What happens if placenta does not come out

What retained placenta means

The placenta normally separates from the inner wall of the uterus after the baby is born and is then expelled during the third stage of labour. The timing varies according to whether physiological or active management is used, but a placenta that has not delivered within the period specified by local clinical protocols is considered potentially retained. Ongoing bleeding before placental delivery can also make the situation urgent, even if the usual time limit has not yet elapsed.

Clinicians generally consider three broad patterns. With placenta adherens, the placenta fails to separate because the normal contraction and separation process has not completed. A trapped placenta has separated from the uterine wall but cannot pass through the cervix, which may have begun to close. In a partial or abnormal accreta, placental tissue is unusually firmly attached to the uterine muscle, making separation difficult or unsafe.

The diagnosis is clinical. The maternity team assesses the amount and pattern of bleeding, uterine firmness, placental separation signs, blood pressure, pulse, temperature, and overall wellbeing. They also examine the delivered placenta when it eventually comes out to determine whether a fragment may

remain inside the uterus.

Why the placenta may not come out

Several factors can delay placenta delivery after birth, and sometimes no clear single cause is identified. The uterus may not contract effectively enough to separate the placenta or compress the blood vessels at the placental site. This reduced uterine tone, called uterine atony after birth, is an important cause of postpartum bleeding and may occur alongside a retained placenta.

The placenta can also be physically trapped. For example, it may have separated but remain behind a contracted cervix. Abnormal attachment is another possibility. Placenta accreta spectrum describes placental villi that extend more deeply into the uterine wall than usual. The degree of attachment ranges from firm adherence to invasion through the uterine muscle, and attempts to forcibly remove an abnormally attached placenta can increase bleeding.

Risk factors described in clinical literature include previous retained placenta, previous uterine surgery or procedures, placental abnormalities, preterm birth, prolonged labour, and certain forms of assisted reproduction. These factors do not predict that the problem will happen, and many people with risk factors deliver the placenta normally. Conversely, a retained placenta can occur without obvious warning.

What healthcare professionals do first

The first priority is maternal safety. The team checks vital signs, estimates blood loss, evaluates uterine tone, and establishes or maintains intravenous access when clinically indicated. Blood tests may assess haemoglobin, platelet count, clotting function, and blood group in case blood products become necessary. The baby can usually remain with a support person or another caregiver while the birthing parent receives assessment and treatment, depending on the clinical circumstances.

If bleeding is limited and the parent is stable, clinicians may allow a carefully monitored period for spontaneous placental separation. They may encourage bladder emptying, assess whether the uterus is contracting, and use medication intended to promote uterine contraction when appropriate. These

decisions depend on local protocols, the type of birth, the analgesia or anaesthesia already in place, and the person’s medical history.

When bleeding is substantial, the placenta will not separate, or the person becomes unstable, treatment is escalated without waiting. The team may activate a postpartum haemorrhage protocol, administer fluids or blood products, and use medicines and uterine techniques to control bleeding. Ultrasound may be considered when the diagnosis is uncertain or when retained fragments are suspected, although urgent management is guided by the clinical picture rather than imaging alone.

Manual removal and other treatments

When the placenta remains inside the uterus and does not deliver safely with initial measures, manual removal of the placenta may be recommended. This is a procedure in which an obstetric clinician separates and removes placental tissue through the vagina and cervix. Appropriate analgesia or anaesthesia is used, and the setting depends on urgency, bleeding, available facilities, and the person’s condition.

Before or during the procedure, clinicians consider whether the placenta appears normally attached. If accreta is suspected, forcibly pulling on the placenta may cause catastrophic hemorrhage. In that circumstance, senior obstetric and anaesthetic specialists may coordinate a different strategy, which can include leaving abnormally adherent tissue in place temporarily or performing surgery. The exact approach is highly individualized and depends on the extent of attachment, bleeding, future fertility considerations, and available expertise.

If only a fragment remains after an apparently complete delivery, clinicians may monitor closely, use medication in selected circumstances, or remove the tissue with a procedure. Antibiotics may be considered around manual or intrauterine procedures according to local policy and individual risk. Treatment is not something to attempt independently: pulling on the umbilical cord or inserting anything into the vagina can worsen bleeding or cause injury.

Risks if it is not treated promptly

The most serious immediate complication is primary postpartum hemorrhage. A retained placenta can prevent the uterus from contracting effectively at the placental attachment site, allowing substantial blood loss. Hemorrhage may develop suddenly or continue as persistent heavy bleeding. Severe blood loss can cause tachycardia, low blood pressure, dizziness, fainting, shortness of breath, confusion, and shock.

Retained placental tissue can also cause ongoing or recurrent bleeding after the initial birth-care period. The uterus may remain enlarged or poorly contracted, and bleeding may become heavier with activity. In the following days, retained tissue may contribute to endometritis, an infection of the uterine lining. Possible features include fever, chills, increasing lower abdominal or pelvic pain, uterine tenderness, foul-smelling vaginal discharge, and feeling increasingly unwell.

Rarely, severe hemorrhage leads to coagulopathy, intensive care admission, or emergency surgery. These outcomes are uncommon when the condition is recognized and treated promptly, but they explain why a delayed placenta is monitored as a potentially urgent obstetric problem. A person should not wait for a routine postnatal appointment if heavy bleeding or systemic symptoms develop.

Recovery and follow-up after a retained placenta

Recovery depends on the amount of blood lost, whether a procedure was required, whether infection developed, and the person’s general health. After significant hemorrhage, clinicians may repeat blood tests and assess for anaemia. Fatigue, reduced exercise tolerance, breathlessness on exertion, palpitations, and headaches can occur with anaemia and should be discussed with a healthcare professional rather than self-diagnosed.

Following manual removal or treatment for suspected retained tissue, follow-up may include review of bleeding, pain, temperature, uterine involution, and emotional wellbeing. Some people undergo ultrasound or other assessment if bleeding persists or if there is concern that tissue remains. Vaginal bleeding normally changes over time after birth, but it should gradually lessen. A sudden increase, large clots, or a return to very heavy bleeding warrants prompt clinical advice.

The experience can be distressing even when physical recovery is uncomplicated. People may feel shocked, frightened, disappointed, or responsible for what happened. A clear explanation of the diagnosis and treatment can help, and a postnatal debrief with the maternity team may be useful. Ask what was found, whether the placenta was complete, whether any abnormal attachment was suspected, and what implications, if any, this has for a future pregnancy.

When to seek urgent help

Anyone who has recently given birth should seek urgent medical help for heavy or rapidly increasing vaginal bleeding, soaking pads quickly, passing very large clots, fainting, severe dizziness, marked weakness, confusion, chest pain, or difficulty breathing. These may indicate significant blood loss or another postpartum emergency. Emergency services should be contacted if the person is collapsing, severely short of breath, or cannot safely travel to a maternity unit.

Contact a maternity unit, midwife, obstetric service, or other appropriate healthcare professional promptly for fever, chills, worsening abdominal pain, uterine tenderness, foul-smelling discharge, persistent moderate bleeding, or a general sense of becoming more unwell. The threshold for assessment should be low after a known retained placenta, manual removal, or postpartum hemorrhage.

Do not attempt to remove a placenta or suspected placental fragment yourself, and do not delay assessment to monitor symptoms at home when bleeding is heavy. Keep any discharge or passed tissue available for clinicians if they request it, but prioritize immediate medical care.