POSTPARTUM VISIT

Overview
An office visit typically occurs 6 weeks postpartum (PP) and primarily addresses late PP concerns such as PP depression, psychosocial issues, thyroid disorders, urinary incontinence, and mastitis. Further breastfeeding support and contraception counseling should also be provided.

Diagnostic Considerations
6 week postpartum visit (fill out 2nd page of Antenatal Record 2)

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Discussion topics
Emotional status/depression: screen by Edinburgh Postnatal Depression Scale
Relationship issues: sexual/relationship concerns, social support, family violence
Future plan: future pregnancies, preconceptual folate, contraception

Common Concerns

1. Lochia:
   - Average duration = 36 +/- 7.5 days (shorter duration seen in breastfeeding)
   - Progresses through colour sequence: Initially red, changes to brownish then yellow

2. Return of Menses:
   - If lactating, 120 days PP in 75% of women
   - Non-lactating: 90 days PP in 75% of women

3. Contraception:
   - Ovulation resumes by 150 days PP in 50% of lactating women and by 90 days in 50% of non-lactating women
   - Combination estrogen-progestin contraceptives (OCP, patch, ring) interfere with breast milk production → consider progestin-only contraceptives for breastfeeding women
   - Due to increased thromboembolism risk, non-breastfeeding women should wait 3 weeks before initiating estrogen-containing birth control
   - Recommended that breastfeeding women wait at least 6 weeks before starting progestin-only contraception
   - Diaphragms and cervical caps must be refitted 6 weeks PP
   - IUDs can be inserted immediately after delivery of placenta but common to wait until the 6 week PP visit due to expulsion risk

4. Sexuality/Decreased Libido:
   - 52% of women experience decreased desire for sex at 5 weeks PP but may last as long as 1 year PP
   - Average time PP for intercourse is 6-8 weeks
   - Many sources recommend waiting until at least 4-6 weeks
   - Hypothesized to be due to decreased estrogen levels
   - Estrogen remains low in breastfeeding women hence may contribute to delayed return of libido
   - Other contributing factors: fatigue, pregnancy concerns, body image

5. Incontinence:
   - Incidence of 2.7-23.4% in first year PP
   - Risk factors: High pre-pregnancy BMI, parity, smoking, prolonged breastfeeding, use of forceps, vaginal delivery and urinary incontinence during pregnancy
   - Pelvic floor exercises found to be effective at reducing incidence and severity of incontinence

6. Thyroid Disorders:
   - Incidence peaks at 2-5 months PP with an overall prevalence of 4-7% in first year PP
   - Consider screening high-risk women (DM I, hx of postpartum thyroiditis or postpartum depression)
   - 25% of women with PP hypothyroidism develop long-term hypothyroidism

7. Breastfeeding:
   - Recommended for at least 6 months with emerging support shown to increase duration
   - Early mastitis managed by increased nursing, milk expression, and NSAIDs
   - Antibiotics (dicloxacillin or cephalaxin) if bacterial infection does not improve within 12-24 hours or if initial presentation is severe
   - Ultrasound can be useful to differentiate mastitis from breast abscess
   - Breastfeeding should be continued throughout treatment

Dr. Michael Evans developed the One-Pager concept to provide clinicians with useful clinical information on primary care topics.
8. PP Depression:

- Incidence of ~13% with onset defined within 4 weeks PP but may occur up to 1 year PP
- If untreated, lasts an average of ~7 months
- Risk factors: Hx of PP depression with previous pregnancy (25-50% have recurrences), antenatal depressive symptoms, hx of MDE, poor social support, major life events or stressor during pregnancy, fhx of PP depression
- Consider screening with Edinburgh Postnatal Depression Scale especially if risk factors present → found to improve rate of diagnosis and facilitate treatment
- Psychotherapy for mild to moderate and as an adjuvant therapy with medication (SSRI ex. sertraline(Zoloft) or paroxetine (Paxil)) in moderate to severe PP depression

9. Rubella immunity:

- If found to be non-immune during pregnancy → immunize

Bottom Line

The PP visit is an excellent opportunity to focus upon a woman’s overall health and wellness, as many preceding visits may have centered upon the newborn. Common discussion points may include mood, sexuality, contraception, and breastfeeding.

References can be found online at http://www.dfcm.utoronto.ca/programs/postgraduateprograme/One_Pager_Project_References.htm