

When the third stage takes too long



What the third stage is and why time matters

The third stage of labor is the interval between birth of the baby and delivery of the placenta. It is usually much shorter than the first or second stage, and in many births it passes quietly. Even so, it is an important transition because the uterus must clamp down on the placental bed to limit bleeding as the placenta separates.

When that separation does not happen promptly, clinicians think about the possibility of a prolonged third stage. The concern is not simply that the placenta is still inside the uterus. The concern is that the longer the placenta remains undelivered, the more time there is for uterine atony, retained placental tissue, or hemorrhage to develop. A prolonged third stage is therefore a practical warning sign, not a diagnosis by itself.

Evidence reviews and clinical guidelines consistently treat this stage as active care, not passive waiting. Supportive measures, close observation, and timely escalation are all part of normal management when the placenta does not deliver as expected.

How clinicians decide that the stage is prolonged

There is no single universal clock that applies to every birth setting, but many guidelines use practical thresholds. In one commonly cited approach, the third stage is considered prolonged at 30 minutes after active management and at 60 minutes after physiological management. Those cutoffs help clinicians decide when the situation needs a more deliberate reassessment.

That said, the number on the clock is only one part of the picture. The amount of bleeding, the mother's vital signs, uterine tone, pain, the degree of placental separation, and the clinical setting all influence what happens next. A person who is stable, with minimal bleeding and some signs that the placenta is separating, may be watched for a little longer. By contrast, visible hemorrhage, worsening pain, or instability lowers the threshold for escalation.

This is why a prolonged third stage is best understood as a dynamic assessment. Timing matters, but it is interpreted alongside the bedside findings.

What the care team watches for

During a long third stage, the team is usually looking for signs that the placenta is separating normally. These may include a lengthening cord, a rise of the uterus, a change in uterine shape, and a surge of bleeding that can accompany separation. They also assess whether the uterus feels firm or boggy, because uterine tone after delivery is central to postpartum hemorrhage prevention.

Providers also watch for retained placenta after birth, which means the placenta has not delivered within the expected window or appears incompletely separated. They may review whether the bladder is full, whether there is ongoing uterine bleeding, and whether the mother is comfortable and hemodynamically stable. If the bleeding is light and the placenta still seems to be separating, observation may be reasonable for a short period. If the picture changes, the plan changes with it.

From the patient's side, this stage can feel oddly suspended. The baby is already here, but the birth is not fully finished. Clear communication is valuable here, because waiting without explanation can be more distressing than the delay itself.

How prolonged third stage is managed

Management depends on the exact clinical situation, but a few approaches recur across guidelines. Active management often includes uterotonic medication after birth to help the uterus contract, along with careful observation and, when appropriate, controlled cord traction performed by trained staff. These steps are used to support placental delivery and reduce bleeding risk.

Evidence summaries also discuss delayed cord clamping and skin-to-skin contact as part of routine birth practices when the newborn is stable. Those practices are not treatments for a retained placenta, but they can fit into overall third-stage care depending on the birth context. Where the placenta is still not delivered and the clinical picture warrants intervention, manual removal of the placenta may be considered in a controlled setting, usually with analgesia or anesthesia and sterile technique.

The exact order of steps varies by institution. What matters is that prolonged third stage is treated as a monitored obstetric problem, not something to ignore until the bleeding becomes obvious.

Why clinicians may wait before manual removal

It can be surprising to learn that clinicians do not always move straight to manual placental extraction when the placenta has not yet delivered. The reason is that, in the absence of active bleeding or instability, a short period of observation may still be appropriate. Some placentas separate late, and immediate invasive removal is not always the best next step.

That balance is described in the literature on prolonged third stage of labor: clinicians are weighing the rising hemorrhage risk against the risks of an invasive procedure. Manual removal is effective when needed, but it is not trivial. It carries procedural risks, may require operating room resources, and is usually reserved for cases where the placenta is not delivering and the clinical context justifies intervention.

This is one reason it helps to stay in a maternity setting until the third stage is clearly complete. If the placenta is slow to deliver, the team can

respond quickly if the situation changes.

What happens after the placenta is delivered

Once the placenta has been delivered, attention shifts to the immediate postpartum period. The uterus should be reassessed for tone, bleeding should be measured or estimated, and the mother's vital signs should be checked. If there has been a prolonged third stage, the team will often stay alert for signs of postpartum hemorrhage, anemia, or retained placental tissue that may not have been obvious at the moment of delivery.

Depending on what happened, follow-up may include watching for dizziness, faintness, persistent heavy bleeding, fever, worsening pain, or a foul discharge in the days after birth. Those are not specific to a prolonged third stage, but they are reasons to seek prompt clinical advice after delivery.

For future pregnancies, a history of a long third stage is worth mentioning early in care. It does not define the next birth, but it gives the team useful context for planning observation and third-stage management.