within a broader protocol and requires close observation.

Persistent bleeding may require uterine artery embolisation, laparotomy, compression sutures, vessel ligation, or hysterectomy. These interventions are uncommon but can be lifesaving when conservative measures fail. A placenta that is abnormally adherent, as in placenta accreta spectrum, may not separate safely with routine manual removal. In that situation, forceful attempts can worsen bleeding, and management must be directed by an experienced obstetric team.

Why medication alone is usually not enough

Oxytocin and other uterotonics help the uterus contract, which can reduce bleeding and support placental separation in some circumstances. However, they do not reliably detach a placenta that remains attached to the uterine wall. A systematic review found no pharmacological treatment with clearly established effectiveness for treating diagnosed retained placenta. Medication should therefore be understood as supportive treatment rather than a substitute for timely assessment and removal when removal is required.

Misoprostol and other medicines have been studied in this context, but evidence is inconsistent and their use varies by setting. A clinician may choose a particular medication based on bleeding, uterine tone, contraindications, the availability of surgical care, and the applicable guideline. Patients should

not take medication independently to try to deliver a retained placenta.

The same principle applies to traditional or home interventions. Waiting at home, pulling on the umbilical cord, inserting anything into the vagina, or using unprescribed medicines can delay emergency care or cause injury. Once retained placenta is suspected after birth, the appropriate action is to remain under the care of the maternity service or seek urgent emergency assistance.

Care after the placenta has been removed

After treatment, clinicians monitor uterine tone, vaginal blood loss, pulse, blood pressure, temperature, urine output, and symptoms of anaemia or infection. The uterus may remain tender for a time, and cramping can occur as it contracts. The patient may receive advice about iron replacement, analgesia, wound or perineal care, and activity based on blood loss and any procedures performed.

Infection can develop after childbirth or after intrauterine procedures. Warning features include fever, worsening lower abdominal pain, uterine tenderness, foul-smelling vaginal discharge, feeling acutely unwell, or bleeding that becomes heavier rather than gradually decreasing. These symptoms require prompt clinical review. Further imaging or evacuation may be considered if bleeding persists and retained tissue is suspected.

Emotional recovery is also relevant. An unexpected procedure, emergency transfer, anaesthesia, or major haemorrhage can be distressing even when the physical outcome is good. A postnatal debrief can help clarify what happened, what treatment was given, and whether future pregnancies require specific planning. Documentation of retained placenta and any haemorrhage should be shared with the patient and included in future maternity records.

When to seek urgent help

Anyone who has recently given birth should seek urgent medical help for heavy or rapidly increasing vaginal bleeding, passing very large clots, faintness, severe weakness, shortness of breath, chest pain, confusion, or a racing heartbeat. Emergency assistance is also needed for severe abdominal pain, collapse, or a feeling that something is seriously wrong.

After leaving hospital or a birth unit, urgent review is warranted for fever, chills, worsening pelvic pain, offensive-smelling discharge, or bleeding that becomes heavier after it had been settling. These symptoms do not prove that placental tissue remains, but they can indicate haemorrhage or infection and should not be assessed solely at home.

Caregivers should not attempt to remove the placenta themselves. If the placenta has not delivered within the timeframe advised by the birth team, or if there is any concern about bleeding, contact the maternity unit immediately. The safest treatment depends on examination, vital signs, blood loss, and access to emergency obstetric care.