The postpartum visit

Why wait 6 weeks?

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BACKGROUND
In many western countries, the traditional '6 week check' is a routine medical review of a mother and her baby 6 weeks after the birth. In Australia, general practitioners perform the majority of postpartum assessments.

OBJECTIVE
This article discusses some of the common issues that concern women following the birth of a baby, and the medical conditions GPs need to address in the postpartum period.

DISCUSSION
The research literature does not support any benefit of a 6 week check. However, clinical evidence, our expertise as GPs, and our personal experiences, clearly indicate that the postpartum period is a time of tremendous change, increased health problems, and emotional upheaval for new parents. General practitioners are in an ideal position to assist families during this period and may consider a sooner rather than later, proactive rather than reactive, approach to postpartum care.

The postpartum period is broadly defined as beginning 1 hour after delivery of the placenta and lasting 6 weeks.[1] The World Health Organisation recognises that this is in keeping with traditional practices of many cultures where a 40 day period of extra support is provided for the new mother and her baby.[2] Although there is little evidence to support the timing and content of the postpartum visit,[3] there is evidence that this is a time of increased health needs for both mother and baby.

Current guidelines for shared maternity care affiliates recommend that the timing of the postpartum visit be individualised to reflect the woman's needs.[4] The postpartum visit should include the physical, emotional and social assessment of both the mother and baby. This article intends to look only at issues pertaining to the mother.

Australian evidence shows that 90% of general practitioners are caring for women in the early weeks following childbirth,[5] most commonly for their '6 week visit'. It also indicates that 96% of women will attend a medical practitioner for a postpartum check,[6] most often their GP. Analysis of Medicare data revealed that in the first 6 months, the mean number of visits by a mother and her baby to a GP is 7.7, with 57% of these visits for the baby and 43% for the mother.[7] A study of self reported maternal health problems during the first 6 month period identified that 94% of mothers have more than one health problem and approximately half would like more help.[8]

Preparing for the postpartum visit

It is a common scenario that a woman presents for her 6 week check – having booked a standard consultation – with (or sometimes without) her baby, all in a fluster, 100 questions in hand, and due for a Pap test. The baby, if in attendance, is unsettled and due for a sleep! A disaster and a lost opportunity to provide good health care.

It is helpful to discuss the postpartum visit during antenatal consultations. Patients receiving antenatal care from an obstetrician or outpatient clinic may also welcome the opportunity to interact with their GP following the baby's birth. Where possible, I encourage all new mothers to return for a postpartum visit 2–4 weeks after delivery, or earlier if needed,

and to include the father. There needs to be one appointment for the mother and one for the baby. It is best to notify Medicare of the baby's birth before the appointment.

The mother should bring the baby health record, any relevant documentation such as a discharge summary, and a list of questions she wants to discuss during the consultation. Raising some of the common issues including breastfeeding, support networks, contraception, and pain management may also assist a smooth transition in the postpartum period.

Maternal assessment

Common problems

A summary of the most common self reported maternal health problems during the first 6–7 months postpartum is provided in *Table 1*. In an Australian survey, both primparous and multiparous women reported these problems at a similar rate (except for perineal pain which was significantly less in multiparous women, 15 vs. 31%); mastitis was only noted in women who had established breastfeeding; and only 5% of mothers stated that they had no health problems.[8] *Table 2* provides a summary of significant postpartum medical conditions.

History and examination

Asking about the labour and birth allows the mother to debrief and address any issues she has, and helps your assessment of possible complications. History and examination should be directed to addressing maternal concerns and identifying common conditions listed in *Table 1* and *2*. Specifically enquire about vaginal blood loss, perineal or caesarean section wound pain, tiredness, backache, urinary symptoms, bowel movements, rectal bleeding, breast and nipple tenderness, sleep patterns and mood. Ask the mother how she feels about the baby, and how the baby is feeding, settling and responding. A summary of suggested physical examination activities is listed in *Table 3*.

The practice of a bimanual vaginal examination to assess uterine involution is not supported by evidence.[1] Therefore it is not recommended as routine practice. If hypertension has not resolved at 3 months postpartum, further investigation is warranted.[9]

Investigations

There is limited evidence and guidelines recommending routine investigations postpartum for all mothers. *Table 4* lists investigations to consider based on individual presentations.

Table 1. Common health conditions reported in first 6–7 months postpartum[8]

Tiredness/exhaustion
Backache
Pain – perineum/lower uterine caesarean section (LUCS) wound
Sexual problems
Haemorrhoids
Relationship with partner
Bowel problems
Urinary incontinence
Contraception
More upper respiratory tract infections (URTI) than usual
Mastitis

Table 2. Common postpartum medical conditions[1,11]

Pain management
Anaemia
Endometritis
Wound infection
Urinary incontinence
Thyroid disorders
Mastitis/breast engorgement
Postpartum depression
Return of fertility
Complications of pregnancy related conditions

Management of common conditions

Blood loss

There is a wide variation in the normal duration and characteristics of postpartum vaginal blood loss.[10] Generally, postpartum lochia loss persists for 4–8 weeks, with red blood loss for the first 2–12 days.[11] Differential diagnosis for secondary postpartum haemorrhage include retained products, endometritis, uterine atony, haematoma or a coagulation disorder. Investigations may include a full blood count and iron studies to assess for anaemia, coagulation profile if the mother has predisposing risk for a bleeding disorder such as a family history or pre-eclampsia, and an ultrasound to asses the uterus. If bleeding is mild and the mother is not unwell, evidence supports a conservative approach treating with empirical antibiotics such as amoxycillin/potassium clavulanate plus metronidazole.[11,12] If the mother is bleeding heavily, has pyrexia and is unwell, she may require intravenous antibiotics and a curettage if she has retained products.

Pain relief

Women often experience 'after pains' – uterine contractions due to the release of oxytocin – which most often occur when the baby breastfeeds. These are more intense in multiparas.[13] Pain can be managed with reassurance and regular paracetamol.[11]

The pain relief needs of women who have a vaginal delivery are often overlooked on discharge from hospital. Local pain relief for perineal pain includes local application of ice packs in the first few days and regular bathing. There is evidence to support bathing in providing relief for perineal discomfort; the addition of salt does not add benefit.[10] Perineal haematoma should be drained. Oral analgesia includes paracetamol 1 g every 6 hours (maximum 4 g every 24 hours) and diclofenac 50 mg every 8 hours.[14] Codeine can be added for stronger pain, but patients should be advised that it may cause constipation and they need to increase their fibre intake.

Women who have undergone a caesarean section have their pain management attended to in hospital but may not be given any analgesia to continue at home, and will require adequate and regular analgesia: paracetamol and diclofenac with the addition of codeine 30–60 mg every 4 hours or tramadol 50 mg twice per day as needed for up to 2 weeks postoperatively. Once again advise about avoiding constipation. Identify any surgical wound infection if present and treat with oral cephalexin 500 mg four times per day.

Table 3. Examinations at postpartum visit[1,2,10–12]

Signs of anaemia
Blood pressure
Breasts and nipples
Breastfeeding position
Perineum – check wounds
LUCS wound
Thyroid
Uterine fundus
Urine – exclude UTI, protein, glucose

Table 4. Investigations to consider at the postpartum visit[1,10–12]

Investigation	Comments
Full blood examination	Asymptomatic women with anaemia should be treated with oral iron therapy. Symptomatic women with a Hb <9.0 g/L may be considered for blood transfusion
Iron studies	If microcytic anaemia – see above
Coagulation studies	If coagulopathy suspected as the cause of secondary postpartum haemorrhage (PPH)
Thyroid stimulating hormone/ antithyroid antibodies	Hypo- or hyper-thyroidism
Midstream urine (MSU)	Exclude or treat UTI, may exacerbate incontinence
Glucose tolerance test	Recommended in women with gestational diabetes or consider if baby birth weight >4000 g, performed at 6 weeks (if normal, repeat every 2 years)[16]
Pap test	If due, do 6–8 weeks postpartum to allow cervical inflammatory processes to return to normal
Rubella antibodies	Give MMR if rubella antibodies are low
Rhesus antibodies	If Rh negative and there is concern about isoimmunisation
Vitamin D levels	Women who have low levels during pregnancy should continue supplementation during breastfeeding. Babies should be offered 0.45 mL Pentavite daily; seek paediatric advice when baby is weaned[17]
Vaginal/wound swabs	May not be of benefit in perineal infection or endometritis as causative organisms are usually commensal

Tiredness and fatigue

Tiredness and fatigue are the most common problems identified by new mothers.[8] Conditions to exclude are anaemia, postpartum depression and thyroid disease. Thyroid disorders, both hypo- and hyper-thyroid, occur in 4–7% of women in the first 12 months postpartum.[1] There is a 10% incidence of antithyroid antibodies at 16 weeks gestation, and half of these women will develop postpartum thyroid dysfunction.[11] General advice to assist mothers with fatigue include:

- ensure adequate dietary and fluid intake
- encourage regular rest periods during the day
- explore social support options, and
- enquire about issues that may be causing anxiety or stress.

Suitable options will depend on each family and their circumstances. Examples of strategies that have worked for patients and friends include hiring a nanny or other additional adult help from 4–7 pm to help out with the evening 'witching hour', the partner working 2–3 days a week for a month rather than taking a block of 2 weeks off, and accepting help from family and friends by asking them to prepare meals or assist with older children, especially with getting them

Table 5. Options for contraception[1,12,18]

Method	Use in breastfeeding	Comments
Lactational amenorrhoea	Yes	97% effective in the first 6 months if woman is fully demand breastfeeding and amenorrhoeic;[12] ovulation may occur before menstruation recommences
Condoms	Yes	Can be used at any time
Diaphragm	Yes	Needs to be refitted after 6 weeks postpartum
Progestogen only pill (POP) – norethisterone – levongesterol	Yes	There is no evidence that progestogen only contraceptives have an effect on breastfed infants. However, many guidelines advocate commencing at 6 weeks in keeping with WHO recommendations.[1] The POP must be taken regularly at the same time each day. In Australia, none of the progestogen only contraceptives are registered for use during breastfeeding
Depo-medroxydepoprovera (MDP)	Yes	Can be given within 48 hours of delivery but generally withheld until 6 weeks; may cause increased or irregular bleeding; ensure the woman is not pregnant at time of administration; avoid use in women with postnatal depression
Implanon	Yes	See as for MDP
IUCD – copper, progestogen (Mirena)	Yes	Can be inserted at time of delivery but to avoid high expulsion rate is usually inserted at 4–6 weeks (progestogen IUCD can cause irregular bleeding)
Oral combined contraceptive pill (OCP)	No	Interferes with breast milk production. To reduce the risk of thromboembolism, nonbreastfeeding women should wait 3 weeks before commencing OCP use; relative contraindication in women with pregnancy related hypertension; monitor closely
Tubal ligation	Yes	May be performed at time of elective LUCS if informed consent gained antenatally; may be performed after 6 weeks postpartum after careful assessment
Vasectomy	Yes	May be performed at any time with due consideration and informed consent

to and from school. If you have any concerns about the mother or her baby, it is useful to contact her maternal and child health nurse who may be able to provide further support, surveillance and advice to the family.

Breastfeeding and postnatal depression

These issues are addressed in separate articles in this issue of *AFP*. However, a postpartum check at 2–4 weeks may be of benefit by providing early intervention in women having difficulties with establishing breastfeeding or with the early identification of postnatal depression.

Sex and contraception

Advice regarding the timing of resumption of sexual intercourse is variable, with most centres recommending a 4–6 week interval. Looking at the list of common postpartum problems identified by women,[8] it is not surprising that libido may be decreased. This can be exacerbated by decreased oestrogen levels (especially if breastfeeding), body image changes, and fear of pregnancy.[1] These issues should be explored with both the mother and her partner, with reassurance that sexual dysfunction postpartum is common.[1,8] Dyspareunia may be eased with vaginal lubricants or vaginal oestrogen.[11]

There are many options for contraception, with the oral combined pill contraindicated during lactation. The timing of ovulation postpartum varies significantly and may occur before menstruation. It is important to discuss and commence contraception as early as possible. A summary of contraception options is provided in *Table 5*.

Infant assessment

Detailed discussion of the assessment of the newborn in the postnatal period is beyond the scope of this article. For further information, refer to The Royal Australian College of General Practitioners *Guidelines for preventive activities in general practice*.[15]

Conclusion

The postpartum period is a time of increased physical, emotional and social change for new parents. Although there is little evidence to show benefit from a 6 week postpartum medical consultation, there is evidence that women experience a number of health problems during this time. General practitioners may want to reconsider the traditional timing of the first postpartum visit to provide earlier intervention as needed.

Conflict of interest: none declared.

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