Postpartum Care

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Learning Outcomes

- Recognize and understand normal maternal physiologic changes in PP period
- Describe the normal components of PP care
- Recognize and understand the issues related to breastfeeding including counseling on importance/benefits of breastfeeding
- Understand contraceptive options for the lacting and non-lactating PP patient
Postpartum complications

• Important PP issues to be covered in other lectures
  – Uterine hemorrhage
  – Infection and other causes of PP fever
  – Wound dehiscence
  – Bladder and bowel complications
  – DVT and PE
Puerperium Physiologic Changes
Non Breast/ Gyn Changes

• CV system
  • Returns to normal in 2-3 wks
  • Immediate volume decrease of 1000ml
  • Decrease in cardiac output and pulse occurs in few hours
    – Women with heart conditions have more complications handling these changes

• Renal/ Urinary system
  • GFR remains elevated for first few weeks
  • SUI incontinence can occur, but kegels and time usually resolves
Puerperium Physiologic Changes

Non Breast Changes

• Involution of the uterus (1000g to 70g)
  • Immediately PP – palpable below belly button
  • 2 wks- within pelvis
  • 6 wks- normal size

• Lochia (normal PP bleeding/ discharge)
  • Lochia Rubra- menses like bleeding for 2-3 days
  • Lochia serosa – lighter bleeding for several more days
  • Lochia alba- whitish discharge may persist for weeks
  • Extensive variation occurs in reality
Puerperium Physiologic Changes

Non Breast Changes

• Vulva/ Vagina
  • Healing varies with extent of episiotomy or lac
  • “Pericare” is encouraged
  • Suture dissolves by 6 week exam in most cases

• Ovarian Function
  • Average time to ovulation if not BF’ ing is 45 days (189 if BF’ ing)
    • Reason we need to discuss CONTRACEPTION in PP period
Puerperium Physiologic Changes

Breast changes

- Initial drop in hormones removes inhibition
- Intensity and duration of production is controlled by stimulus of nursing
  - Prolactin is essential (Sheehan Syndrome)
- Colostrum begins to be secreted after delivery (dominant for 5 days)
  - High in nutrients, protein, IgA
- Milk
  - Contains all vitamins except K (baby gets an injection) and minimal D (recommend supplementation)
Breastfeeding Counseling
(ideally initiated during antepartum care)

- Breast milk is the IDEAL nutrient for baby exclusively for 6 months

- Benefits to mom
  - Maternal child bonding, lactation amenorrhea, decrease risk of hormonal sensitive cancers, weight loss, and a healthier – smarter baby

- Benefits to baby
  - Less ear and URI, less GI infections, less SIDS, less allergic and atopic dz, less type 1 DM, less childhood cancers
  - Improved cognitive function
Contraindications to Breastfeeding

- HIV
- Untreated TB and some TB medications
- Maternal Substance or Alcohol abuse
- Maternal Breast Cancer undergoing treatment
- Other medications
- Infant with galactosemia
Puerperium Physiologic Changes

Breast changes

• Non-breast feeders
  – Engorgement
    • Occurs in first few days and gradually goes away
      – Painful sx (usually day 3-5) can be treated with ice packs and pain meds
      – Recommend supportive bra
      – Ovoid nipple stimulation and expression of milk
    • “milk fever”
      – Common with engorgement
      – Seldom lasts longer than 4-16 hrs
Breast feeding trouble shooting

• Care of breast
  – Lanolin, all purpose nipple cream, nipple shield
  – Proper LATCH

• Mastitis
  – Develops in 1/3 of BF’ing moms
  – Often starts with flu-like symptoms and unilateral breast tenderness/engorgement
  – Encourage to continue to feed and treat with Dicloxacillin
    » EES if PCN allergic

• Breast Abscess
  – Suspect if mastitis does not resolve after 48 hrs of tx or with palpable mass. Tx is surgical

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PP care while in the hospital

• Early ambulation
• Perineal care (topical products, sitz baths...)
• Bladder/Bowel function
• Depression assessment
  – Baby Blues - mild, self-limited, usually 2-3 days, but up to 10
  – If possible be aware of risk from prenatal care
  – 10-20% develop during 6 months pp
• Assistance with breastfeeding
• Plan for contraception (slides to follow)
PP Contraception

- When to initiate contraception can be controversial.
- Ovulation, in non-breastfeeding moms, can occur as early as 28 days PP, but typically occurs 5-11 wks PP.
- Breastfeeding alone is not contraception, especially as the number or frequency of feedings decreases with addition of other food.
PP Contraception Breastfeeding

- Estrogen containing methods are generally contraindicated while breastfeeding because they decrease milk supply.
- All FDA approved methods recommend initiation after 4-6 weeks in breastfeeding
  - Generally accepted this is not necessary, but because studies are not done in women less than 4-6 wk pp
  - Family planning literature supports use earlier if patient is at high risk to not attend PP visit or repeat pregnancy
PP Contraception Breastfeeding

- Depomedroxyprogesterone Acetate (depo)
  - 3 month injection
- Progestin Only Pills (35 mcg Norethindrone)
  - Daily, thicken cervical mucous
- Nexplanon® (3 year etonogestrol Implant)
- Mirena® (5 yr Levonorgestrol IUD)
- Skyla® (3 yr Levonorgestrol IUD)
- Paragard® (10 yr Copper IUD)
PP Contraception - Non-breastfeeding

• All those available for breast feeding AND:
  • Combined Oral Contraceptive Pills
    – Daily, many formulations
  • Contraceptive Vaginal Ring (Nuvaring®)
    – monthly
  • Contraceptive Patch (Ortho Evra®)
    – weekly
PP contraception - Sterilization

- PERMANENT
- Convenient- either in CD or immediate PP
- Safe – often uses existing anesthesia
- Successful – compared to interval sterilization or all reversible methods
- Often not completed during PP period despite a pt’s desire – have a back-up plan
Postpartum Care Summary

The 5 B’s

• Baby
  – Boy/girl (Circ)
  – Healthy or in NICU

• Bleeding
  – Lochia, early ambulation (prevent DVT)

• Breast/Bottle

• Blues/ Depression

• Birth Control