RCPath Indications for referral of placentas for pathological examination

Referral of placenta for examination is **essential** for singletons or multiples as indicated below:

- stillbirth (antepartum or intrapartum)
- miscarriage (14+0–23+6 completed weeks' gestation)
- severe fetal distress defined as: pH <7.05 or Base Excess ≥–12 or scalp lactate >4.8mmol/l
- preterm birth (less than 32+0 weeks' gestation)
- fetal growth restriction defined as: birthweight below 3rd centile or drop in fetal growth velocity of >2 quartiles or >50 percentiles
- abnormal umbilical artery Dopplers (absent or reversed end diastolic flow)
- fetal hydrops
- early-onset (<32 weeks) severe pre-eclampsia requiring iatrogenic delivery
- caesarean peripartum hysterectomy for morbidly adherent placenta
- severe maternal sepsis requiring adult intensive care admission and/or fetal sepsis requiring ventilation or level 3 NICU admission (following swab taken from the placenta for microbiology at delivery)
- massive placental abruption with retroplacental clot
- monochorionic twins with TTTS.

Referral is **not** indicated in the following conditions as histopathological examination is unlikely to provide useful information:

- cholestasis of pregnancy
- 'gritty' placenta
- pruritis of pregnancy
- maternal diabetes with normal pregnancy outcome
- hepatitis B, HIV, etc
- other maternal disease with normal pregnancy outcome
- placenta praevia
- post-partum haemorrhage
- polyhydramnios
- rhesus negative mother with no fetal hydrops
- history of maternal Group B streptococcus
- maternal coagulopathy
- maternal substance abuse
- uncomplicated twin pregnancy
- congenital anomaly
- common aneuploidies
- low grade pyrexia in labour
- history of previous molar pregnancy
- normal pregnancy
- accessory lobe
- lobe uncomplicated velamentous cord

Consultant request: If there are queries, examination may be possible following discussion with your receiving consultant pathologist.