[Color index: Important | Notes | Extra | video case]
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Postpartum Care

Objectives:

- Discuss the normal physiologic changes of the postpartum period
- Discuss the normal physiologic changes of the postpartum period
- Outline topics to cover in postpartum patient counseling
- Describe appropriate postpartum contraception

I recommend reviewing physiological changes in pregnancy lecture before starting because postpartum changes are the reverse.

References : 433 team, Hacker and Moore's, Kaplan
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Postpartum Changes

System	Change
Reproductive tract changes	1.**Uterus :** return to non- pregnancy place in pelvis by 2 week PP, and back to normal size by 6 week PP 2.**Lochia :** These are superficial layers of the endometrial decidua that are shed through the vagina during the first 3 postpartum weeks. A. Lochia rubra (red): first few days PP B. Lochia serosa (pinkish, watery) : few week PP C. Lochia alba (yellowish): 6-8 week PP **3. Vagina and vulva :** change in vaginal tone /pelvic floor muscles may cause urinary incontinence , **Kegel's exercise** help to recovery phase **4. Cramping :** myometrial contractions after delivery constrict the uterine venous sinuses, thus preventing hemorrhage may be painful , **managed** by analgesics **5. Perineal pain :** Discomfort from an episiotomy or perineal lacerations can be minimized in the first 24 hours with ice packs to decrease the inflammatory response edema. A heat lamp or sitz bath is more helpful after the first day to help mobilize tissue fluids.
Urinary tract changes	1.**Hypotonic bladder :** Intrapartum bladder trauma can result in increased postvoid residual volumes. If the residuals exceed 250 mL,the detrusor muscle can be stimulated to contract with bethanechol (Urecholine). Occasionally an indwelling Foley catheter may need to be placed for a few days. 2.**Stress urinary incontinence** 3.**Dysuria :** Pain with urination may be seen from urethral irritation from frequent intrapartum catheterizations. Conservative management may be all that is necessary. A urinary analgesic may be required occasionally. 4.**Kidney function :** GFR stile increase to 2-3 week PP, the GFR ↑ leads to a creatinine ↓ so even if there is a slight increase it is sensitive to renal problems
GIT changes	**1. Constipations :**Decreased GI tract motility, because of perineal pain and fluid mobilization, can lead to constipation. Management is oral hydration and stool softeners. **2. Hemorrhoids:** Prolonged second-stage pushing efforts can exaggerate pre existing hemorrhoids. **Management** : oral hydration + stool softeners.
CVS changes	Normal CVS functions retune by 2-3 week PP
coagulation	Pregnancy is a hypercoagulation state to prevent bleeding during delivery⟶ increase VTE in pregnancy especially PP. System back to normal balance state by 6-8 week PP. advise them to walk regularly after delivery to prevent DVT

Psychosocial changes	**1. Bonding** : Impaired maternal–infant bonding is seen in the first few days post delivery. Lack of interest or emotions for the newborn is noted(Mom shows no interest in baby). Risk is increased if contact with the baby is limited because of neonatal intensive care, as well as poor social support. **Management** is Psychosocial evaluation and support (outpatients) **2. Blues**: Postpartum blues are very common within the first few weeks of delivery. Mood swings and tearfulness occur. Normal physical activity continues and care of self and baby is seen(Mom cares for baby). **Management** is conservative with support (outpatients) **3. Depression**: Postpartum depression is common but is frequently delayed up to a month after delivery. Feelings of despair and hopelessness occur. The patient often does not get out of bed with care of self and baby neglected. **Management** is psychotherapy and antidepressants. (outpatients) **4. Psychosis**:Postpartum psychosis is rare, developing within the first few weeks after delivery. Loss of reality and hallucinations occur. Behavior may be bizarre. **Management** is hospitalization, antipsychotic medication and psychotherapy

The 7b aspect for PP care

1.**Breast vs. bottle:** recommended breastfeeding at least 6 months

From hacker: advantages to breastfeeding. **First**,breast milk is the ideal food for the newborn, is inexpensive, and is usually in good supply. **Second**, nursing accelerates the involution of the uterus. **Third**, and probably most important, there are immunologic advantages for the baby from breastfeeding.Breastfeeding thereby provides the newborn with passive immunity.**Fourth**, it is a way of transferring appropriate maternal bacteria to the infant's gut.

2.**Bladder:** urinary incontinence vs. urinary retention (by nerve compression during delivery or Anesthesia)

3.**Bowel movement**

4.**Bleeding**

5.**Bottom (perineum)**

6.**Blues :** risk factors: history of depression , poor social support

7.**Birth control:**

•**Breast feeding:** Lactation is associated with temporary anovulation, so contraceptive use may be deferred for **3 months**. A definitive method should be used after that time.

•**Diaphragm:** Fitting for a vaginal diaphragm should be performed after involution of pregnancy changes, usually at the **6-week** postpartum visit.

•**Intrauterine Device (IUD):** Higher IUD retention rates, and decreased expulsions, are seen if IUD placement takes place at **6 weeks** postpartum.

•**Combination Modalities:** Combined estrogen-progestin formulations (e.g., pills, patch, vaginal ring) **should not be used** in breastfeeding women because of the estrogen effect of diminishing milk production. In nonlactating women, they should be started after **3 weeks** postpartum to allow reversal of the hypercoagulable state of pregnancy and thus decrease the risk of deep venous thrombosis.

•**Progestin-only Contraception:** Progestin steroids (e.g., mini-pill, Depo-Provera, Nexplanon) do not diminish milk production so can safely be used during lactation. They can be begun **immediately** after delivery.

Postpartum Immunizations

RhoGAM: If the mother is Rh(D) negative, and her baby is Rh(D) positive, she should be administered 300 µg of RhoGAM IM within 72 hours of delivery.
Rubella: If the mother is rubella IgG antibody negative, she should be administered active immunization with the live-attenuated rubella virus. She should avoid pregnancy for 1 month to avoid potential fetal infection.

Case

A 22 year-old multigravida delivered her third healthy child vaginally without complication. During sign-out and hand-off, the patient is described as ready for discharge from the hospital. She is breastfeeding, as she has with all of her children, but reports difficulty latching on. Although she is not married, she is in a stable relationship. She is considering permanent sterilization (Permanent procedures to prevent pregnancy like tubal ligation and Hysteroscopy tube occlusion) and wants to discuss it at her postpartum check-up. She states that she does not want any contraception at discharge, since she is breastfeeding and thinks she does not need any. On further questioning, she alludes to a vague history of a possible deep venous thrombosis (DVT) and history suggestive of postpartum depression after a prior pregnancy. Even though she is not a new mother, she asks about when she should expect her period.

1. What are you going to tell the patient about her difficulty with latching on?

- Discuss the indications for referral to and role of a lactation consultant prior to discharge.

that wouldn't be the first thing to do "you should first teach her or even let her show a video that visualize the technique for her"

2. How are you going to answer the patient's question about resumption of menses?

- The average time to ovulation is 45 days in non-lactating women and 189 days in lactating women.
- The likelihood of ovulation increases as the frequency and duration of breastfeeding decreases.
- Review the physiological basis [reactivation of the HPOA axis] for clinically relevant postpartum changes such as resumption of ovulation and menstruation.

3. What type of contraceptive counseling are you going to provide?

- Provide contraceptive counseling while the patient is still in the hospital. Include the CDC recommendations for timing of initiation of postpartum contraception to minimize the risk of DVT and methods appropriate for a history of DVT according to the CDC US Medical Eligibility Criteria for Contraceptive Use. Emphasize that unless women are breastfeeding every 3-4 hours around the clock, they may be fertile before the 6 week postpartum checkup.
- Combined estrogen-progestin oral contraceptives should not be used during the first 21 days after delivery as there is an increased risk of VTE (venous thromboembolism during this period. The current CDC guidelines further state that during days 21-42 postpartum, women who don't have risk factors (age> 35 years, recent cesarean section, or smoking) for VTE generally can initiate combined hormonal contraception. After 42 days postpartum, in the absence of medical conditions that may increase the risk for VTE, no restrictions on the use of combined hormonal contraceptives based on postpartum status apply (refer to updated CDC guidelines in our reference below)
- Progestin-only oral contraceptives, depot medroxyprogesterone acetate injections and implants may be initiated immediately postpartum whether exclusively breastfeeding or not. They are not associated with an increase in complications. Although IUD expulsion rates are higher during the first 6 weeks postpartum, IUDs can be inserted immediately postpartum. Once lactation is established, neither the volume nor the composition of breast milk is adversely affected by progestin contraceptives

4. How would your contraceptive counseling change if the patient had persistently elevated blood pressure? Doctor said these questions are not for our level, a simpler more direct in the exam

- Presume the patient is hypertensive and counsel according to the CDC US Medical Eligibility Criteria for Contraceptive Use. (See CDC US Medical Eligibility Criteria Chart -updated in June 2012)

5. How would contraception counseling change if the patient had gestational diabetes? Doctor said these questions are not for our level, a simpler more direct in the exam

- Counsel according to the CDC US Medical Eligibility Criteria for Contraceptive Use.

6. How are you going to include the history of potential postpartum depression in your management plan? Doctor said these questions are not for our level, a simpler more direct in the exam

- Review the risk factors for postpartum depression, screening methods (e.g., Edinburgh Postnatal Depression Scale), and indications for immediate intervention. See APGO Educational Topic 29, Anxiety and Depression.

7. What discharge instructions are you going to give this patient?

- Discuss the content of discharge instructions, including warning signs and symptoms and what the patient should do if she experiences them.
- Inform the patient that 70% to 80% of women report feeling sad, anxious or angry beginning 2 – 4 days after birth. These postpartum blues may come and go throughout the day, are usually mild, and abate within 1 – 2 weeks. Approximately 10% to 15% of new mothers experience postpartum depression (PPD), which is a more serious disorder and usually requires medication and counseling. PPD differs from postpartum blues in the severity and duration of symptoms.
- PPD features pronounced feelings of sadness, anxiety, and despair that interfere with activities of daily living. These symptoms do not abate but worsen over several weeks.
- Postpartum psychosis is the most severe form of mental derangement and is most common in women with pre existing disorders, such as bipolar disorder and schizophrenia. This condition should be considered a medical emergency and the patient should be referred for immediate, often inpatient treatment.