Placenta delivery and what happens after birth

The third stage of labor

The third stage of labor begins after the baby is born and ends when the placenta and membranes have been delivered. Although it may feel less dramatic than the pushing stage and delivery, it is clinically important because the placental site is a large vascular area. Once the placenta separates, the uterus must contract firmly to compress the maternal blood vessels that supplied it.

Placental separation usually happens because the uterus continues to contract after birth. As the uterine muscle shortens, the placental attachment area becomes smaller, and the placenta shears away from the uterine wall. Clinicians may observe signs such as a sudden small gush of blood, lengthening of the umbilical cord, and a change in the shape or height of the uterus. These signs suggest separation, but the care team also assesses the person’s bleeding, uterine tone, and overall condition.

The placenta is often delivered within a short time after birth. In many settings, especially with active management, this may occur within several minutes. With physiological management, it may take longer if bleeding is normal and the birthing person remains stable. Local protocols vary, but a

retained placenta is commonly considered when the placenta has not delivered within a defined time after birth or sooner if there is significant bleeding or instability.

Active management and physiological management

There are two broad approaches to placental separation and delivery: active management and physiological, or expectant, management. The safest option depends on medical history, bleeding risk, birth setting, preferences, and what is happening in the moment.

Active management typically includes giving a uterotonic medication, most often oxytocin, soon after the baby is born. Oxytocin stimulates uterine contractions and helps reduce the risk of postpartum hemorrhage. The clinician may use controlled cord traction, meaning gentle traction on the umbilical cord while supporting the uterus, once there are signs that the placenta has separated. This should be performed by trained staff because improper traction can cause complications.

Physiological management avoids routine uterotonic medication unless it becomes clinically necessary. The placenta is allowed to separate and deliver with the body's own contractions, and the birthing person may push when they feel pressure or contractions. This approach may be appropriate for some low-risk births when bleeding is minimal and monitoring is available.

Plans can change quickly. If bleeding becomes heavier, the uterus feels soft or boggy, or the placenta is delayed, clinicians may recommend oxytocin, uterine massage, bladder emptying, controlled cord traction, or further assessment. Needing a change in management is not a failure; it is a response to physiology and safety.

What happens immediately after the baby is born

The minutes after birth often involve several overlapping priorities: supporting the baby's transition, encouraging bonding when possible, monitoring maternal bleeding, and helping the uterus contract. If both parent and baby are stable, immediate skin-to-skin contact is often encouraged. This can support warmth, early feeding cues, and oxytocin release, which may also help uterine

contraction.

The umbilical cord may be clamped and cut after a short delay if the baby is well and there is no urgent reason to intervene sooner. Delayed cord clamping practices vary by setting and clinical situation. While this is happening, the care team continues to watch for placental separation and estimates blood loss.

Clinicians often palpate the uterus through the abdomen to assess tone. A firm, central uterus is reassuring because it suggests the muscle is contracting effectively. A soft uterus may be massaged to encourage contraction. The bladder may also matter: a full bladder can interfere with uterine contraction and descent of the placenta, so urination or catheterization may be recommended in some situations.

Vital signs, symptoms, and the appearance of bleeding are monitored closely. Some bleeding is expected, but continuous heavy bleeding, large clots, dizziness, pallor, rapid pulse, or low blood pressure can indicate postpartum hemorrhage and require urgent treatment.

Delivering and examining the placenta

Once the placenta has separated, it usually descends into the lower uterus or vagina and is delivered with a contraction, maternal effort, or assisted traction depending on the management approach. The sensation can range from mild pressure to cramping, but for many people it feels easier than delivering the baby because the placenta is soft and compressible.

After delivery, the placenta and membranes are examined. This inspection checks whether the maternal surface appears complete, whether the membranes are intact, and whether the umbilical cord insertion or placental appearance raises concerns. The goal is not simply curiosity; retained fragments can keep the uterus from contracting well and may increase bleeding or infection risk.

The care team may also assess the genital tract for tears, bleeding points, or hematoma formation. Perineal, vaginal, cervical, or labial tears may be repaired with sutures if needed. Local anesthetic, regional anesthesia, or existing epidural analgesia may be used depending on the situation. At the same time, clinicians continue to monitor uterine tone and blood loss because

bleeding can come from both uterine atony and trauma.

Parents who want to see the placenta can usually ask, if circumstances allow. Some find it meaningful to understand the organ that supported pregnancy. If there are medical concerns, the placenta may be sent for pathology, especially when there has been infection, fetal growth restriction, preterm birth, abnormal bleeding, or other complications.

Retained placenta and retained tissue

A retained placenta means the placenta has not delivered within the expected time after birth, or it cannot be delivered safely without intervention. Definitions vary across protocols and may differ for active versus physiological management, but retained placenta is taken seriously because it can cause significant hemorrhage. Retained placental tissue can also remain after the main placenta has delivered, especially if a lobe or membrane fragment is left behind.

Risk factors discussed in medical literature include previous retained placenta, preterm birth, uterine surgery, placenta accreta spectrum, induced labor, prolonged labor, stillbirth, and other factors that affect uterine contraction or placental adherence. However, retained placenta can also occur without an obvious risk factor.

Management depends on bleeding, stability, pain control, and local practice. Initial steps may include uterotonics, bladder emptying, uterine massage, and controlled cord traction by trained clinicians. If the placenta remains undelivered or bleeding is concerning, manual removal may be recommended. This involves a clinician inserting a hand into the uterus to detach and remove the placenta, usually with adequate analgesia or anesthesia and sterile technique.

After manual removal or suspected retained tissue, clinicians monitor closely for hemorrhage, infection, uterine atony, and ongoing bleeding. Antibiotics may be considered according to local protocols, but decisions should be made by the treating healthcare team. Follow-up is important if postpartum bleeding becomes heavy again, has a foul odor, is accompanied by fever, or persists in an unusual pattern.

The fourth stage of labor and early recovery

The first one to two hours after placental delivery are sometimes called the fourth stage of labor. This is a period of active observation, not simply rest. The uterus should remain firm and gradually sit lower in the abdomen. Nurses, midwives, or physicians may check the fundus, bleeding, blood pressure, pulse, temperature, pain level, bladder status, and level of alertness.

Cramping after birth, sometimes called afterpains, is common as the uterus contracts. These contractions can feel stronger during breastfeeding or chestfeeding because nipple stimulation increases endogenous oxytocin. People who have given birth before may notice more intense afterpains. Pain relief options should be discussed with the healthcare team, especially if there are medical conditions, allergies, or concerns about medications while feeding.

Lochia, the normal postpartum vaginal discharge of blood, mucus, and uterine tissue, starts soon after birth. It is usually heaviest at first and gradually lightens over days to weeks. Passing a few small clots can be normal early on, but soaking pads rapidly, passing large clots, feeling faint, or bleeding that suddenly increases should be assessed promptly.

Emotional responses also vary. Some people feel relief, joy, shakiness, tearfulness, or exhaustion all at once. Birth hormones, blood loss, sleep deprivation, pain, and the intensity of the experience can all contribute. Supportive, nonjudgmental care in this window matters, especially for people who had an emergency intervention, severe pain, hemorrhage, or separation from the baby.

Questions to ask your care team

It is reasonable to ask clear questions during and after placental delivery, even if events are moving quickly. Understanding what is happening can reduce fear and help you participate in decisions when time allows.

Has the placenta separated, and is my bleeding within the expected range?
Are you recommending active management, physiological management, or a change in approach?
Was the placenta complete when examined?

Do I have any tears or bleeding sites that need repair?
What symptoms should prompt urgent help after I go home?

If you have a history of retained placenta, postpartum hemorrhage, placenta accreta spectrum, uterine surgery, or bleeding disorders, discuss this before birth when possible. A birth plan can include preferences for immediate skin-to-skin contact, cord clamping, and placenta management, but it should also leave room for rapid medical decisions if bleeding or instability occurs.