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Body Wise Birth Services
Childbirth Education & Doula Training

Natural verses 'Active Management of the 3rd stage of labour...

Natural verses active management of the 3rd stage of labour

The majority of caregivers will recommend the routine use of synthetic oxytocics (Syntocinon) and the active management of the 3rd stage of labour rather than allow for a physiological 3rd stage, using expectant management. The main motivation for caregivers to actively manage the 3rd stage is to avoid the complication of a **postpartum haemorrhage (PPH).**

To understand why caregivers (and parents) choose to actively or expectantly manage the 3rd stage and to put these options in perspective it helps to have an appreciation of the issues surrounding postpartum haemorrhage.

It also helps to know that when choosing a birthplace you may need to make your preferences known to your caregiver before birth, because the management of the 3rd stage can be 'routine' depending on where you plan to have your baby.

An Introduction to postpartum haemorrhage

Postpartum Haemorrhage (or PPH) is defined in Australia as being 600 mls of blood loss or more in the first 24 hours after the birth or any amount of blood where the woman's general condition is affected.

A severe postpartum haemorrhage would be 1800 to 2000mls or more. This volume of blood would most likely cause the woman to be very unwell, probably requiring a blood transfusion.

More than 2000 mls can be life threatening for the mother (Be aware that the amount of blood lost to make the woman unwell will also depend on the woman's health and **haemogloblin** blood level before she experienced the blood loss.)

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Rates of postpartum haemorrhage are controversial. This is because the amount of blood loss is a visual estimate and not an actual measure by your caregiver, meaning the amount written down is a personal interpretation, more like a rough approximation.

The average rate of postpartum haemorrhage is believed to be about 6%. Documentation of postpartum haemorrhage rates can vary from between 5% and 18%, probably due to discrepancies in estimating blood loss. This is despite the routine use of synthetic oxytocic drugs and the active management of the 3rd stage.

Postpartum haemorrhage (PPH) can be a serious and debilitating complication for the woman and in rare cases it is still capable of causing death even when the active management of the 3rd stage is routinely used. Active management does not eliminate the possibility of a severe postpartum haemorrhage occurring but it can reduce the chances of it happening

Why actively manage the 3rd stage?

Actively managing the 3rd stage reduces the amount of blood the woman can lose and the chance of her having a PPH or a severe PPH. This is because the degree of blood lost is associated with how quickly the placenta separates and is expelled from the uterus and how effectively the uterine muscles contract around the torn blood vessels where the placenta was attached.

Active management and synthetic oxytocic drugs shorten the duration (or time to complete) of the 3rd stage and in most cases increase the uterus' ability to contract.

Studies assessing the most appropriate way to manage the 3rd stage have been conducted over the last decade. The earlier research in the late 1980's and early 1990's showed that active management was better than expectant management, but critics felt that the caregivers conducting the studies (one famous one being the Bristol Trial) were inexperienced in managing a natural 3rd stage and therefore viewed the results with caution.

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A more recent trial addressed this issue, called the Hinchingbrooke Trial published in 1998, and showed that there were still clear benefits even for well women at a low risk of postpartum haemorrhage, related to routinely managing the 3rd stage actively. Benefits included a reduction in the overall amount of average blood loss for women (by 80 mls), a 2 to 3 times less chance of mild postpartum haemorrhage (PPH) and less chance of the woman experiencing a severe PPH. There was also less chance of the woman needing further doses of synthetic oxytocic drugs for continued bleeding and less chance of needing a blood transfusion.

Other proposed benefits that can be associated with preventing even a mild postpartum haemorrhage were possibly less tiredness, less chance of becoming depressed and less chance of being anaemic or having a low **haemoglobin** (Hb) blood level after the birth.

NOTE: If you are having your baby in the hospital, then you will generally automatically have an actively managed 3rd stage, including an injection of an oxytocic medication, unless you specifically request not to have this. Some hospital policies ask that you sign a disclaimer if you decline an actively managed 3rd stage (although whether this is legally binding is debatable). You may wish to discuss these issues with your caregiver before the birth or address it in your **birth plan.**

Why choose a natural 3rd stage?

Expectant management or a natural 3rd stage of labour is still popular in parts of northern Europe, in community based midwifery care programs in some countries and in birth centres and homebirth in Australia as well as in developing countries. A minority of women continue to choose to have a natural 3rd stage because they have philosophical beliefs about birth being a natural process and they wish to avoid the need for an injection and any possible side effects from the drugs used, especially if Syntocinon is used.

The rates for postpartum haemorrhage were compared between one birth centre attached to a major Sydney hospital and the hospital's delivery suite. In the delivery suite active management of the 3rd stage was used routinely for 90% of the women and the postpartum haemorrhage rate was 5%. In the birth centre where a natural third stage was used routinely and oxytocics were used if there were problems, the haemorrhage rate was about 7%.

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Benefits of a physiological third stage of labour & delayed cord Clamping

Delayed cord clamping allows the baby to receive his or her full blood volume and optimal iron stores (Prendiville and Ellbourne, 1989, Inch, 1983). This may be as much as 40% circulating volume and is important in maintaining haematocrit levels (Yao & Lind, 1974). Early cord clamping deprives the baby of 75-125mls of transfused blood. (Bristol Trial, 1988, and Hinchingbrooke Trial 1998).

With delayed cord clamping the placenta is less bulky, and more readily expelled (Dunn et al. 1966). Delayed cord clamping allows the baby's lifeline to continue to supply oxygenated blood, facilitating perfusion of the lungs, and supporting the baby's transition to breathing for himself without incurring oxygen deprivation.

The baby is less likely to require resuscitation after birth, and less likely to have idiopathic respiratory distress. (The term Idiopathic Respiratory Distress describes breathing difficulties for no apparent reason, and is believed to be linked to interference with the delicate and complex changes in the baby's heart and circulatory systems - Dunn, 1989; Inch, 1983)

Delayed cord clamping reduces the risk of feto-maternal transfusion, which is especially important for Rh negative mothers (Lapido, 1971; Rogers et al, 1998). Delayed cord clamping reduces the risk of infection in both the mother and the baby because the mother has reduced clot formation if the maternal end of the cord is not clamped, and the baby has less stagnant blood left in the cord stump.
Clots and stagnant blood provide an ideal environment for infection. The cord may separate more rapidly postnatally if cord clamping is delayed (Sleep, 1993).
Avoiding controlled cord traction eliminates the risk of pulling out an incompletely separated placenta, tearing or snapping the cord, partial or full inversion of the uterus, and pain associated with uterine handling.
The woman and baby can remain undisturbed and unhurried, enhancing bonding opportunities, facilitating early breastfeeding and maximising hormonal balance.