Advantages of choosing a physiological (natural) third stage

- No immediate time constraints to deliver the placenta so you can relax after your baby is born, having a calm & quiet time.
- Your baby stays attached to you for longer, giving you some time to get to know each other straightaway, & without anyone taking your baby away from you.
- Your baby continues to receive oxygen through the pulsating cord for a while as he or she starts to breathe by themselves.
- Your baby's blood in the placenta and cord move back into your baby's body, rather than being lost to the baby.

If there are problems with blood loss or the placenta does not separate, it is possible to have uterotonics later when they are needed, rather than on a 'just in case' basis.

Considerations if you choose a natural third stage

A natural third stage is controlled by hormones and particularly by a hormone called oxytocin which contracts the uterus. Oxytocin is released when the environment is quiet and peaceful and in response to being close to your baby (especially when there is skin-to-skin contact) and to breastfeeding

Discuss your wishes with your carers and make sure that your midwives are familiar with all aspects of a physiological third stage, such as leaving the cord unclamped and not applying controlled cord traction.

Understand that the natural process may not happen properly if your labour has involved medical interventions such as your labour being induced or accelerated with a drip or if you have had forceps or ventouse. In these circumstances it may be safer to have a managed third stage.

Be particularly aware if you are at risk of PPH, because of your medical history. It may safer to have a managed third stage. You should prepared for your carers to act quickly if they think there is a risk of PPH after your baby has been born.

If after some time your placenta fails to separate or you are bleeding significantly you may need to be given drugs to contract the uterus. Try to remain flexible if this happens.

If active management is an established part of the routine where you are having your baby, then if you choose to have a natural third stage you will have to ask clearly for it. You should discuss with your carers in advance if it is possible for you to have a natural third stage.

Advantages of choosing a managed (active) third stage.

Research shows that women having an active third stage have a smaller amount of blood loss (6.8% chance of a significant blood loss compared with 16.5% if you do it naturally).

Labour is completed more quickly.

If you are risk of PPH because of your medical history or because of events during labour, research shows that it is safer for you to have an active third stage.

Considerations of choosing a managed third stage.

There can be a feeling of a "race against the clock" trying to ensure that the placenta separates and is delivered.

There may be a higher risk of having a retained placenta which may then need to be removed under anaesthetic.

Some of the drugs can cause side effects such as nausea, vomiting and high blood pressure, although drugs with fewer side effects are more commonly used in preference nowadays.

There can be a risk if there is an undiagnosed twin (although this is rare due to the extensive use of ultrasound scans in pregnancy).

If the cord is clamped early the baby does not receive enough blood through the cord. In some circumstances it is possible to delay cord clamping with a managed third stage which significantly increases the amount of the baby's blood volume.

There are some risks with controlled cord traction such as snapping of the cord making it more difficult to deliver the placenta quickly, the risk of pulling out an incompletely separated placenta, and the very small risk of causing the uterus to invert which will require surgery to reverse.

THE 3rd STAGE

Ripple Effect Yoga

The 3rd Stage

Immediately after birth, they may place the baby up on mum's belly, or may take the baby over to a warming table, depending on the condition of the baby and on hospital policy.

Ideally **skin to skin** should happen and baby should stay on mum's belly or chest for at least the first hour of birth in a low lit room, blanket over mum and baby and encouraging bonding between mum, dad and baby.

The midwife will deliver the placenta: you may need to do a few more light pushes. Then your perineum will be examined and you will be offered the opportunity to have any tears repaired.

If you required an episiotomy this will be repaired automatically using a local anaesthetic by your midwife or possibly by the senior member of staff on duty depending on the type of stitching required.

Managed or Physiological—delivering your placenta

For a woman who has just given birth, the most important thing that is happening is that she is meeting her baby for the first time, and will be spending time holding and cuddling her new baby. This is a very special moment for both.

However, labour is not yet finished. After the baby is born, the uterus carries on contracting. This causes the placenta to come away from the wall of the uterus. Here, the muscle fibres of the uterus wall are arranged in a criss-cross pattern. As the uterus contracts, they close around the mother's blood vessels and limit the amount of blood loss. The placenta and membranes are passed out of the uterus into the birth canal and are delivered.

This process where the placenta and membranes come away from the uterus is called 'the third stage of labour' or simply 'third stage'.

Third stage may be left to proceed naturally, often called a '**physiological third stage**' or it can be managed with a package of interventions aimed at preventing problems with blood loss, often called an '**active third stage'**.

What are the options?

Active or managed third stage

Drug given to make the uterus contract ('uterotonic')
Cord cut and clamped following birth of baby, sometimes immediately although in some circumstances it may be delayed
Controlled cord traction where cord is pulled gently to help deliver the placenta
Placenta delivered by midwife
Process takes 4 to 7 minutes
May be given routinely for all women or only for women at increased risk of PPH
Usually recommended if there have been interventions during labour

Physiological or natural third stage

No drug given
Cord not clamped until it stops pulsating
No traction (pulling) applied to cord
Placenta delivered through woman's effort
Process may take from a few minutes to over an hour (average about 30 minutes)
Can happen for women at low risk of PPH but could be chosen by women at increased risk
Not usually recommended if there have been medical interventions during labour

Choosing between a physiological third stage and active management

There is no doubt that the use of uterotonic drugs has saved many lives which would have been lost to postpartum haemorrhage (PPH) throughout the world. As a result, active management of third stage to prevent PPH has become a routine practice in many places.

However, third stage is much more than just a medical event. It represents the time just after your baby has been born, when your body stops being pregnant and you become a mother. Your baby begins to adjust to life in the outside world. For some women this is a very precious time which they don't want speeded up with drugs.

Therefore, some people have questioned whether it should be routine for all women or if women's individual circumstances and wishes should be taken into account in deciding on how to manage third stage.

The research evidence

There is limited evidence from studies comparing having a natural third stage with having active management, largely because there are several different inter-dependent components of these practices, and different women have different levels of risk. There are several trials currently in progress to try to produce more evidence about how third stage of labour should be managed.

A review of several studies suggests that active management of third stage reduces blood loss and the likelihood of having a PPH (blood loss over 500mls) or severe PPH (blood loss over 1000mls). It can also reduce anaemia after the birth and the need for a blood transfusion. [See the Cochrane Review on third stage.]

However, some of the studies included in this review may have limitations.

Some included women who were at high risk of PPH or who had complications during their labour which could have contributed to an increased risk of PPH.

In some of the trials, the method of active management of third stage varied, and some of the women receiving a physiological third stage may have had some elements managed (e.g. early cord clamping or controlled cord traction) which may have contributed to blood loss.

In most of the trials, the usual practice was an active third stage and some of the midwives were unfamiliar or not confident with the practice of allowing a physiological third stage.

Even so, many obstetricians recommend that women should routinely have a managed third stage to prevent postpartum haemorrhage. However they should also recognise that women who request a natural third stage should be supported in their choice.