POSITION STATEMENT

Active Management of the Third Stage of Labor

The American College of Nurse-Midwives (ACNM) and its members are committed to providing evidence-based care for women, newborns, and childbearing families. Postpartum hemorrhage, which can occur in hospital, birth center and home birth settings, is the leading cause of maternal mortality worldwide. In an effort to reduce the risk of postpartum hemorrhage, it is the position of the American College of Nurse-Midwives (ACNM) that

- Evidence indicates that active management of the third stage of labor (AMTSL), specifically administration of oxytocin, reduces the risk of severe postpartum hemorrhage (> 1000 mL blood loss) and the need for blood transfusion. However, in women considered low risk for postpartum hemorrhage, the advantages are not as clear.
- Research is lacking regarding the potential effect of synthetic oxytocin administration, particularly as part of the AMTSL, on maternal endogenous oxytocin, mother-infant bonding, and breastfeeding initiation.
- It is the responsibility of midwives and other maternity care providers to discuss the benefits and potential risks of AMTSL with women so that they can make informed decisions regarding labor and birth.

Background

Postpartum hemorrhage (PPH), the leading cause of maternal morbidity and mortality globally, is responsible for 130,000 maternal deaths annually.[1,2] In the United States, 125,000 (2.9%) women who give birth will experience postpartum hemorrhage each year.[3] Postpartum hemorrhage is defined as blood loss of 500 ml or more within 24 hours of birth; loss of 1000 ml or more is defined as major PPH.[4] The World Health Organization, International Federation of Obstetricians and Gynecologists, and the International Confederation of Midwives recommend AMTSL for all vaginal, singleton births.[4,5]

Active management of the third stage of labor has been shown to reduce the incidence of PPH, the need for blood transfusion, and the use of therapeutic uterotonics during the third stage of labor and/or within the first 24 hours after birth.[4,6] However, in a recent meta-analysis, women considered low risk had a reduction in blood loss and need for blood transfusion but no difference in the incidence of severe (>1000ml) PPH.[6] Active management of the third stage of labor does not increase the risk of retained placenta,[4] but it may be associated with increased maternal blood pressure (specifically with ergotamine products), vomiting, after-pains, and use of analgesia postpartum. [6]

The practice of AMTSL varies among providers,[7] and recommendations differ among professional organizations worldwide.[8] The World Health Organization released an updated guideline for AMTSL that emphasized the primary effectiveness of oxytocin to prevent postpartum hemorrhage.[4] Recommendations include the following:

1. Offer a uterotonic agent immediately after birth. Oxytocin is the preferred drug to prevent postpartum hemorrhage.
2. Delay clamping the cord for at least 1-3 minutes to reduce rates of infant anemia.
3. Perform controlled cord traction as required. The World Health Organization does not recommend the use of controlled cord traction by non-skilled birth attendants.

The World Health Organization also emphasized the importance of immediate assessment of uterine tone and continuation of this assessment every 15 minutes for 2 hours.[4] Controlled cord traction and fundal massage are now considered optional steps based on indications and the woman's wishes. Continuous uterine massage is not recommended for women who receive oxytocin.[4] Because ergot alkaloid medications such as methylergonovine increase risk of elevated diastolic blood pressure, vomiting, and need for medication to manage postpartum pain, oxytocin is the preferred uterotonic agent.[4, 9] Misoprostol and other injectable medications such as carboprost can used as alternatives.[4,9] Recent evidence does not support the administration of misoprostol in combination with prophylactic routine oxytocin.[9]

It is important to note that early cord clamping is no longer a recommended part of AMTSL. In a Cochrane review, investigators found no difference in outcomes related to maternal hemorrhage between women with early versus late cord clamping.[10] Delayed cord clamping is associated with multiple benefits for preterm and term infants.[11,12]

Active management of the third stage of labor as described above should be discussed with women and their families in the antepartum period to allow for risk identification and informed decision making. More research is needed to better understand how other labor and birth practices that support physiologic birth influence risk of PPH. In low-resource settings, AMTSL should be considered the standard of care.

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Note. Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB).

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