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## Effect of routine controlled cord traction as part of the active management of the third stage of labour on postpartum haemorrhage: multicentre randomised controlled trial (TRACOR).

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### ► To cite this version:

Catherine Deneux-Tharoux, Loic Sentilhes, Françoise Maillard, Emmanuel Closset, Delphine Vardon, et al.. Effect of routine controlled cord traction as part of the active management of the third stage of labour on postpartum haemorrhage: multicentre randomised controlled trial (TRACOR).. *BMJ*, 2013, 346, pp.f1541. inserm-00809184

**HAL Id: inserm-00809184**

**<https://inserm.hal.science/inserm-00809184>**

Submitted on 8 Apr 2013

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1 **Should routine controlled cord traction be part of the active management of third stage**  
2 **of labour? The Tracor multicenter randomized controlled trial**

3

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20

21 **Abstract**

22 **Objectives** Active management of the third stage of labour is recommended for preventing postpartum  
23 haemorrhage (PPH). However, the specific effects of each of its components have not been adequately  
24 evaluated. The TRACOR Study aimed to assess the impact of controlled cord traction on the incidence  
25 of PPH and other characteristics of the third stage of labour, in a high-resource setting.

26 **Design** Randomized controlled trial conducted between January 1, 2010, and January 31, 2011.

27 **Setting** Five French university hospital maternity units

28 **Participants** Women aged  $\geq 18$ , with a planned vaginal delivery, at a gestational age  $\geq 35$  weeks, with  
29 a singleton fetus.

30 **Interventions** Women were randomly assigned to have third stage of labor managed either by  
31 controlled cord traction (CCT), or by standard placenta expulsion (SPE) i.e. awaiting the spontaneous  
32 placental separation before facilitating its expulsion. Prophylactic oxytocin just after birth of the baby  
33 was administered in the 2 arms.

34 **Main outcome measures** The primary outcome was the incidence of PPH  $\geq 500$  mL as measured in a  
35 collector bag.

36 **Results** The incidence of PPH was not different in the CCT group (9.8% (196/2005) and in the SPE  
37 group (10.3% (206/2008), RR 0.95, 95% CI (0.79 to 1.15). The need for manual removal of placenta  
38 was significantly less frequent in the CCT than in the SPE group (4.2%(85/2033) and 6.1%(123/2024),  
39 RR 0.69, 95%CI (0.53 to 0.90)); as was third stage  $> 15$  minutes (4.5% (91/2030) and 14.3%  
40 (289/2020), RR 0.31, 95%CI 0.25 to 0.39)). Women in the CCT group reported a significantly lower  
41 intensity of pain and discomfort during the third stage than those in the SPE group. No uterine  
42 inversion occurred in either arm.

43 **Conclusions** In a high-resource setting, the use of CCT for the management of placenta expulsion had  
44 no significant effect on the incidence of PPH and other markers of postpartum blood loss. Therefore,  
45 there is no evidence to recommend routine CCT for the management of placenta expulsion in order to  
46 prevent PPH.

47 **Trial registration** ClinicalTrials.gov NCT01044082.

48

49 **“What this paper adds “ box**

50 **What is already known on this subject**

- 51 • Active management of the third stage of labour includes the administration of an uterotonic  
52 drug immediately after child birth and controlled cord traction (CCT), and is recommended for  
53 the prevention of PPH.
- 54 • The management of third stage of labour without CCT does not increase the risk of severe  
55 PPH in low and middle income countries, and therefore could be omitted in non-hospital  
56 settings.
- 57 • However, the impact of CCT on PPH incidence and other characteristics of third stage in the  
58 context of high-resource settings is unknown.

59 **What this study adds**

- 60 • In a high-resource setting, the use of CCT for the management of placenta expulsion has no  
61 significant effect on the incidence of PPH and other markers of postpartum blood loss.  
62 Therefore, there is no evidence to recommend routine CCT for the management of placenta  
63 expulsion in order to prevent PPH.
- 64 • However, CCT is safe, reduces the length of third stage, the need for manual removal of  
65 placenta and for additional uterotonics after placenta delivery, and results in a better  
66 experience of the third stage for women.

67

68 **INTRODUCTION**

69 Postpartum haemorrhage (PPH) remains a major complication of childbirth worldwide. (1)  
70 Population-based studies in high-resource countries report a prevalence of severe PPH from 0.5% to  
71 1% of deliveries,(2-5) making it the main component of severe maternal morbidity. Uterine atony is  
72 the leading cause of PPH, accounting for 60 to 80% of cases(6). Prevention of atonic PPH is thus  
73 crucial, and preventive measures are recommended for all women giving birth, given that individual  
74 risk factors are poor predictors.  
75 Active management of the third stage of labour (AMTSL) has been proposed for the prevention of  
76 PPH(7). Its standard definition combines the following three procedures: administration of an oxytocic  
77 drug immediately after child birth, early cord clamping and cutting, and controlled cord traction.  
78 Several trials(8-11) combined in a meta-analysis(12) showed that AMTSL is associated with a 60%  
79 reduction in the incidence of PPH compared with expectant management. Given its efficacy, AMTSL  
80 has been included in international(13, 14) and national(15-17) guidelines for the prevention of PPH.  
81 However, an adequate evaluation of the specific efficacy of each of its components has not been done.  
82 The independent efficacy of preventive oxytocics has been shown with a good level of evidence(18)  
83 and it is therefore often considered the essential component of AMTSL. This is not the case for  
84 controlled cord traction (CCT).(19) Although most guidelines for prevention of PPH include CCT, its  
85 actual implementation is highly variable, varying in Europe from 12% in Hungary to 95% in  
86 Ireland.(20) In countries, such as France, where CCT is not recommended, pulling the cord in the  
87 absence of any sign of placenta separation is considered poor practice because of the potential risk of  
88 uterine inversion.(21)  
89 The variation in use of CCT may be explained by the paucity of available evidence for assessing either  
90 the efficacy of CCT for the prevention of PPH or its potential risks. Until recently, only two trials  
91 conducted in the 1960's (19, 22) and with important limitations had assessed the specific effect of  
92 CCT and they had conflicting results. Very recently, a large randomized controlled trial conducted in  
93 eight low and middle income countries reported that the omission of CCT as part of AMTSL did not  
94 increase the risk of severe PPH(23). The authors concluded that CCT could be omitted in non-hospital

95 settings. However, the results of this trial may be relevant for low/middle income countries and not  
96 applicable to other countries.

97 The TRACOR Study aimed to assess the impact of controlled cord traction on the incidence of PPH  
98 and other characteristics of the third stage of labour, in a high-resource setting.

99

## 100 **METHODS**

### 101 *Trial design*

102 The TRACOR (TRAction of the CORd) trial was a multicenter randomized controlled trial with two  
103 parallel groups and took place in five French university hospitals between January 1, 2010, and  
104 January 31, 2011.

105 CCT was not a standard part of third-stage management in any of the participating units before the  
106 trial. Before the beginning of the trial, all staff likely to recruit women into the trial (midwives and  
107 obstetricians) were trained in the trial procedures and more particularly in the technique of CCT. In  
108 each participating centre, several training meetings were led by a team from the steering committee  
109 pairing a midwife with an obstetrician. Films demonstrated the placement of the collector bag and the  
110 practice of CCT. Following this initial training, a period of one month was devoted to using CCT in  
111 actual practice. Before the inclusion period, a meeting was organized in each unit to verify the  
112 attendants' adherence to the protocol and their ease in practicing the relevant procedures.

### 113 *Participants*

114 Women aged 18 or more, with a planned vaginal delivery, at a gestational age  $\geq 35$  weeks, with a  
115 singleton foetus, were eligible for inclusion. We excluded women with a severe haemostasis disease,  
116 those with placenta praevia, in utero foetal death, and multiple gestations. We also excluded women  
117 who did not understand French. Eligible women were approached and offered information about the  
118 study during a prenatal visit in the third trimester of pregnancy by a midwife or an obstetrician. This  
119 information was repeated after their arrival in delivery room for the planned vaginal delivery; the  
120 women then confirmed their participation and provided informed written consent.

### 121 *Interventions*

122 We compared CCT with standard management of placental expulsion.

123 In the intervention arm, CCT was implemented immediately after the delivery of the baby upon  
124 obtaining a uterine contraction, as initially described,(19) according to the following instructions: 1)  
125 after birth, CCT is started with a firm uterine contraction without waiting for placenta separation; 2)  
126 with one hand, grasp the lower segment between the thumb and index finger and exert steady pressure  
127 upwards; 3)at the same time, hold the cord in the other hand, and exert steady cord traction  
128 downwards and backwards, exactly countered by the upwards pressure of first hand, so that the  
129 position of the uterus remains unchanged. 4) If the placenta is not expelled on the first attempt, repeat  
130 CCT with counter-pressure with the next uterine contraction.

131 In the control arm, the attendant awaited the signs of spontaneous placental separation and descent into  
132 the lower uterine segment. Once the placenta was separated, it was then delivered through the  
133 mother's efforts (helped by fundal pressure or soft tension on the cord to facilitate placental expulsion  
134 through the vagina if needed). This standard placental expulsion (SPE) is the usual management in  
135 France, as taught in university hospitals and midwifery schools, and it was the routine procedure in the  
136 five participating centers before the trial.

137 All other aspects of third stage management were identical in both arms: IV injection of 5 IU oxytocin  
138 within 2 minutes after birth; clamping and cutting the cord within the 2 minutes following birth;  
139 placement of a graduated collection bag (manufactured by MVF Merivaara France, 100 mL  
140 graduation) just after birth, left in place until the birth attendant judged that the postpartum bleeding  
141 had stopped and that there was no reason to further monitor it(24), and always at least for 15 minutes;  
142 manual removal of the placenta at 30 minutes after birth if not expelled. A blood sample was taken  
143 from all women on the second day after delivery for the measurement of haemoglobin (Hb) and  
144 haematocrit (Ht).

#### 145 *Outcomes*

146 The primary outcome of the trial was the incidence of PPH defined by blood loss  $\geq 500$  ml, measured  
147 with a graduated collector bag (25). The main secondary outcomes were other objective measures of  
148 postpartum bleeding: measured blood loss  $\geq 1000$  mL at bag removal; mean measured blood loss at 15

149 minutes after birth (the bag had to be left in place at least 15 minutes to have one measure of blood  
150 loss at the same time point in all women); mean measured postpartum blood loss at bag removal; mean  
151 changes in peripartum haemoglobin and haematocrit (difference between Hb/Ht before delivery and  
152 D2). Other secondary outcomes included: supplementary uterotonic treatment, postpartum transfusion  
153 (until discharge), arterial embolization or emergency surgery for PPH; other characteristics of the  
154 third stage, including its duration, manual removal of the placenta; and women's experience of the  
155 third stage, assessed by a self-administered questionnaire on D2 postpartum. Safety outcomes included  
156 uterine inversion, cord rupture, and pain.

157 The detail of procedures used to manage the third stage, as well as all clinical outcomes identified  
158 during the immediate postpartum, were prospectively collected by the midwife or the obstetrician in  
159 charge of the delivery and recorded in the woman's electronic form in the labour room. Other data  
160 were collected by a research assistant, independent of the local medical team. An independent Data  
161 Monitoring Committee, which met monthly, was responsible for reviewing adherence to the trial  
162 procedures, the recruitment and safety data; the quality of collected outcome data was checked in each  
163 centre for 10% of the included women, randomly selected, and in all PPH cases.

#### 164 *Sample size*

165 We assumed a 7% incidence of PPH in the absence of CCT. This incidence is that found in the cohort  
166 as a whole in the Pithagore6 trial in 6 French perinatal networks in 2006 from a total of approximately  
167 147 000 births.(26) We hypothesized that CCT might explain half of the 60% reduction in PPH  
168 incidence described in the meta-analysis measuring the overall effect of active management. To show  
169 a reduction of at least 30% in the incidence of PPH in the CCT arm -that is, a PPH incidence of 4.9%  
170 or less in this arm , with  $\alpha = 0.05$ ,  $1-\beta = 0.80$ , and a bilateral test, the study required 1990 women with  
171 vaginal deliveries in each group, for a total of 3980 patients.

172 Given the expected proportion of women with a caesarean delivery in labour after randomization  
173 (estimated at 5% to 10%), a higher number of women needed to be randomized to include the needed  
174 number of women with vaginal deliveries. The decision to stop inclusions was made by the

175 independent Data Monitoring Committee, which was able to access the electronic inclusion system to  
176 determine the real-time cumulative number of randomized women and their mode of delivery.

177 This sample size provided a 70% statistical power to detect a reduction in the incidence of severe PPH  
178 (defined by blood loss  $\geq$  1000 ml) from 2% to 1% or less of deliveries.

### 179 *Randomization*

180 Randomization took place after women completed the participation form, during labour and before  
181 delivery. It was performed centrally through an automated web-based system, which ensured  
182 allocation concealment. Allocation was stratified by centre.

### 183 *Statistical methods*

184 The two groups were compared for main and secondary outcomes in an intention-to-treat analysis. The  
185 effects of CCT were expressed as mean differences with their 95% confidence intervals for  
186 quantitative outcomes, and as relative risks with their 95% confidence intervals for categorical  
187 outcomes. To test the consistency of the primary outcome across centres, we used the Mantel-  
188 Haenszel homogeneity test. The incidence of each adverse event (cord rupture and uterine inversion)  
189 was expressed as a proportion with binomial exact confidence intervals.

190 An analysis including women who had a caesarean delivery after randomization (for a total of 2172  
191 and 2180 women in the CCT and SPE groups, respectively), for secondary outcomes available in these  
192 women (mean change in Hb, mean change in Ht, postpartum transfusion, arterial embolization or  
193 emergency surgery) was conducted.

194 A post-hoc “per protocol” analysis was conducted among women who were managed in accordance  
195 with the protocol and the allocation, i.e who had all the following procedures: prophylactic oxytocin  
196 administration at birth, cord clamping and cutting within 2 minutes, management of placenta  
197 expulsion in accordance with the allocation group (CCT or SPE) and blood collection bag left in place  
198 at least 15 minutes.

199 Software used for analysis was Stata 10.1 (Stata Corporation, USA).

### 200 *Ethics*

201 The trial protocol was approved by the Paris-Ile de France III Committee for the Protection of  
202 Research Subjects (Ethics Committee) in September 2009 (n°B90885-20).

### 203 *Registration*

204 This trial is registered (ClinicalTrials.gov), number NCT01044082.

205 The full trial protocol can be accessed at: <http://www.u953.idf.inserm.fr/page.asp?page=5211>

## 206 **RESULTS**

### 207 **RESULTS**

208 Figure 1 shows the trial profile. The trial was carried out in all five hospitals between 1 January 2010  
209 and 31 January 2011. In all, 4355 women in labour were enrolled and randomly assigned. After  
210 randomization and before delivery, 294 (6.8%) women became ineligible because an intrapartum  
211 caesarean was performed, and 3 others declined to participate. Thus 4058 randomized participants  
212 delivered vaginally: 2034 assigned to CCT and 2024 to SPE. Baseline demographic and obstetric  
213 characteristics were similar in the two groups (Table1).

214 The management of the third stage of labour is described in Table 2. Overall, the adherence to the  
215 protocol was high in both groups. The reasons for deviating from the allocated intervention are  
216 detailed in Figure1.

217 Primary outcome data were collected for 4013 (98.9%) participants. The proportion of women with a  
218 measured postpartum blood loss of 500mL or more at bag removal did not differ between the 2 groups  
219 (196/2005, 9.8% in the CCT group and 206/2008, 10.3% in the SPE group, relative risk 0.95, 95% CI  
220 (0.79;1.15))(Table 3). There was no significant heterogeneity between centres for this result (Table3).

221 Similarly, the incidence of PPH  $\geq$  1000mL at bag removal did not differ between the 2 groups; nor did  
222 the mean measured blood loss at 15 minutes and at removal of the bag (Table3).

223 Outcome data related to blood count indicators before and after delivery were available for  
224 1963/2034(96.5%) women in the CCT group and 1953/2024 (96.5%) in the SPE group (at least one  
225 peripartum change in Hb or Ht available). Twenty women (11 in the CCT group and 9 in the SPE  
226 group) had transfusion before day 2 and were excluded from this analysis. There was no significant  
227 difference in the mean peripartum change in Hb or Ht (Table3). The proportion of women with a

228 peripartum drop in Hb of 4g/dl or more did not differ between the 2 groups, 2.1% (41/1961) in the  
229 CCT group and 1.8% (35/1953) in the SPE group, (RR 1.17, 95% CI (0.75;1.82)).  
230 Women in the CCT group had fewer manual removals of the placenta than those in the SPE group  
231 (RR 0.69, 95% CI (0.53; 0.90)) (Table 3). Third stage was shorter in the CCT group.  
232 Regarding safety, no uterine inversion occurred among the 1943 women who had controlled cord  
233 traction (incidence 0.0%, one sided 97.5% CI (0.0%-0.18%)). Cord rupture occurred in 89 (incidence  
234 4.6%, 95% CI (3.6%; 5.5%); among those 89 women, manual removal of the placenta was needed in  
235 43 (48%). No other adverse events occurred in the two groups.  
236 Women in the CCT group reported a significantly lower intensity of pain and discomfort during the  
237 third stage than those in the SPE group; they were less likely to have felt tired and anxious and to  
238 report that the duration of third stage was long (Table 4).  
239 The per-protocol analysis was conducted in 1437/1999(71.9%) women in the CCT arm, and  
240 1574/1990 (79.1%) in the SPE arm. The proportion of women with a measured postpartum blood loss  
241 of 500mL or more at bag removal did not differ between the two groups (11.7% (168/1431) in the  
242 CCT group and 10.7% (168/1570) in the SPE group, relative risk 1.10, 95% CI (0.90 ;1.34 )).  
243 Finally, the analysis including women who had a caesarean delivery after randomization provided  
244 results similar to those of the main analysis (data not shown).

245

## 246 **DISCUSSION**

247 In this large multicenter randomized trial, we found that the use of controlled cord traction as one  
248 component of the active management of third stage of labour had no significant effect on the incidence  
249 of PPH. However, CCT reduced the duration of the third stage and the need for manual removal of  
250 placenta. Moreover, women in the CCT group reported a significantly lower intensity of pain and  
251 discomfort as well as less fatigue and anxiety.

252 This trial included a large population of pregnant women with few exclusion criteria. Hence, the  
253 results are likely to be generalizable to women with vaginal deliveries in similar contexts of care.

254 Moreover, the adherence to the allocated intervention and other standardized aspects of third stage  
255 management was high, making it possible to isolate the effect of CCT.

256 It was not possible to blind this intervention as the procedures being tested require different actions by  
257 the attendants. However, the trial primary and main secondary outcomes (change in peripartum Hb  
258 and Ht ) were objective measures of postpartum blood loss as opposed to other definitions of PPH  
259 based on visual estimation or interventions, influenced by caregiver decisions. Although the quality of  
260 the CCT technique was not formally evaluated, a real difference in the management of placenta  
261 expulsion between the 2 groups is very likely given the emphasis on the initial training. Moreover, the  
262 attendants in the two groups clearly reported different procedures, and the length of the third stage was  
263 significantly shorter and the incidence of cord rupture higher in the CCT group.

264 Two small trials in the 1960's (19, 22, 27) assessed the specific effects of CCT during the third stage.  
265 Both had important methodological weaknesses including inadequate method of randomization, visual  
266 estimation of blood loss for determining outcome measures and limited sample sizes. Very recently, a  
267 large randomized controlled trial conducted in eight low and middle income countries compared CCT  
268 with "hands-off " management of third stage(23) . The results showed that the omission of CCT did  
269 not result in an increased risk of measured blood loss of 1000 mL or more. However, heterogeneity  
270 between centres in other components of third stage management (type of uterotonic used, combination  
271 with uterine massage), absence of report on the actual duration of blood loss measurement in each arm  
272 and absence of outcomes based on blood counts, may limit the interpretation of the results. In addition,  
273 although it is of major importance to conduct research studies in low and middle income countries, the  
274 generalizability of their results for high income settings needs to be tested. Indeed, characteristics of  
275 women, management of labour, resources and organization of care in the labour ward clearly differ  
276 between low and high resource countries, and these differences may impact the risk and the  
277 characteristics of PPH. Mechanisms of PPH and effective preventive procedures may differ between  
278 settings. It is noteworthy that the incidence of PPH  $\geq$  500 mL in the reference group of the previous  
279 CCT trial was about 30% higher than the incidence found in the Tracor trial, which might indicate  
280 higher exposure to the risk of PPH. For these reasons, our results provide valuable additional evidence

281 that CCT is not an essential component of management of the third stage of labour for prevention of  
282 PPH, in high resource countries.

283 Cord rupture occurred in about 1 in 22 women who had CCT. This rate may appear notable at first.  
284 However, in the majority of cases (52%), delivery of the placenta occurred without any extra  
285 intervention; and overall, the rate of manual removal of placenta was lower in women who had CCT.  
286 In consequence, cord rupture should not be considered an important adverse effect of CCT and does  
287 not imply manual removal of placenta.

288 The 30% reduction in the need for manual removal of placenta found in the CCT arm may provide a  
289 meaningful decrease in morbidity considering the need for analgesia and antibiotics, separation of  
290 mother and baby, and the risk of infection associated with this intervention (28). However, we cannot  
291 exclude the possibility that such a difference may have been less important (or even not significant) if  
292 the French policy was more conservative, allowing a duration of third stage greater than 30 minutes  
293 before manually removing the placenta, in particular in the SPE group. Our finding of a lower risk of  
294 manual removal of placenta when its expulsion is managed with CCT is in contrast with the  
295 conclusions of the trial cited above(29). However, in this study, manual removal of placenta was  
296 performed in less than 1% of deliveries in both arms, which is low in comparison with previous  
297 reports from high resource countries (30, 31), and may actually illustrate the variations in policies for  
298 the management of the third stage of labour between settings (32). Our trial also showed that CCT  
299 significantly reduced the duration of third stage. This result may have implications for optimizing the  
300 organization of postpartum surveillance and care, in particular in hospitals where the number of  
301 midwives or birth attendants in labour wards is limited. In addition, the shorter third stage and lesser  
302 need for manual removal of placenta associated with CCT are likely to be the main reasons why  
303 women reported a better experience of the third stage of labour in the CCT arm, although we cannot  
304 exclude a patient preference bias since the study was not blinded.

305 Another controversial aspect of the management of the third stage of labour is the timing of cord  
306 clamping. Recent results from a trial conducted in Sweden showed that, even in a region with low  
307 prevalence of iron deficiency, delayed cord clamping reduced the prevalence of neonatal anaemia and

308 improved iron status at 4 months of age in term deliveries (33), confirming the findings of previous  
309 trials conducted in low and middle income populations(34). CCT, as it is classically performed, is not  
310 compatible with delayed cord clamping. Our finding that CCT has no significant effect on maternal  
311 postpartum haemorrhage constitutes reassuring information for clinicians willing to implement a  
312 policy of delayed cord clamping, from both maternal and neonatal perspectives.

313 In a high-resource setting, the use of CCT for the management of placenta expulsion has no significant  
314 effect on the incidence of PPH and other markers of postpartum blood loss. Therefore, there is no  
315 evidence to recommend routine CCT for the management of placenta expulsion in order to prevent  
316 PPH.

317

318 **ACKNOWLEDGEMENTS**

319 The authors want to thank the independent data monitoring committee chaired by Pr JM Treluyer from  
320 the Unité de Recherche Clinique Paris Centre.

321 The authors also thank the women who participated in the trial, the staff from the participating  
322 maternity units for including women, and the members of the Tracor Study Group (see list in  
323 appendix).

324 Inserm Unit 953 has received a grant from the Bettencourt Foundation (Coups d'élan pour la  
325 Recherche française) in support of its research activities.

326

327 **Contribution of authors**

328 CDT participated in the design of the study, obtained funding participated in the central monitoring of  
329 data collection, supervised the cleaning, analysis, and interpretation of the data and the drafting and  
330 revision of the paper, and has seen and approved the final version. She had full access to all of the data  
331 in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

332 As the Corresponding Author, she has the right to grant on behalf of all authors and does grant on  
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335 BMJ PGL products and sublicences to exploit all subsidiary rights.

336 LS participated in the design of the study, supervised the inclusion of women and the running of the  
337 trial in his hospital, participated in the revision of the paper, and has seen and approved the final  
338 version.

339 FM participated in the central monitoring of data collection, supervised the cleaning of the data,  
340 conducted the analysis and participated in the drafting and the revision of the paper and has seen and  
341 approved the final version.

342 EC participated in the design of the study, supervised the inclusion of women and the running of the  
343 trial in his hospital, participated in the revision of the paper, and has seen and approved the final  
344 version.

345 DV participated in the design of the study, supervised the inclusion of women and the running of the  
346 trial in her hospital, participated in the revision of the paper, and has seen and approved the final  
347 version.

348 JL participated in the design of the study, supervised the inclusion of women and the running of the  
349 trial in his hospital, participated in the revision of the paper, and has seen and approved the final  
350 version.

351 FG is the principal investigator of the trial; he participated in the design of the study, obtained funding  
352 for it, participated in the central monitoring of data collection, supervised the cleaning, analysis, and  
353 interpretation of the data and the drafting and revision of the paper, and has seen and approved the  
354 final version. He had full access to all of the data in the study and takes responsibility for the integrity  
355 of the data and the accuracy of the data analysis.

356

357 All authors have completed the ICMJE uniform disclosure form at [www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf)  
358 (available on request from the corresponding author) and declare: had support from the French  
359 Ministry of Health for the submitted work; LS had relationships (board membership, consultancy and  
360 lectures) with Ferring; other authors had no financial relationships with any organisations that might  
361 have an interest in the submitted work in the previous 3 years; no other relationships or activities that  
362 could appear to have influenced the submitted work.

363

#### 364 **Funding**

365 The Tracor trial was funded by the French Ministry of Health under its Clinical Research Hospital  
366 Program (contract n° P081206). The Ministry of Health had no role in the design and conduct of the  
367 study, no role in the collection, management, analysis, or interpretation of the data, and no role in the  
368 preparation, review and approval of the manuscript or in the decision to submit for publication.

369

370 Data sharing: no additional data available.

371

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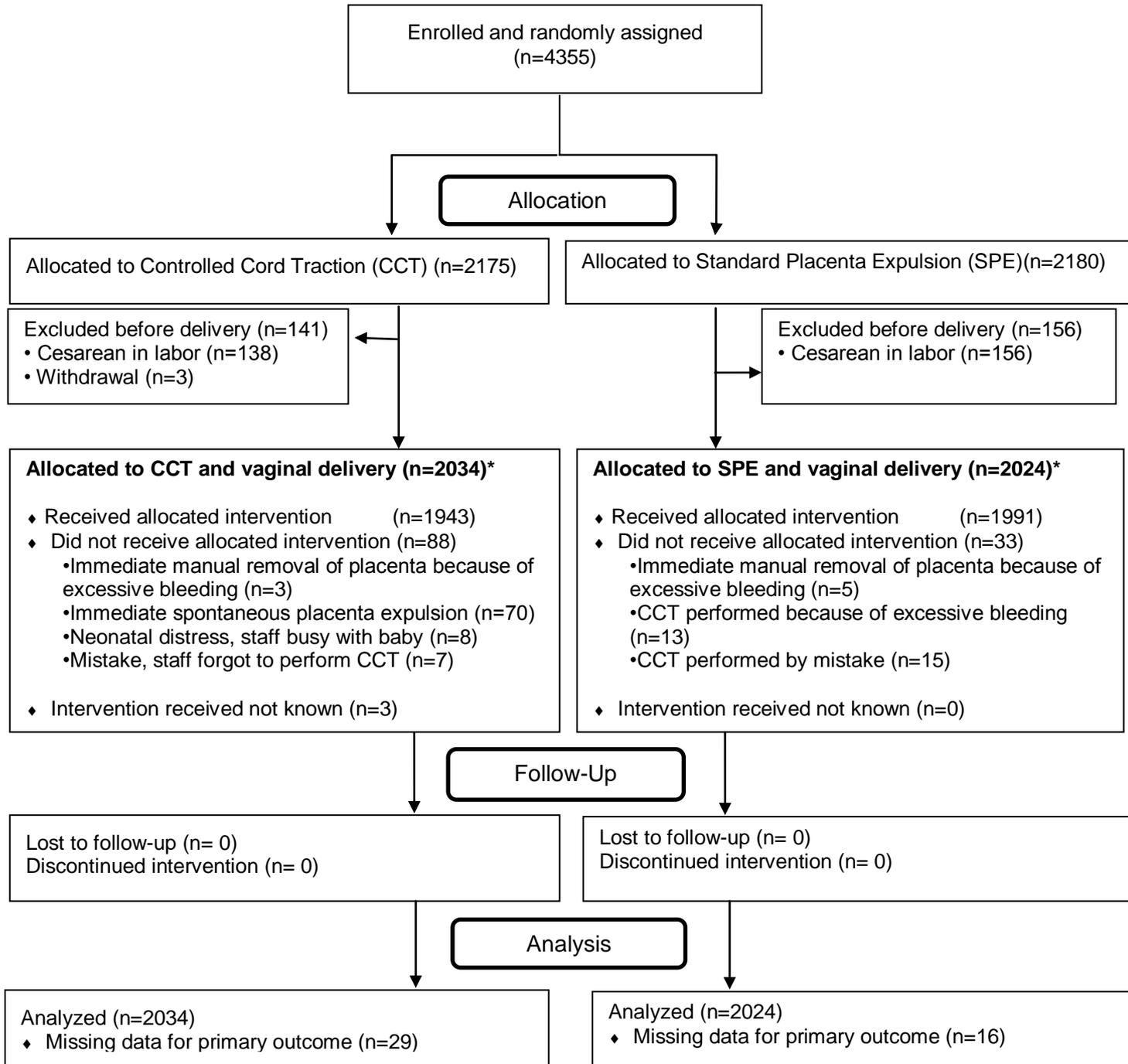
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**Figure 1: Trial flow diagram**



\* During the inclusion period, 12 391 women meeting the inclusion criteria had vaginal deliveries at the 5 participating hospitals; the trial thus recruited 32.7% (4058/12391) of the eligible women. The exact number of women assessed for eligibility was not collected.

**Table 1.** Baseline characteristics of women

Characteristics	Controlled Cord Traction (N= 2034)	Standard Placenta Expulsion (N= 2024)
Hospital		
A	485/2034 (23.8)	489/2024 (24.1)
B	213/2034 (10.5)	202/2024 (10.0)
C	345/2034 (17.0)	332/2024 (16.4)
D	446/2034 (21.9)	443/2024 (21.9)
E	545/2034 (26.8)	558/2024 (27.6)
Age (years) ( mean (SD) (n))	30.2 (5.2) (2034)	30.0 (5.2) (2024)
French nationality	1838/2000 (91.9)	1814/1995 (90.9)
Body Mass Index (mean (SD)(n))	22.8 (4.3) (2031)	22.7 (4.1) (2017)
Nulliparous	1074/2030 (52.9)	1031/2010 (51.3)
Previous PPH <sup>a</sup>	43/2030 (2.1)	39/2010 (1.9)
Uterine scar	132/2033 (6.5)	120/2021 (5.9)
Prenatal Hb <sup>b</sup> (g/dL) (mean (SD) (n))	12.0 (1.0) (2005)	12.0 (1.0) (1990)
Prenatal Ht <sup>c</sup> (%) (mean (SD) (n))	35.6 (1.0) (1952)	35.5 (2.9) (1933)
GA <sup>d</sup> at delivery (wks) (mean (SD) (n))	39.4 (1.2) (2034)	39.4 (1.2) (2024)
Induction of labour	381/2034 (18.7)	406/2024 (20.1)
Epidural analgesia	1975/2033 (97.1)	1957/2023 (96.7)
Oxytocin during labour (1 <sup>st</sup> and 2 <sup>nd</sup> stages)	1352/2033 (66.5)	1362/2020 (67.4)
Instrumental delivery	367/2034 (18.0)	381/2024 (18.8)
Episiotomy	597/2034 (29.3)	586/2024 (29.0)
Perineal tear	1036/2033 (51.0)	1024/2024 (50.6)
Birth weight (grams) (mean (SD) (n))	3365 (428) (2032)	3390 (433) (2022)
Birth weight $\geq$ 4000 grams	159/2032 (7.8)	157/2022 (7.8)

Data are n/N (%) unless otherwise stated

<sup>a</sup> Postpartum haemorrhage

<sup>b</sup> Haemoglobin

<sup>c</sup> Haematocrit

<sup>d</sup> Gestational age

**Table 2.** Adherence to allocated intervention and other aspects of third stage management

	<b>Controlled Cord Traction</b>	<b>Standard Placenta Expulsion</b>
Prophylactic oxytocin administration at birth	1977/2029 (97.4)	1961/2022 (97.0)
Cord clamping and cutting within 2 minutes of birth	1933/2026 (95.4)	1944/2019 (96.3)
Cord management according to protocol	1943/2031 (95.7) <sup>a</sup>	1991/2024 (98.4) <sup>a</sup>
Blood collection bag	2016/2028 (99.4)	2015 (2020 (99.7)
Duration of blood collection (min) (mean (SD) (n))	27 (16) (1990)	29 (16) (1987)
Blood collection bag in place $\geq$ 15 minutes	1609/2002 (80.4)	1717/1992 (86.2)

Data are n/N (%) unless otherwise stated

<sup>a</sup> The reasons why 88 women in the CCT group and 33 women in the SPE group did not receive the allocated intervention are mentioned in Figure 1

**Table 3.** Trial outcomes

	Controlled Cord Traction	Standard Placenta Expulsion	Risk ratio (95% CI)	Mean difference (95% CI)
Blood loss $\geq$ 500mL	196/2005 (9.8)	206/2008 (10.3)	0.95 (0.79-1.15)	/
By hospital			0.31 <sup>a</sup>	
A	46/473 (9.7)	37/482 (7.7)	1.27 (0.84-1.92)	/
B	20/199 (10.1)	14/196 (7.1)	1.41 (0.73-2.71)	/
C	40/344 (11.6)	49/330 (14.9)	0.78 (0.53-1.16)	/
D	38/445 (8.5)	42/443 (9.5)	0.90 (0.59-1.37)	/
E	52/544 (9.6)	64/557 (11.5)	0.83 (0.59-1.18)	/
Blood loss $\geq$ 1000 mL	34/2005 (1.7)	37/2008 (1.8)	0.92 (0.58-1.46)	/
Blood loss at 15 minutes (mL) (mean (SD) (n))	163 (4) (2005)	161 (4) (2001)	/	1.7 (-8.8;12.2)
Total blood loss (mL) (mean (SD) (n))	207 (5) (2005)	217 (6) (2008)	/	-9.4 (-24.8;6.0)
Blood transfusion for PPH	12/2034 (0.6)	9/2024 (0.4)	1.33 (0.56-3.14)	/
Arterial embolization/surgery for PPH	3/2034 (0.1)	5/2024 (0.3)	0.60 (0.14-2.49)	/
Peripartum change in Hb <sup>b</sup> (g/dL) (mean (SD) (n))	0.9 (0.0) (1961)	0.9 (0.0) (1953)	/	-0.02 (-0.10;0.07)
Peripartum change in Ht <sup>c</sup> (%) (mean (SD) (n))	2.1 (0.1) (1904)	2.2 (0.1) (1890)	/	-0.05 (-0.29;0.19)
Duration of third stage (min) (mean (SD) (n))	5.5 (0.1) (2030)	8.7 (0.1) (2020)	/	-3.26 (-3.62; -2.90)
Third stage $\geq$ 15 min	91/2030 (4.5)	289/2020 (14.3)	0.31 (0.25-0.39)	/
Manual removal of placenta	85/2033 (4.2)	123/2024 (6.1)	0.69 (0.53-0.90)	/
Additional uterotonics after placenta delivery	727/2030 (35.8)	805/2024 (39.8)	0.92 (0.83-0.97)	/
Maternal pain during 3 <sup>rd</sup> stage	109/1892 (5.8)	138/1868 (7.4)	0.78 (0.61-0.99)	/
Cord rupture	89/2034 (4.4)	2/2024 (0.1)	44.3 (10.9-179.6)	/

Uterine inversion	0/2034 (0.0)	0/2024 (0.0)	/	/
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Data are n/N (%) unless otherwise stated

<sup>a</sup> p for Mantel-Haenszel test of homogeneity across centers

<sup>b</sup> Prepartum Hb measured within 8<sup>th</sup> month of gestation and arrival in labour ward in 1778 (90.7%) and 1760 (90.1%), at arrival in labour ward in 95 (4.8%) and 99 (5.1%) and between the 5<sup>th</sup>-7<sup>th</sup> months of gestation in 88 (4.5%) and 94 (4.8%), in the CCT and SPE groups, respectively ; postpartum Hb measured at Day 2 in 1793 (91.4%) and 1787 (91.5%), and on another day between 1 and 8 days in 168 (8.6%) and 166 (8.5%) , in the CCT and SPE groups, respectively.

<sup>c</sup> Prepartum Ht measured within 8<sup>th</sup> month of gestation and arrival in labour ward in 1724 (90.5%) and 1707 (90.3%), at arrival in labour ward in 95 (5.0%) and 99 (5.2%) and between the 5<sup>th</sup>-7<sup>th</sup> months of gestation in 85 (4.5%) and 84 (4.4%), in the CCT and SPE groups, respectively; postpartum Ht measured at Day 2 in 1737 (91.2%) and 1725 (91.3%), and on another day between 1 and 8 days in 167 (8.8%) and 165 (8.7%) , in the CCT and SPE groups, respectively.

**Table 4.** Women's experience of third stage

		Controlled Cord Traction	Standard Placenta Expulsion	P <sup>a</sup>
Completed forms		1838/2034 (90.4)	1844/2024 (91.2)	0.41
Felt tired	Not at all	466/1829 (25.5)	426/1838 (23.2)	
	A little	656/1829 (35.9)	621/1838 (33.8)	
	Moderately	378/1829 (20.6)	445/1838 (24.2)	0.017
	Very	252/1829 (13.8)	285/1838 (15.5)	
	Extremely	77/1829 (4.2)	61/1838 (3.3)	
Felt anxious	Not at all	1191/1821 (65.4)	1073/1821 (58.9)	
	A little	398/1821 (21.9)	475/1821 (26.1)	
	Moderately	154/1821 (8.5)	168/1821 (9.2)	<0.001
	Very	59/1821 (3.2)	94/1821 (5.2)	
	Extremely	19/1821 (1.0)	11/1821 (0.6)	
Felt 3 <sup>rd</sup> stage was long	Not at all	1590/1830 (86.9)	1451/1833 (79.2)	
	A little	137/1830 (7.5)	219/1833 (11.9)	
	Moderately	68/1830 (3.7)	110/1833 (6.0)	<0.001
	Very	23/1830 (1.2)	43/1833 (2.4)	
	Extremely	12/1830 (0.7)	10/1833 (0.5)	
Felt satisfied	Not at all	4/1832 (0.2)	3/1840 (0.2)	
	A little	6/1832 (0.3)	11/1840 (0.6)	
	Moderately	63/1832 (3.4)	81/1840 (4.4)	0.21
	Very	716/1832 (39.1)	751/1840 (40.8)	
	Extremely	1043/1832 (57.0)	994/1840 (54.0)	
Discomfort <sup>b</sup>	≤ 2	1408/1830 (76.9)	1285/1834 (70.1)	
	3-7	371/1830 (20.3)	475/1834 (25.9)	<0.001
	≥ 8	51/1830 (2.8)	74/1834 (4.0)	
Pain intensity <sup>c</sup>	≤ 2	1475/1828 (80.7)	1362/1837 (74.1)	
	3-7	309/1828 (16.9)	413/1837 (22.5)	<0.001
	≥ 8	44/1828 (2.4)	62/1837 (3.4)	

Data are n/N (%)

<sup>a</sup> Chi2 test<sup>b</sup> graded from 0 (no discomfort) to 10<sup>c</sup> graded from 0 (no pain) to 10