

Checking placenta after delivery



Why the placenta is examined

The placenta is a temporary organ that supports fetal oxygenation, nutrition, waste removal, and endocrine signaling during pregnancy. Its appearance can reflect aspects of placental function and the intrauterine environment. Examining it after birth therefore complements the clinical history, maternal assessment, and newborn examination.

A focused gross examination is recommended for placentas as part of routine obstetric and neonatal care. The purpose is not to assign a diagnosis from appearance alone. Rather, clinicians look for findings that confirm the placenta was delivered completely, explain an event such as bleeding or fetal compromise, or indicate that pathology review could provide useful information.

Examples of situations in which the placenta may receive closer attention include preterm birth, fetal growth restriction, hypertensive disorders of pregnancy, suspected infection, placental abruption, unexplained bleeding, abnormal fetal monitoring, stillbirth, neonatal complications, or a visibly unusual placenta. The exact policy varies among hospitals and regions.

The initial bedside inspection

The examination is generally performed soon after the placenta is delivered, once immediate maternal and newborn priorities are addressed. The clinician handles the placenta on a suitable surface and inspects it systematically. The placenta may be examined fresh or after it has been placed in an appropriate container, depending on local practice and whether pathology assessment is planned.

First, the clinician considers the overall shape, size, thickness, and condition of the placental disc. A typical placenta has a relatively smooth fetal surface and a lobulated maternal surface. Visible clots, areas of pallor, firm or calcified regions, tears, discoloration, or accessory tissue may be documented. A visual observation is interpreted alongside the circumstances of the birth; it is not, by itself, a definitive explanation for a clinical problem.

The placenta is then checked from both sides. Turning it over allows the examiner to assess the maternal surface and determine whether the lobules, also called cotyledons, appear intact. The clinician may gently bring the lobules together like pieces of a jigsaw puzzle to look for an area that is absent or disrupted.

Examining the fetal surface and membranes

The fetal surface is the shiny side of the placenta that faced the amniotic cavity. It is covered by the amnion, through which the chorionic vessels can often be seen radiating from the umbilical cord toward the edge of the disc. The examiner assesses the color, surface, vessel pattern, and any clots or lesions that are visible without magnification.

The membranes are inspected for their point of rupture, integrity, color, odor, and evidence of inflammation or abnormal insertion. The amnion and chorion should be followed around the circumference of the placenta to identify whether a piece appears to be missing. A torn membrane edge can be normal after delivery, but an irregular gap or a separate piece of tissue may prompt concern about retained membranes or an accessory placental lobe.

The membranes can also provide clues about the intrauterine environment. Green

or brown staining may be associated with meconium exposure, while opaque, foul-smelling, or thickened membranes may be relevant when infection is suspected. These findings need clinical correlation because color and odor can be influenced by labor events and handling.

Clinicians also note the insertion of the cord into the placental disc. A central or slightly off-center insertion is common, whereas marginal or membranous insertion may have implications in particular pregnancies. The cord should be examined along its length for knots, hematoma, abnormal twisting, or other visible changes.

Checking the maternal surface and completeness

The maternal surface is the dark red, lobulated side that was attached to the uterine wall. Its cotyledons should collectively account for the entire disc. The examiner looks for a smooth, complete surface and checks whether any deep defect, ragged area, or separate fragment suggests that tissue may have remained inside the uterus.

This is one reason postpartum placental completeness matters. Retained placental tissue can interfere with effective uterine contraction and may be associated with continued or delayed postpartum bleeding. It can also increase the risk of infection. The placenta may appear complete while a small fragment is difficult to recognize, so clinicians consider the amount of bleeding, uterine tone, the ease of placental delivery, and other examination findings as well.

A separate accessory lobe, sometimes called a succenturiate lobe, is important to identify because it may be connected by vessels or membranes and can be left behind after the main disc is delivered. If the clinician suspects incomplete delivery, they may perform additional maternal assessment and decide whether imaging, treatment, or a procedure is needed. These decisions are individualized and should be made by the maternity team.

Small areas of calcification, infarction, or clot may be seen in otherwise uncomplicated placentas. Their significance depends on their extent, location, the gestational age, and the clinical context. A single visible feature rarely provides a complete account of pregnancy or birth.

Assessing the umbilical cord

The cord is reviewed for its length, diameter, insertion site, color, coiling, knots, and the number of blood vessels. Most umbilical cords contain two arteries and one vein. A different vessel count may be associated with fetal or neonatal findings and is usually interpreted with the newborn examination and prenatal imaging.

Clinicians may document true knots, which form in the cord itself, and nuchal loops, in which the cord lies around the newborn's neck. These findings do not automatically indicate harm; they are assessed in relation to fetal monitoring, the mode of birth, and the condition of the newborn. A cord hematoma, marked edema, thrombosis, or unusual fragility may be a reason for more detailed review.

Cord blood may also be collected in some circumstances, such as when assessment of acid-base status is clinically indicated. This is separate from the visual inspection of the placenta. The cord and placenta findings may later help clinicians understand an unexpected neonatal condition, but they should not be interpreted without the broader medical record.

When pathology examination is considered

Gross inspection at the bedside and microscopic pathology examination are different processes. Gross examination involves looking at the intact placenta, membranes, and cord. Histopathology involves sampling tissue for laboratory processing and microscopic analysis. Not every placenta needs to be submitted to pathology, and hospital criteria differ.

Pathology may be considered when there is stillbirth or neonatal death, significant prematurity, suspected placental abruption, severe maternal disease, fetal growth restriction, suspected infection, unexplained maternal or neonatal deterioration, or an abnormal gross appearance. A placenta may also be submitted when the clinical team believes microscopic information could affect counseling, documentation, or care in a future pregnancy.

The report may describe placental weight, cord and membrane findings,

inflammation, vascular lesions, infarction, thrombi, or other patterns. Terms such as maternal vascular malperfusion and fetal vascular malperfusion refer to patterns of placental injury or altered blood flow; they are not diagnoses that should be inferred from a brief conversation or a single photograph. The report must be interpreted by a qualified clinician in light of the pregnancy and birth history.

Results may take time because tissue processing and microscopic review are required. Ask when results are expected, who will explain them, and whether the findings change any postpartum care or future pregnancy planning.

What the examination means for recovery

Checking the placenta is only one part of assessing the third stage of labor and the early postpartum period. The clinical team also monitors vaginal blood loss, pulse, blood pressure, temperature, uterine firmness, pain, and overall condition. If bleeding is heavier than expected or the uterus is not contracting appropriately, clinicians act based on the complete assessment rather than waiting for a placental report.

After discharge, seek urgent medical advice for sudden or heavy vaginal bleeding, large clots, faintness, marked weakness, shortness of breath, severe or worsening abdominal pain, fever, chills, or foul-smelling vaginal discharge. These symptoms can have several causes, including postpartum hemorrhage or infection, and require prompt professional assessment. Do not attempt to examine the uterus or remove tissue yourself.

If you were told that the placenta was incomplete, an accessory lobe was present, or pathology was requested, ask for a clear follow-up plan. You may wish to record the explanation in your postpartum notes and discuss whether the finding has implications for a future pregnancy. It is reasonable to ask questions even when the birth was uncomplicated and the examination was described as normal.

Questions to ask your maternity team

A brief conversation can make the examination more understandable and reduce uncertainty. Useful questions include:

Did the placenta, membranes, and cord appear complete?

Were all placental lobules present, and was an accessory lobe seen?

How many umbilical cord vessels were identified?

Was anything unusual observed on the fetal or maternal surface?

Was the placenta sent to pathology, and when should results be available?

Does the finding affect my recovery, newborn follow-up, or future pregnancies?

If the birth involved an emergency, stillbirth, neonatal illness, or substantial bleeding, you can request a dedicated debrief with an obstetric clinician or midwife. A debrief should explain what was observed, what was done, and what follow-up is available without implying certainty where the evidence is limited.