Mersey and West Lancashire Teaching Hospitals NHS Trust

Manual Removal of the Placenta (afterbirth) and Management of Ragged Membranes

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لطفاً با یکی از کارکنان صحبت کنید تا آن را برای شما تهیه کند.

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proszę skontaktować się z członkiem personelu, który ją dla Państwa przygotuje.

Dacă aveți nevoie de această broșură într-o altă limbă sau într-un format accesibil,
vă rog să discutați cu un membru al personalului să se ocupe
de acest lucru pentru dumneavoastră

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إذا احتجت إلى هذه النشرة بلغة أُخرى، أو بتنسيق
يسهل الوصول إليه، يرجى التحدث إلى أحد الموظفين لترتيب ذلك لك.

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What is the nature of the procedure?

Following the birth of your baby, the placenta (afterbirth) normally delivers with ease. Sometimes the placenta gets stuck on the wall of the womb (retained placenta), and does not deliver and in these circumstances, you would usually require a manual removal of the placenta under anaesthetic (either a general or regional anaesthetic).

- The third stage is the time between the birth of the baby and delivery of the placenta and membranes. It takes anything from about 30 minutes to one hour if it is allowed to happen naturally. This is known as a **physiological third stage.**
- It may be speeded up with an injection in your thigh given just as the baby is being born (**Actively Managed Third Stage**)**.**
- The injection used is an Oxytocic drug to speed up the delivery of the placenta, as this reduces the risk of haemorrhage.
- A Managed Third Stage usually lasts between five and 10 minutes.

Why and how does a retained placenta happen?

- A common reason is a snapped cord during 'controlled cord traction'. In other words, the pulling of the cord.
- If you have a Managed Third Stage, the Oxytocic injection will cause your womb to contract, shearing the placenta away from the uterine wall.
- The midwife will wait for signs that the placenta has separated and will then put one hand on your tummy to keep your womb steady whilst pulling gently on the cord with her other hand.
- If the placenta has separated and is ready to come out, it will slide easily through the vagina.
- If it has not completely separated, if the cord is very thin or if too much traction is used, the cord may snap, leaving the placenta inside the womb.
- Breastfeeding your baby will cause the womb to contract and may help to expel the placenta.
- A change in your position or emptying your bladder may also work.

Sometimes a piece of the placenta can be retained. It can be connected to the main part of the placenta by a blood vessel. This is called a Succenturiate Lobe. The midwife will examine the placenta and membranes carefully after delivery to ensure that they are complete. If she notices an unattached blood vessel this will alert her to the possibility that part of the placenta could be retained in your womb.

Sometimes a part of the placenta may stick to a fibroid, or a scar from a previous caesarean section. A rare cause of a retained placenta is known as Placenta Accreta. This happens very rarely, approximately 1 in 2500 births and is not discussed in this leaflet.

Risks of the Procedure?

- Normally after the placenta is delivered, the empty womb contracts down to close off all the blood vessels inside the womb.
- If the placenta only partially separates, the womb cannot contract properly, so the blood vessels inside will continue to bleed.
- If the placenta is not delivered within about 40 minutes after delivery of the baby, there is a tenfold increased risk of heavy bleeding.
- Heavy bleeding in the first 24 hours after birth is known as **Primary Postpartum Haemorrhage** (PPH).

If all attempts to remove the placenta fail, a manual removal will be necessary. This will be done under general anaesthetic. A spinal or epidural will be used so that the obstetrician can safely and painlessly remove the placenta. You will also need a course of antibiotics to prevent infection.

I had a retained placenta with my first labour.

I'm pregnant again - can I do anything to stop it happening again?

If you have already had a retained placenta in a previous delivery, you are at greater risk of it happening again. There is not much you can do to prevent it happening again if it was due to the placenta sticking to an old Caesarean scar, or placenta accreta.

Retained placenta is more common in premature births than at full term. So, if you have another preterm labour, it is possible it may happen again.

However, if the retained placenta happened because the cord snapped or the cervix closed too quickly after having the Oxytocic injection, you may wish to discuss with your midwife whether or not to have a physiological third stage with your next baby. By allowing the placenta to deliver naturally, you avoid the possibility of the cervix closing too quickly and trapping the placenta.

What do I look for?

If small fragments of placenta or membrane are retained and are not detected immediately, this may cause:

- Heavy bleeding, and
- Infection later on.

Heavy bleeding, which happens from 24 hours until six weeks after the birth is known as Secondary PPH and happens in about one per cent of deliveries.

You must inform your midwife or GP if you have any of the following:

- Heavy bleeding
- Pass blood clots
- Offensive (bad odour) vaginal discharge
- Flu like symptoms
- Abdominal (stomach) pains.

If you have any heavy bleeding or pass blood clots, you must keep any pads or clots so they can see how much you have lost and see if there is any placenta tissue.

If you have prolonged heavy bleeding in the days or weeks following the birth, you may be referred to the hospital to see if there are any retained products of conception in your womb. If this is diagnosed then treatment may involve waiting to see if your body breaks down the products, or a procedure known as Evacuation of Retained Products of Conception (ERPC), which is like a D&C or 'scrape'. This is done under anaesthetic and treatment with antibiotics. These choices will be discussed with you by the doctor.

Ragged Membranes

I have been told I have 'ragged membranes' but what does this mean?

- Ragged membranes can be discovered when the midwife examines your placenta after birth. Sometimes small pieces of the membranes can be left inside the uterus. This happens in 5-10% of births (between five and ten women in one hundred) and does not normally cause any problems.
- A small number of women can be at risk of infection when they have ragged membranes, this happens in less than 1% of women (one in one hundred) with ragged membranes.
- We do not recommend routine antibiotics if you are otherwise well.
- It is important to know the early signs of infection and seek help from your midwife or GP if you think you are developing any symptoms. The important symptoms include:

- A high temperature (fever)
- Pain in your lower tummy area
- A smelly discharge from the vagina
- Heavy bleeding or blood clots from the vagina
- Pain on having sex or passing urine
- Feeling generally unwell.

If you have any questions, please contact your community midwife, GP or the Maternity Unit for advice

If you have been discharged from midwifery care and over 28 day postnatal then contact your GP

Useful Telephone Numbers:-

Community Office: 0151 430 1492 (office hours)

Switchboard: 0151 426 1600 and ask for the Maternity Bleep holder.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Whiston Hospital
Warrington Road,
Prescot, Merseyside, L35 5DR
Telephone: 0151 426 1600

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Marshall Cross Road,
St Helens, Merseyside, WA9 3DA
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