Is placenta delivery painful

What happens during placenta delivery

Placenta delivery is the third stage of labor: the period after the baby is born and before the placenta and membranes have been expelled or removed. After birth, the uterus continues contracting. These contractions help shear the placenta away from the uterine wall, compress the spiral arteries, and reduce bleeding. Clinicians watch for signs of placental separation, such as a small gush of blood, lengthening of the umbilical cord, and a firm, rising uterus.

In a vaginal birth, the placenta usually delivers through the vagina with one or a few pushes, or sometimes with gentle help from the care team. Many parents are holding their baby, beginning skin-to-skin contact, or recovering from the intensity of birth when this happens. Because the cervix and vagina have already stretched for the baby, the placenta, which is soft and compressible, usually passes with much less sensation than the baby did.

The placenta must then be examined to confirm that it appears complete. This matters because retained placental tissue can interfere with uterine contraction and increase bleeding or infection risk. Even when the delivery feels easy, the care team’s assessment is an important safety step.

Is it usually painful after a vaginal birth

For most people, the delivery of the placenta is not very painful. Research on women’s experiences of birthing the placenta found that many described it as easy, gentle, or painless. This fits with common clinical experience: the contractions of the third stage are typically milder than active labor contractions, and the placenta itself is soft rather than hard or bony.

That said, "not painful" does not always mean "nothing at all." Some people feel menstrual-like cramping, pelvic pressure, a slippery or warm sensation, or an urge to push. Others are too focused on their baby, their perineum, or the relief of birth being over to notice the placenta delivery after birth as a distinct event.

Sensation also depends on context. If someone had an epidural, they may feel little more than pressure. Without regional anesthesia, they may feel more uterine cramping. If there is perineal trauma, an episiotomy, swelling, or significant pelvic floor tenderness, even the passage of the placenta can feel uncomfortable because tissues are already sore. Emotional state matters too: exhaustion, fear, or feeling rushed can amplify pain perception, while clear communication and supportive care can make the third stage feel calmer.

Active management, physiological management, and afterpains

There are two broad approaches to the third stage: physiological management and active management. In physiological management, the care team waits for the placenta to separate and deliver with maternal effort and natural uterine contractions, provided bleeding remains safe and there are no clinical concerns. In active management, a uterotonic medication, commonly oxytocin, is given to stimulate uterine contraction and reduce the risk of excessive bleeding.

Active management can be protective, especially for people at higher risk of postpartum hemorrhage risk. However, stronger uterine activity may be felt as cramps or afterpains. A Cochrane review reported that active management reduces bleeding but may increase afterpains and the need for analgesia from birth until discharge. In practical terms, the placenta delivery itself may still be brief and not sharply painful, while the uterine cramping around it may be more

noticeable.

Afterpains are contractions of the uterus as it returns toward its pre-pregnancy size and clamps down on blood vessels. They can be more intense after subsequent births, during breastfeeding or chestfeeding because of endogenous oxytocin release, and when uterotonic medications are used. These pains are usually intermittent and cramp-like, but they should be discussed with the care team if they are severe, one-sided, worsening, or associated with heavy bleeding, fever, or feeling faint.

When placenta delivery can hurt more

Placenta delivery can become painful or distressing when the third stage is not straightforward. One example is controlled cord traction, in which a clinician applies gentle traction to the umbilical cord while supporting the uterus. When done appropriately, it can help deliver a separated placenta. Some people barely notice it; others describe discomfort, tugging, or pain, particularly if traction occurs before complete separation or if they are already tender.

More significant pain can occur with a retained placenta, meaning the placenta does not deliver within the expected time frame or remains partially attached. Management depends on bleeding, the time elapsed, local protocols, and the person’s clinical stability. Sometimes medication, bladder emptying, breastfeeding stimulation, position changes, or additional time may help. In other cases, manual removal of the placenta is needed.

Manual removal means a clinician places a hand into the uterus to separate and remove the placenta. This is usually performed with appropriate analgesia or anesthesia because it can be painful. It may be urgent if there is heavy bleeding or concern that the uterus cannot contract effectively. The experience can feel especially upsetting because it happens after the baby is already born, when many people expected the most intense procedures to be finished. If this intervention is needed, it is reasonable to ask what pain relief is available, what is happening step by step, and whether antibiotics, monitoring, or follow-up are recommended.

Pain may also be influenced by uterine atony after birth, laceration repair, perineal trauma, bladder distension, or emotional distress after a difficult

labor. In other words, pain during the third stage is not always caused by the placenta passing through the vagina; it may come from the uterus, genital tract tissues, procedures, or the broader birth experience.

Placenta removal during cesarean birth

During a cesarean birth, the placenta is removed through the uterine incision by the obstetric clinician rather than delivered vaginally. Because cesarean birth is performed under regional anesthesia, such as spinal or epidural anesthesia, or occasionally general anesthesia, the parent should not feel sharp pain from placental removal itself. They may feel pressure, pulling, movement, or nausea depending on anesthesia, uterine manipulation, medications, and individual sensitivity.

After the placenta is removed, the uterus is checked for tone and bleeding, and the surgical team closes the uterus and abdominal layers. Oxytocin or other uterotonic medications may be used to encourage uterine contraction and reduce bleeding. As with vaginal birth, these contractions can contribute to cramping afterward. Postoperative cesarean pain control focuses not only on the incision but also on uterine afterpains, gas pain, mobility, and breastfeeding-related cramping.

If pain becomes sharp, escalating, localized, or associated with heavy bleeding, dizziness, fever, wound concerns, or shortness of breath, it should not be dismissed as ordinary cesarean recovery. Prompt clinical assessment is important because postpartum pain can have several causes, and some require urgent treatment.

What you can ask for during the third stage

Feeling informed can make placenta delivery less frightening. Before birth, you can ask your clinician or midwife how they usually manage the third stage, when they recommend oxytocin, how they handle delayed cord clamping, and what circumstances would change the plan. If you have a history of postpartum hemorrhage, retained placenta, uterine surgery, placenta accreta spectrum risk factors, severe anemia, or bleeding disorders, individualized planning is especially important.

During the third stage, it is appropriate to ask for clear explanations. Helpful phrases include: "Has the placenta separated yet?", "Are you applying traction?", "Is my bleeding normal?", "What pain relief is available if you need to examine me?", and "Do you think this is becoming a retained placenta?" These questions are not confrontational; they help you understand your care in real time.

Comfort measures may include slow breathing, warm blankets, position adjustments, reassurance, skin-to-skin contact if safe, and adequate analgesia for laceration repair or uterine exploration. If you have an epidural in place, the anesthesia team may be able to adjust it if additional procedures are needed. If you do not have regional anesthesia and manual removal becomes necessary, the team should discuss urgent pain-control options as the clinical situation allows.

After the placenta is delivered: normal soreness versus warning signs

Some cramping after the placenta is delivered is normal. The uterus needs to remain firm to limit bleeding, and this firmness is often checked by abdominal palpation. Fundal massage can be uncomfortable, sometimes more so than the placenta delivery itself, but it may be used when the uterus is soft or bleeding is heavier than expected. Tell your care team if the pain feels severe or if you need a pause or analgesia.

Normal postpartum bleeding, called lochia, is usually heaviest at first and then gradually decreases, though it can temporarily increase with standing, breastfeeding, or activity. What is not normal is soaking pads rapidly, passing very large clots, feeling faint, or having severe pelvic pain. These can be signs of postpartum hemorrhage, retained tissue, infection, or another complication that needs assessment.

Emotional recovery also matters. If the third stage felt invasive, frightening, or painful, even if it was medically necessary, it can help to request a debrief with your midwife, obstetrician, or postpartum team. Understanding why decisions were made may reduce anxiety and support future birth planning. Your pain and your interpretation of the experience are valid, even when the clinical outcome was safe.