Postpartum Care

6 weeks and beyond

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Key Message

- The postnatal period is a rapidly changing period for new parents.
- GPs have an essential role in addressing maternal physical, emotional and mental health needs.
- The postnatal visit requires a comprehensive assessment, including:
  - birth and antenatal history,
  - physical examination,
  - appropriate investigations
  - counselling,
  - advice and management.
  - Preventative healthcare

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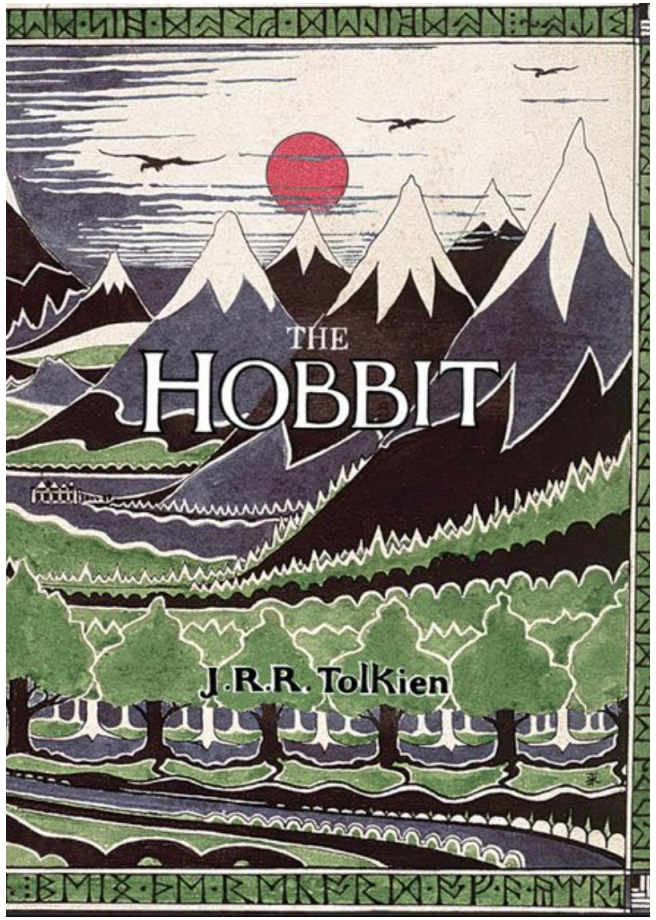
Scope of presentation

Briefly stay in the shire...

- Basics of postnatal care

Journey through middle earth…

- Birth trauma
- Pelvic floor anatomy & injury



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Basics of postnatal care

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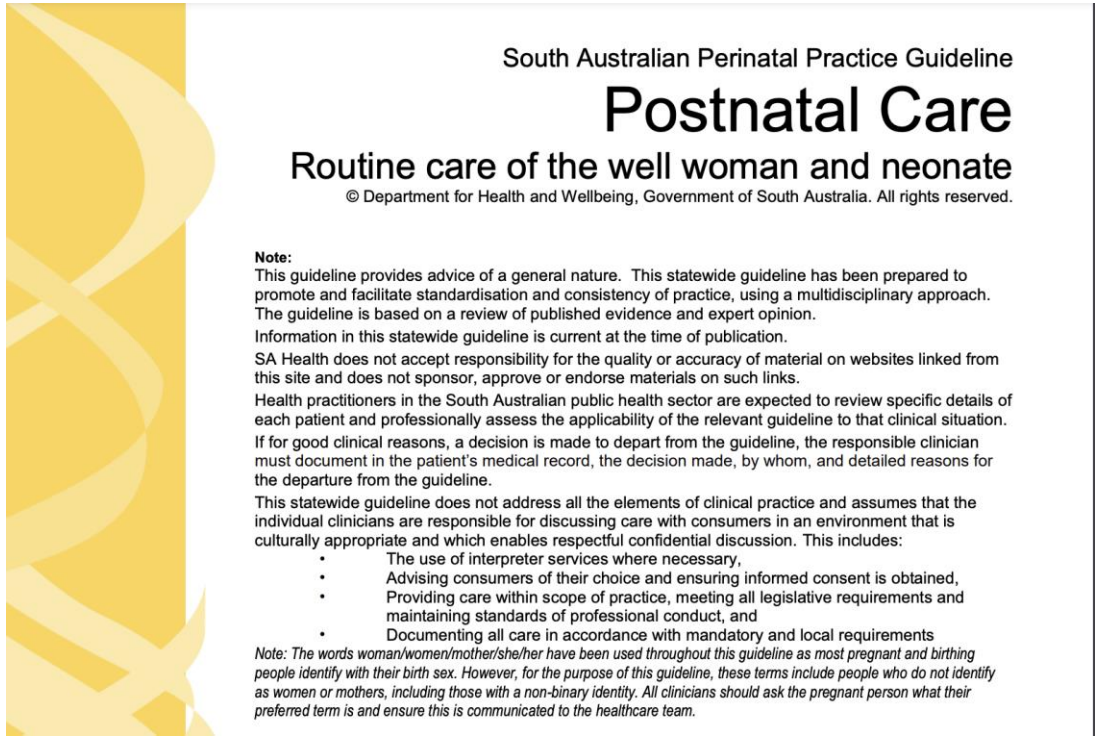
Resources - SA Health



South Australian Perinatal Practice Guideline

Postnatal Care

Routine care of the well woman and neonate

Note:
This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

SAPPG

- 16 page guideline
- Focusses on hospital management.

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Resources - RACGP

Postnatal care

The general practitioner visit

CPD

Talila Milroy, Jacqueline Frayne

Background
The postnatal period is a rapidly changing and challenging time for new parents. General practitioners are well placed to provide support, advice, clinical care and intervention for common psychosocial and physical concerns in this critical period.

Objective
The aim of this article is to outline a consistent approach to the content and structure of the postnatal visit in the general practice setting, along with key management strategies for common postnatal conditions and comorbidities.

Discussion
Common physical and mental health

THE POSTNATAL PERIOD is characterised as beginning after delivery of the placenta and lasting for six weeks,[1] with some groups advocating to include up to 12 weeks, comprising what has been termed the fourth trimester.[2] The postnatal visit is crucial for effective healthcare education, preventive medicine and treatment, and it occurs at a time of major life transition and increased need.[3] In addition to a review after birth, the World Health Organization recommends at least three postnatal contacts in this period, including the six-week visit.[3] Early postnatal contact is increasingly considered important and, depending on individual circumstances, may transition into chronic condition management.[2]

Current guidelines for shared maternity time to provide support and education and answer the many questions likely to occur during this rapid and evolving period. Most often, presentation occurs between six and eight weeks postpartum, coinciding with immunisations, with earlier attendance encouraged if needed.[5] Ideally, it is recommended that both mother and baby have individual 20–30-minute appointments for assessment, physical examination and vaccinations. If a support person is unavailable, a pram or carrier is helpful to facilitate assessment. The infant health record, relevant documentation including discharge summary, and a list of discussion questions should accompany the woman.

AJGP - March 2022

- 6 page article
- Focusses on GP visit
- Excellent resource

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Postnatal Care

General Approach

- “Physical, emotional and social assessment of both mother and baby”
- History
- Physical examination
- Follow up of antenatal comorbidities
- Management of common conditions
- Contraception

Postnatal Care - History

Pregnancy

- Pregnancy complication
- Labour and mode of delivery
- Perineal tear
- Immediate postnatal complications
- Length of hospital stay

After Birth

- Bowel and bladder issues
- Breast concerns
- Sleep
- Home situation / relationship concerns
- Maternal concerns about the infant
- Mental health assessment
- Sexual health, contraception and future pregnancy planning
- Immunisations / Rhesus

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Postnatal Care - Examination

Physical Examination

- Blood pressure, heart rate
- Breast examination
- Fundal involution
- Abdominal examination (Divarication of rectus)
- Cervical screening test
- +/- Pelvic floor assessment (Bruising, suture healing & oedema)

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Postnatal Care – Common Problems

Common postnatal concerns (First 6 months)

- Vaginal blood loss
- Perineal or caesarean section wound pain
- Tiredness / sleep patterns
- Urinary symptoms
- Bowel symptoms
- Rectal bleeding / haemorrhoids
- Breast and nipple tenderness
- Mood / psychological adjustments
- Sexual problems / contraception
- Relationship issues

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Contraception

Postnatal contraception

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Postnatal Care - Contraception

Contraception

- 51% of women are sexually active before the 6 week post partum visit.

Return to Fertility

- Unpredictable
- Lactating vs Non-Lactating

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Ovulation post partum

Non-Lactating

- Average time to first Ovulation 45-94 days
- Earliest reported ovulations at 25 & 27 days
- 20% of women will ovulate prior to first menses,
- 94% Ovulated in subsequent cycles

Lactating

- 20-56% of breastfeeding women are not amenorrhoeic at 6 months
- Of the women who resumed menses whilst exclusively breastfeeding
  - 45% Ovulated prior to their first menses
  - 66% Ovulated during subsequent cycles whilst still breastfeeding

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Contraception

	Contraceptive Option	Timing	Effectiveness
LARCS	Copper T	<48hrs or >4 wks	>99% effective
	Mirena	<48hrs or >4 wks	>99% effective
	Implanon	Anytime	>99% effective & *can't fall out!!*
	Depo-provera	Anytime	97% effective
	Progesterone Only Pills	Anytime	90-97% effective 3hr window
	Condoms	Anytime	85% effective
	Combined OCP	Not before 21-30 days	Interferes with breastfeeding under 6 months

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Contraception

Post Placental IUD

- NALHN performs post placental IUD insertion
- Information for GP's
  - May need strings shortened at 6 weeks
  - Modbury Hospital Ambulatory Gynae Unit (AGU) will accept direct referrals for lost mirena's*

    *Provided USS shows it is located in uterine cavity

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Long-term Health

Long-term health consequences of pregnancy

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Long term health - Pre-eclampsia

- Pregnancy-related hypertensive disorders (preeclampsia, gestational hypertension) increases risk:
  - Hypertension, cardiovascular disease (CVD, including coronary heart disease, stroke, and heart failure), and kidney disease later in life.
  - Early all-cause mortality and some cause-specific mortality (ischemic heart disease, stroke, diabetes).
- Risk of cardiovascular morbidity and mortality
  - Severity of preeclampsia,
  - Gestational age when delivery was required
  - Number of disease recurrences.

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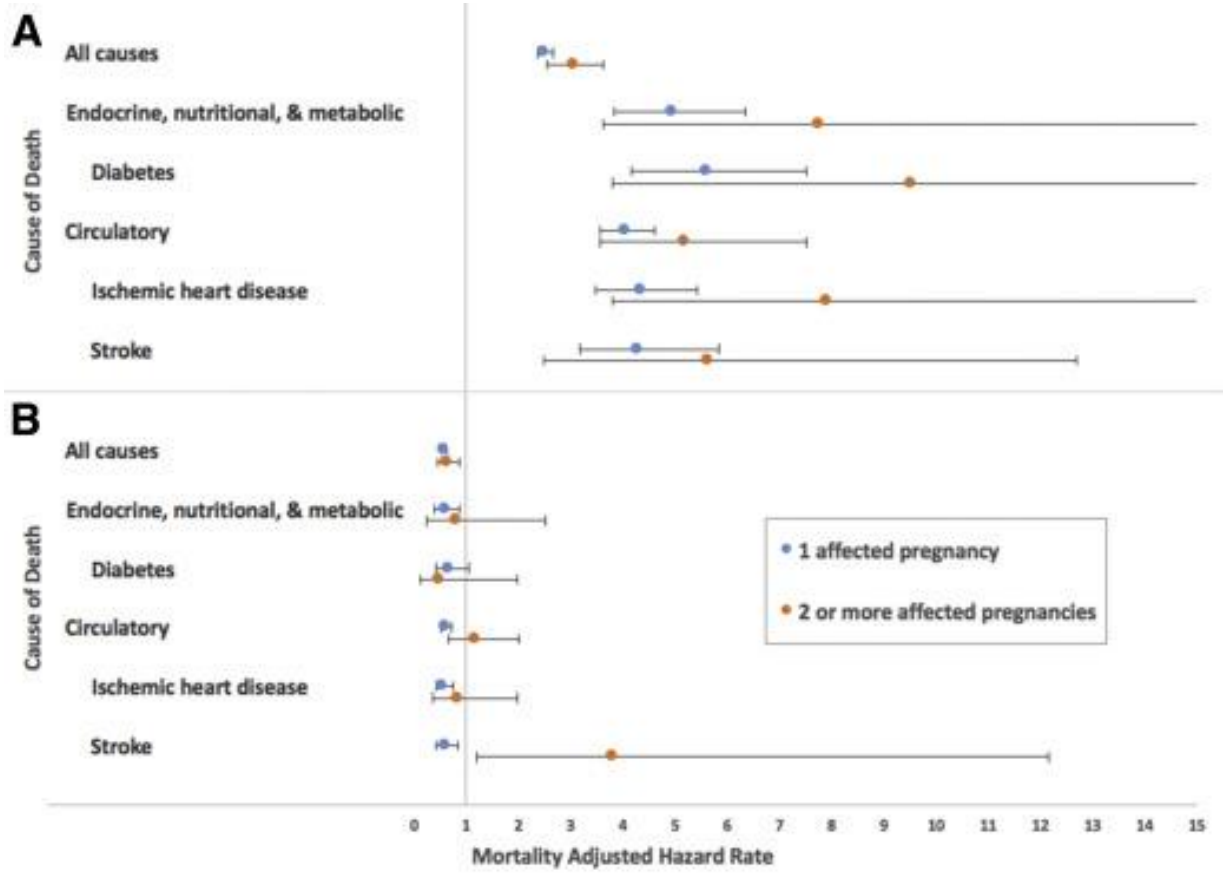
Long term health - Pre-eclampsia

≤ 50 years

> 50 years



- Pre-eclampsia is associated with increased mortality in women aged under 50

Adjusted hazard rate ratios for association between number of pregnancies complicated by hypertensive disease of pregnancy and deaths occurring **A** , ≤50 or **B** , >50 years of age.

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Long term health - Pre-eclampsia

Strategies to reduce mortality

- There is no consensus as to how these patients should be followed in the years after the affected pregnancy, including the type and frequency of screening for CVD.

Practical Approach:

- Increased awareness about their CVD
- More aggressive lifestyle modification
  - Women < 50 not traditionally considered at risk for CVD.
- Extended lactation (decreases risk of maternal hypertension and CVD)
- Optimal body mass index, Smoking cessation, Healthy diet, Regular exercise

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Long term health risk - GDM

Condition	Increased risk	Notes
GDM in subsequent pregnancy	30-70% Chance of recurrence	
Type 2 Diabetes	10 x increased risk (RR 9.5)	Absolute risks at: - 1 to 5 years = 9% - 5 - 10 years = 12% - Lifetime = 50-60% - Lower risk with normal BMI
Cardiovascular disease	2 x increased risk (RR 1.98)	
Type 1 Diabetes	Increased risk	
Metabolic syndrome	Increased risk	

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GDM – Screening after pregnancy

Normal BMI

- Type 2 diabetes develops <25% who achieve normal BMI after delivery.
- OGTT 6-8 weeks post partum
- Screen every 2-3 years
- Screen prior to pregnancy

Obesity BMI >30

- Type 2 diabetes develops in 50-75%
- OGTT 6-8 weeks post partum
- Screen every 1-2 years
- Screen prior to pregnancy

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Birth Trauma

Exploring birth trauma and long term pelvic floor heatlh

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Birth Trauma

NSW Birth Trauma Inquiry

- 2023
- Parliamentary inquiry
- 4,000 submissions

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Australian Birth Trauma Association

19 July 2022

Birth injuries:
the hidden epidemic

Australian Birth Trauma Association:

- Survey 801 women (Aus, UK, NZ)
  - Self identified as having experienced birth injuries
  - 2016-2022

Limitations: Selection bias

Strengths: Highlights experiences of women with traumatic births.

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Birth Trauma

- Research shows that feeling traumatised by a birthing experience is not uncommon:
  - 1 in 3 women experience birth trauma
  - PTSD occurs in 2-3 % of women after childbirth
  - Early identification and treatment reduces PTSD

- The birth does not have to be ‘abnormal’ in the clinician’s view for women to feel traumatised.
- For some women childbirth is not fulfilling and becomes one of the most traumatic experiences of their lives

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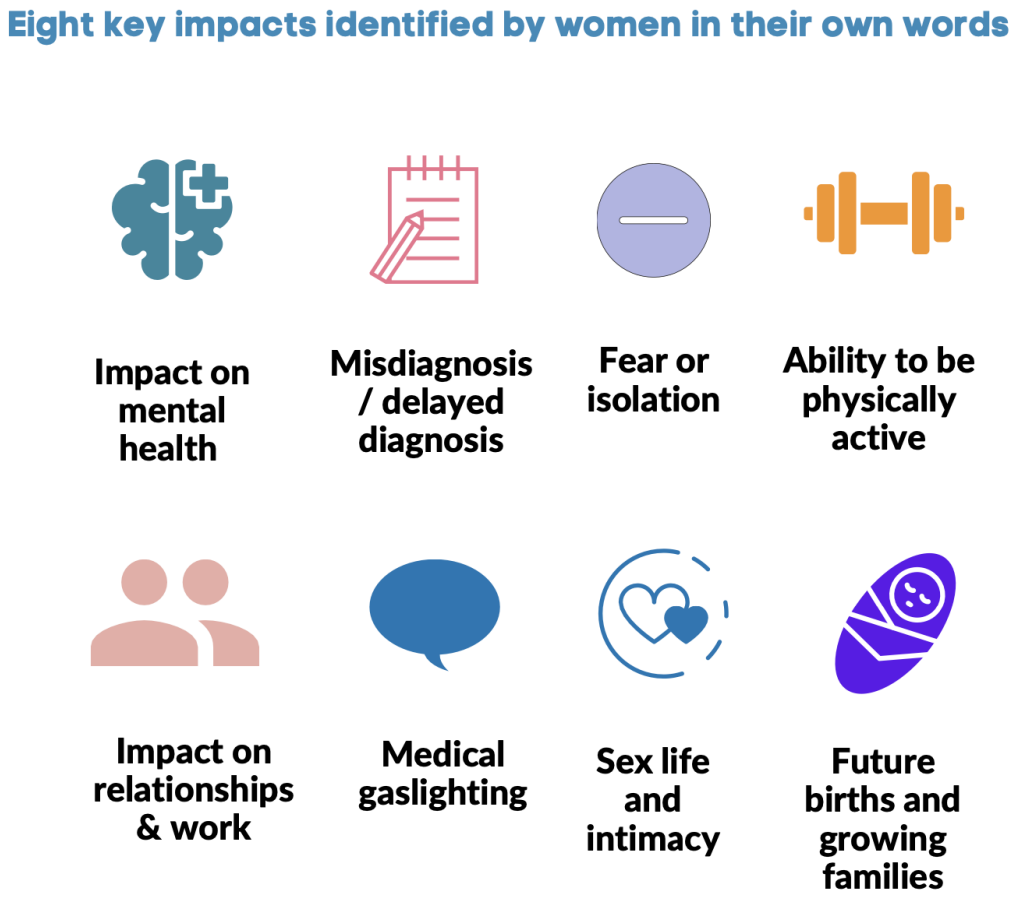
Birth Trauma



Medical contributors

- Misdiagnosis / delayed diagnosis
- Medical gaslighting

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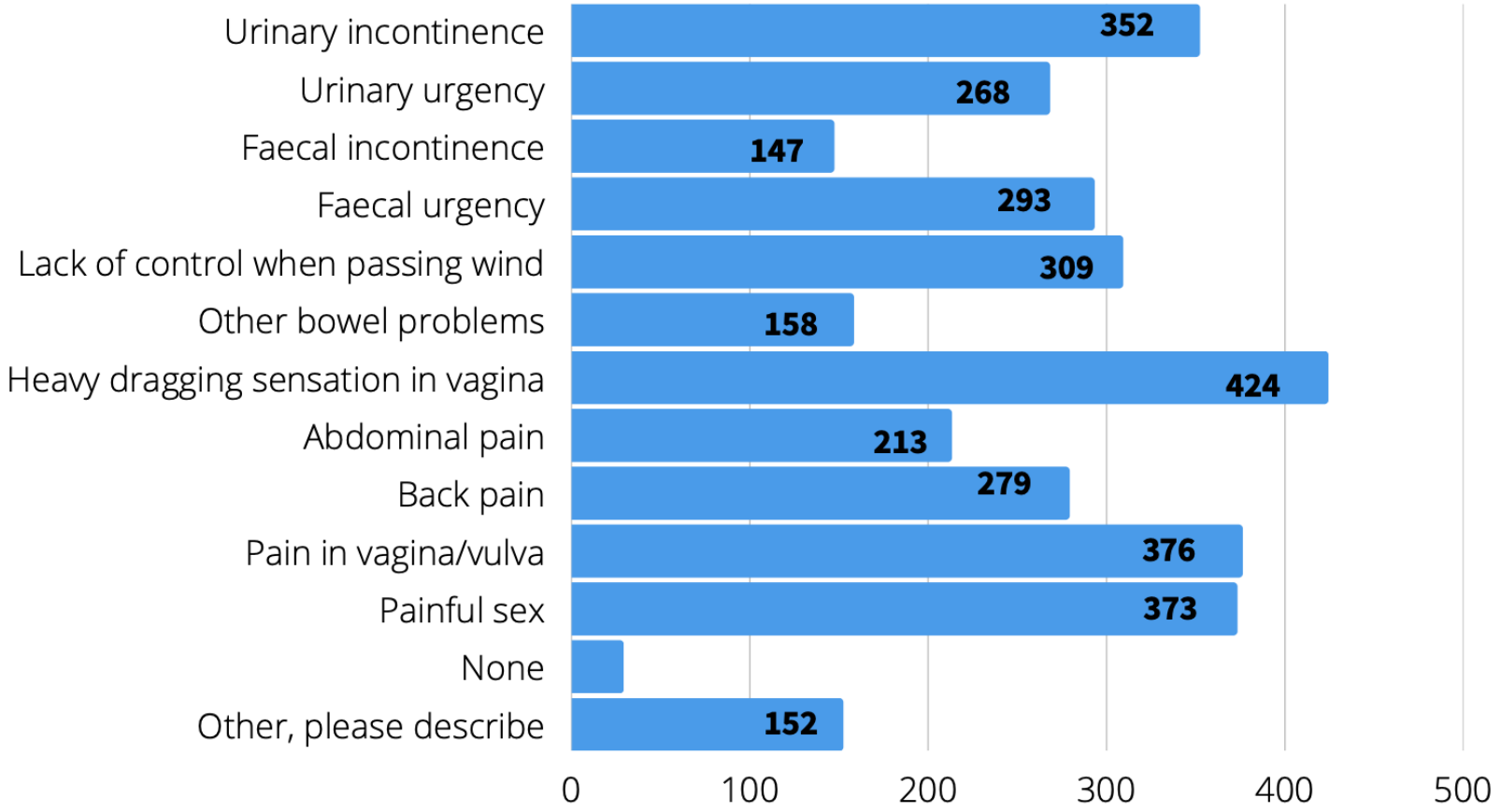
Birth Trauma - Symptoms



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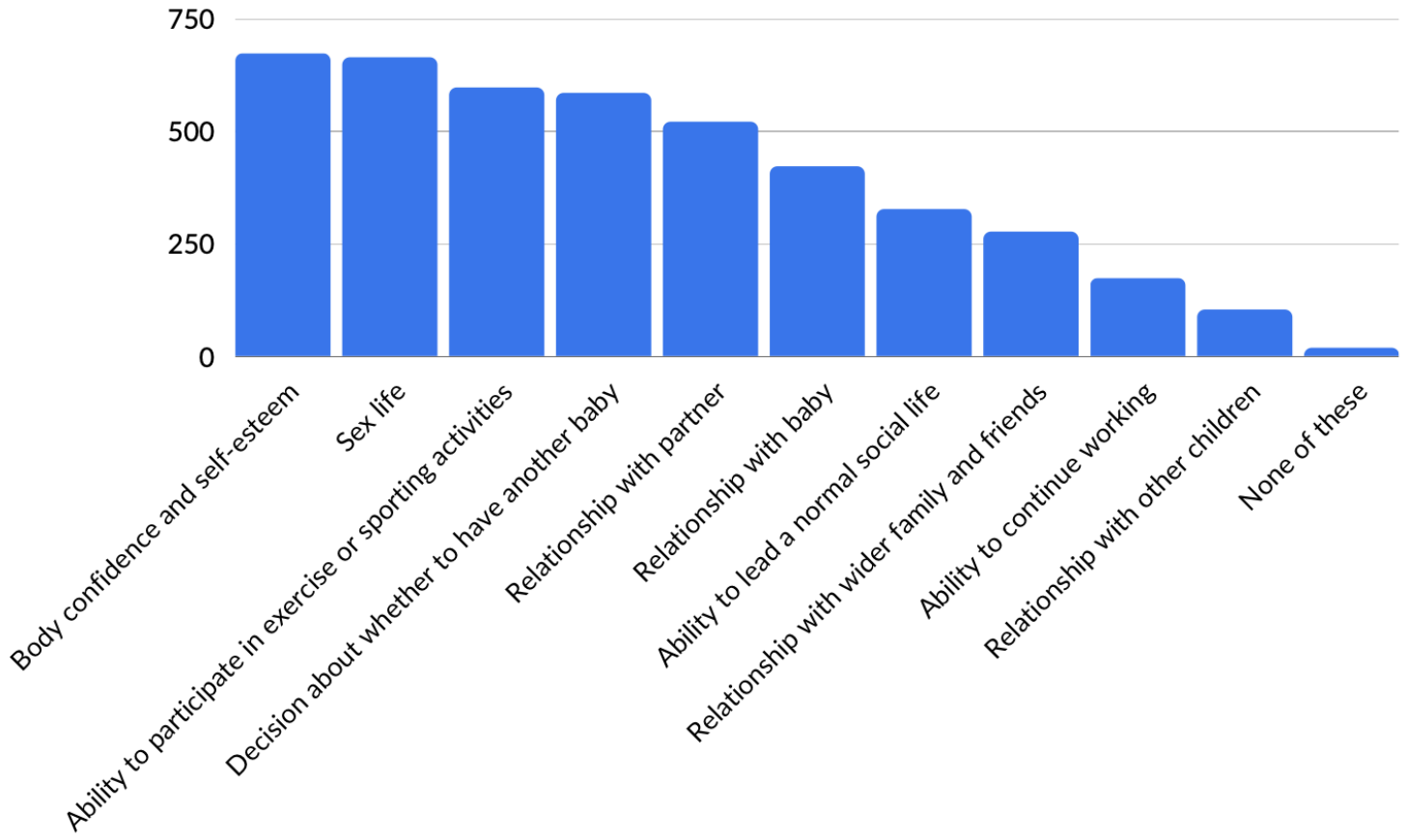
Birth Trauma - Symptoms

Did your birth injury ever affect any of the following (select all that apply):



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Birth Trauma

GP's role in reducing birth trauma

- Generally, not involved in the birth / traumatic event.
- Consider rethinking… "pregnancy trauma" rather than just "birth trauma"

- Understand factors that lead to birth trauma
  - Antenatal education
  - Postpartum management
  - Understand management pathways
  - "Misdiagnosis and delayed diagnosis" & "Medical Gaslighting"

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Pelvic Floor

Brief anatomy review

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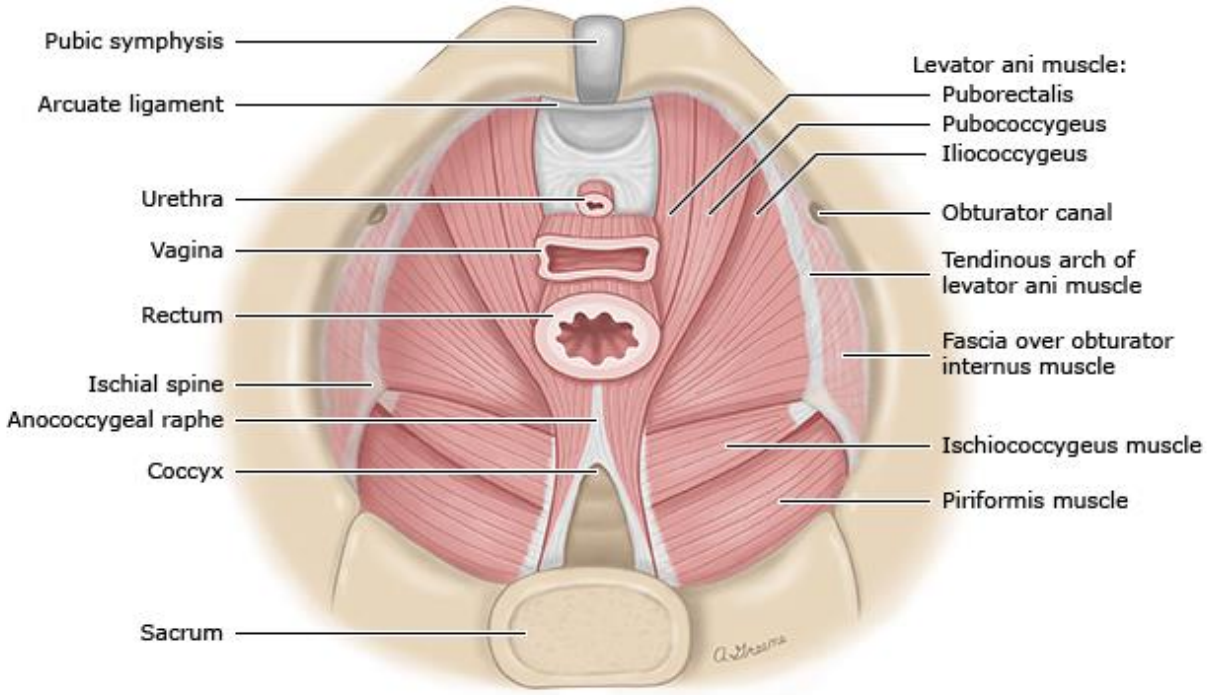
Pelvic Floor Anatomy

Components of Pelvic Floor

- Muscles
- Nerves
- Connective tissue / Fascia



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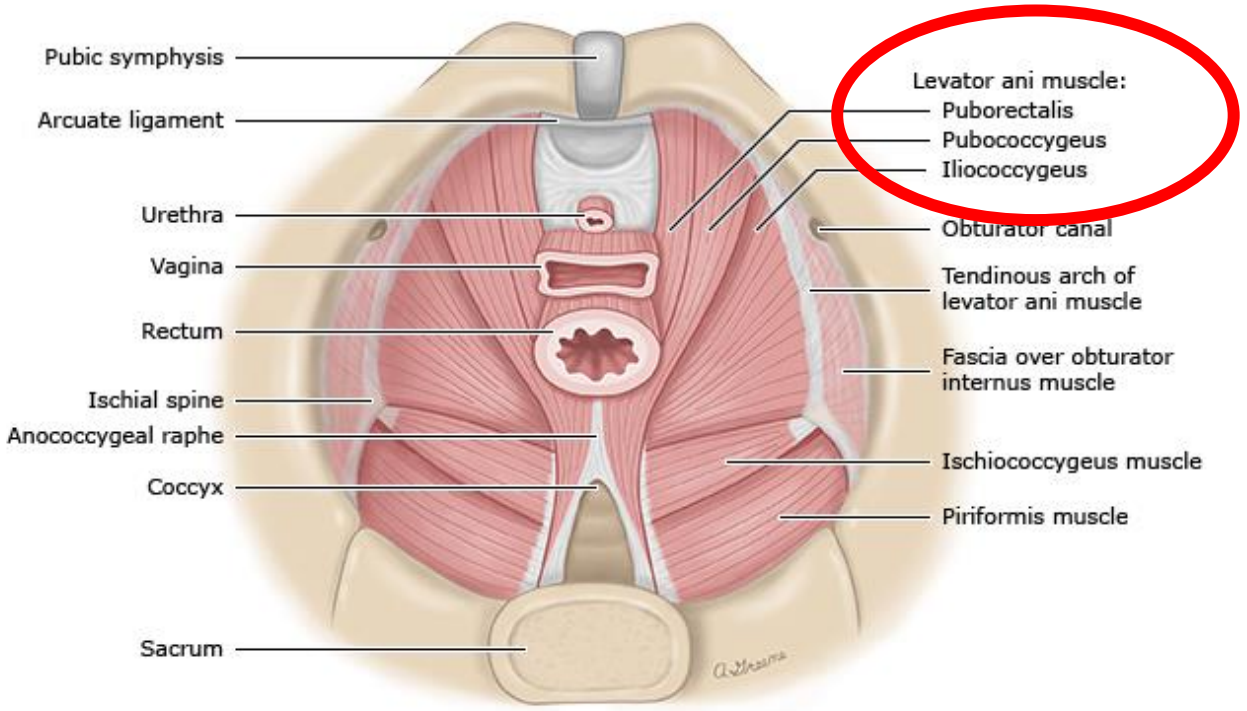
Pelvic Floor Anatomy

Pelvic Floor Muscles:

- Levator ani
  - Broad, thin muscle group.
  - Pubococcygeus
  - Iliococcygeus
  - Puborectalis.

  Note: can have different names
- Coccygeus muscle



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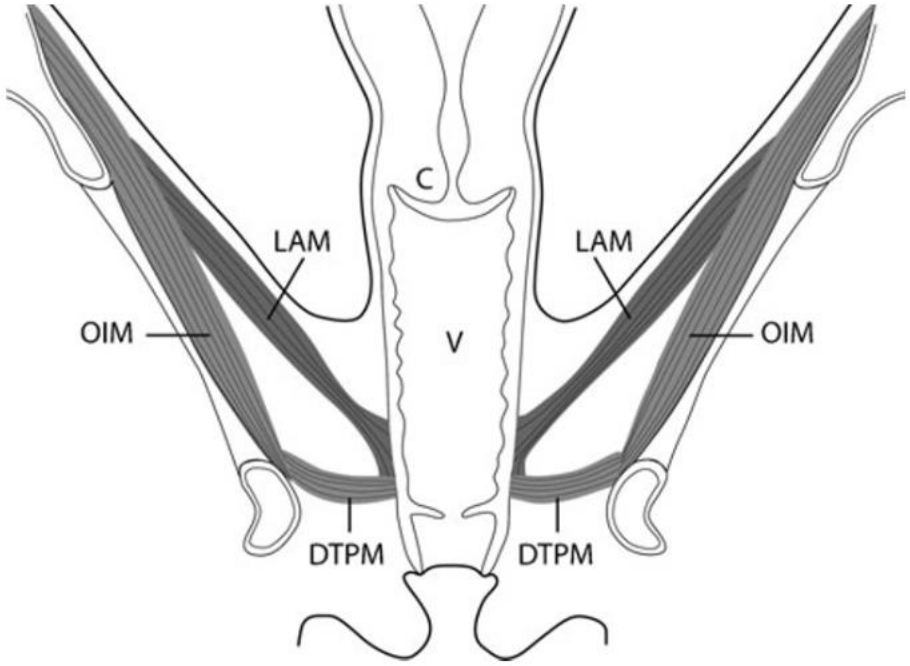
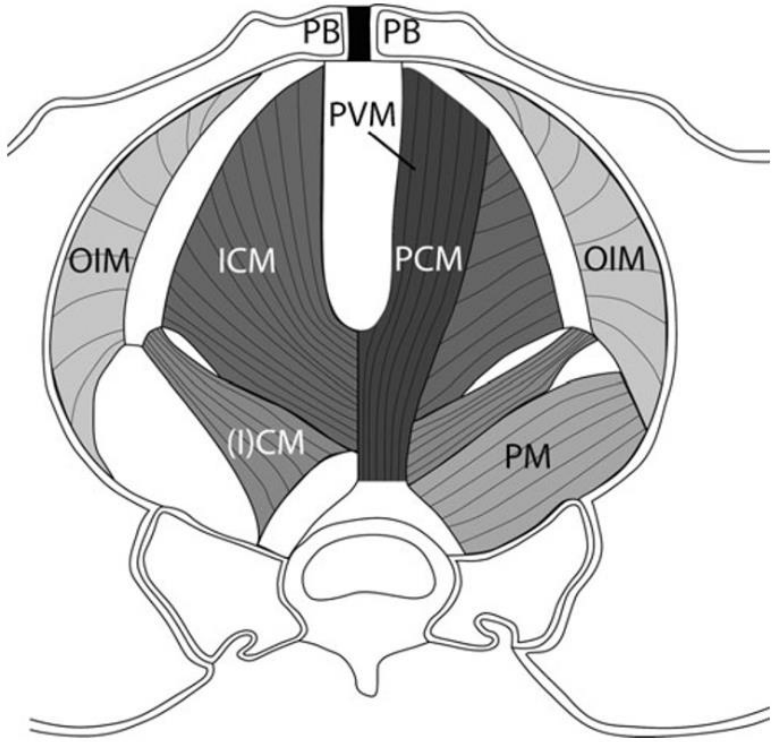
Pelvic Floor Anatomy

Levator:





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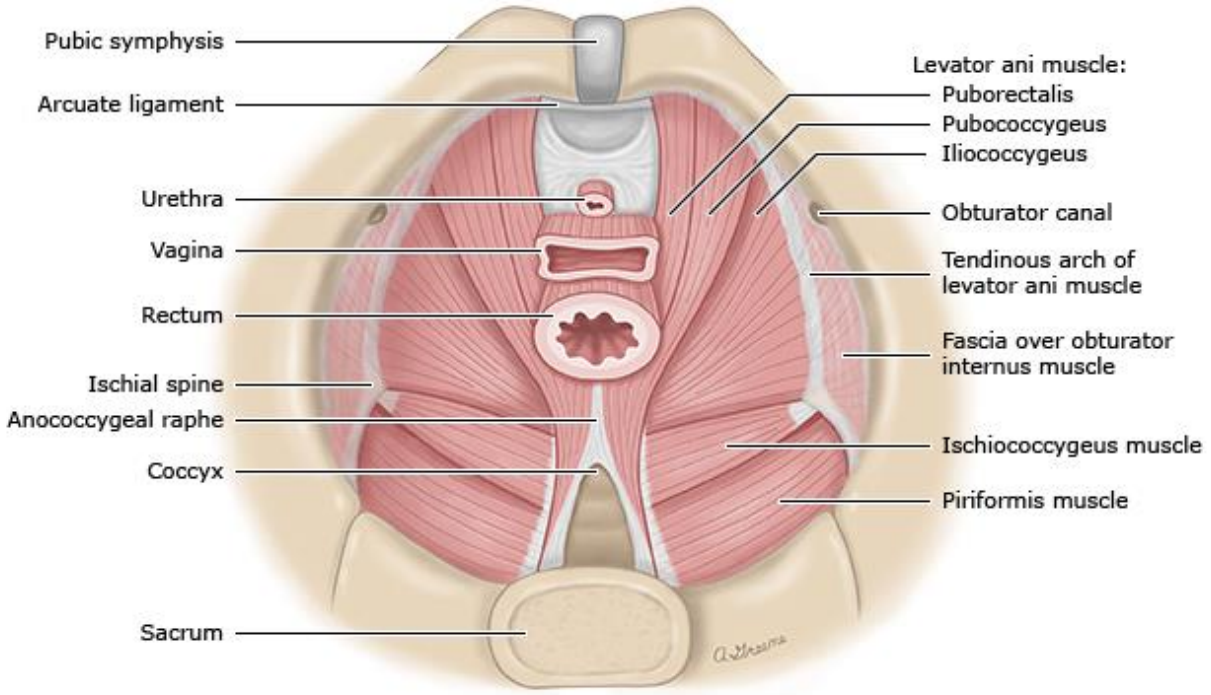
Pelvic Floor Anatomy

Function:

- Levator ani muscle complex is critical to pelvic floor function.
  - U-shaped sling around the pelvic viscera
  - Resting tone keeps the urogenital hiatus closed and supported
  - Voluntary contraction can further augment vaginal closure force and compress rectum, vagina and urethra.



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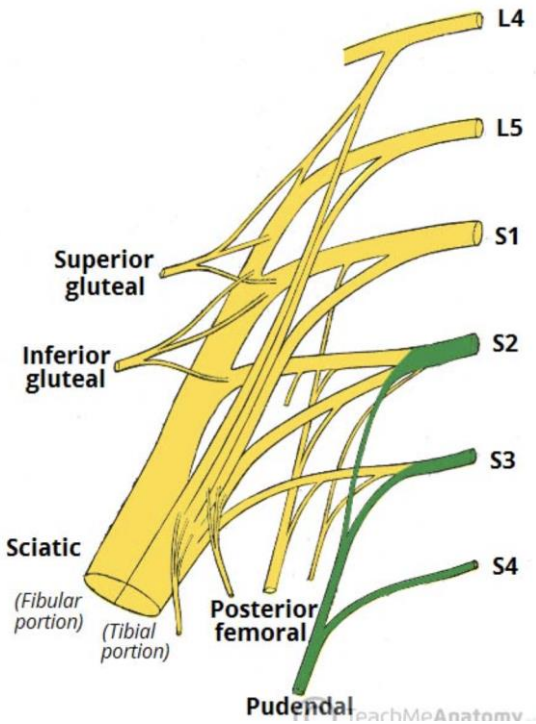
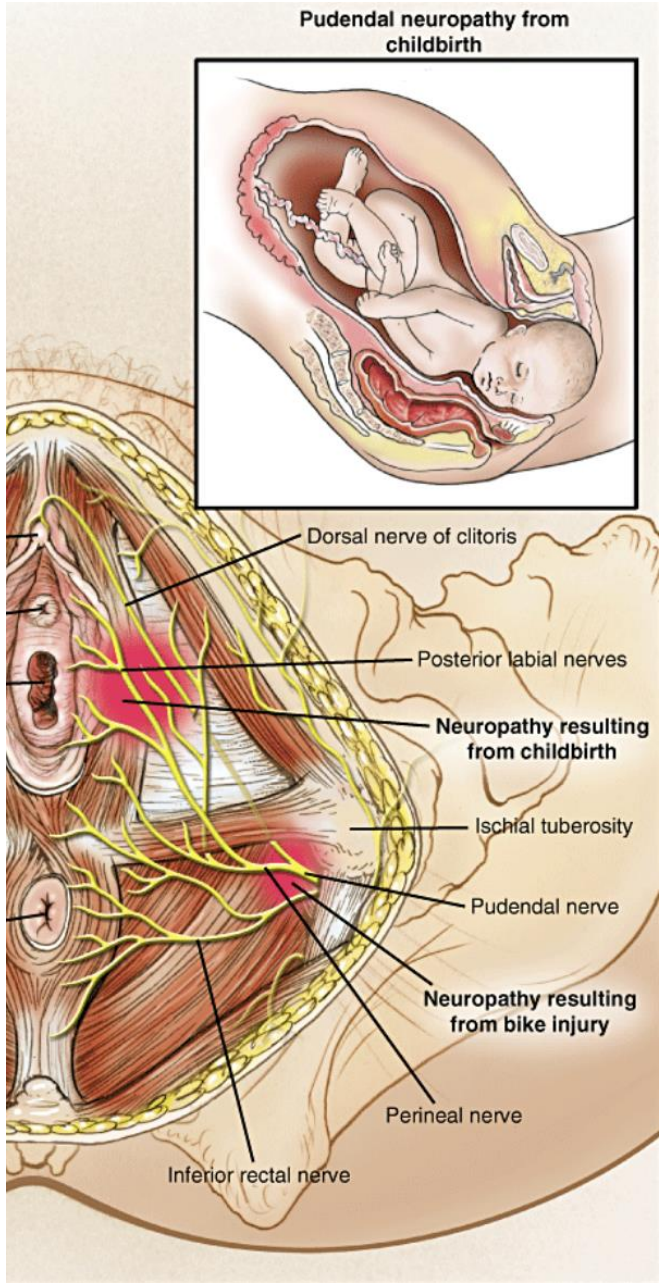
Pelvic Floor Anatomy

Innervation

- S2, S3, S4
- Pudendal nerve
  - Periurethral striated muscle.
  - External anal sphincter
- Direct connection
  - Levator, coccygeus muscles

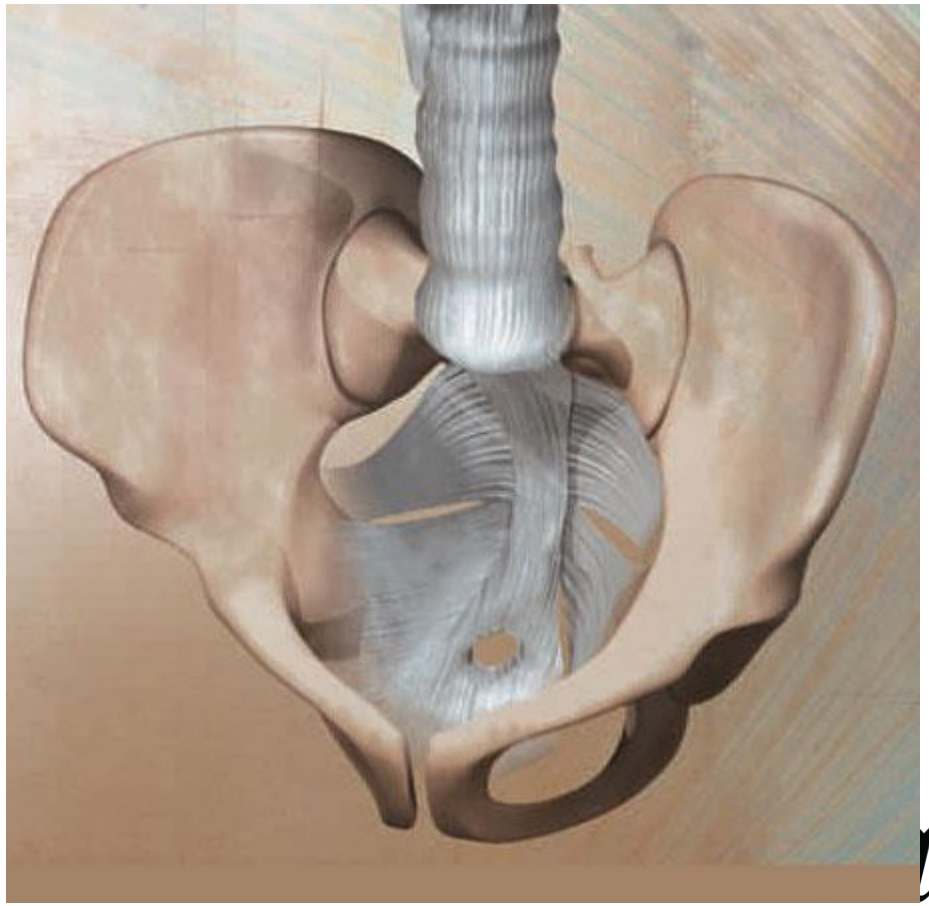




Pelvic Floor Anatomy

Fascia

- Fascial defects repaired during prolapse repair



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Pelvic Floor Injury

Exploring the effect of pregnancy on the pelvic floor

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Pelvic Floor Injury

Mechanism of Injury

Muscle, nerve and connective tissue

- Compression
- Stretching
- Tearing
- of nerve, muscle, and connective tissue.

- Nerve damage
  - Abnormal conduction in perineal branch of pudendal nerve
  - Intact neuromuscular function and pelvic organ support are both critical to normal function of pelvic viscera.

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Pelvic Floor Injury

Risk Factors for Pelvic Floor Injury

- Advanced maternal age
  - 10% increase in risk for every year
  - Muscle and connective tissue are less elastic
- Operative delivery
  - Forceps delivery ++
- Caesarean section does not completely prevent pelvic floor disorders

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Pelvic Floor Injury

Not associated with Pelvic Floor Dysfunction

- Labour in the absence of vaginal delivery
- Vacuum delivery not associated with pelvic organ prolapse, stress incontinence.
- Episiotomy liberal vs restrictive use has no association with incontinence or prolapse.

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Pelvic organ prolapse

Non-Obstetric Factors

- Family history
- Advancing age
- Heavy lifting
- Chronically increased abdominal pressure
- Smoking
- Middle-European decent
- Higher BMI

Obstetric Factors

- Vaginal birth
- Forceps delivery

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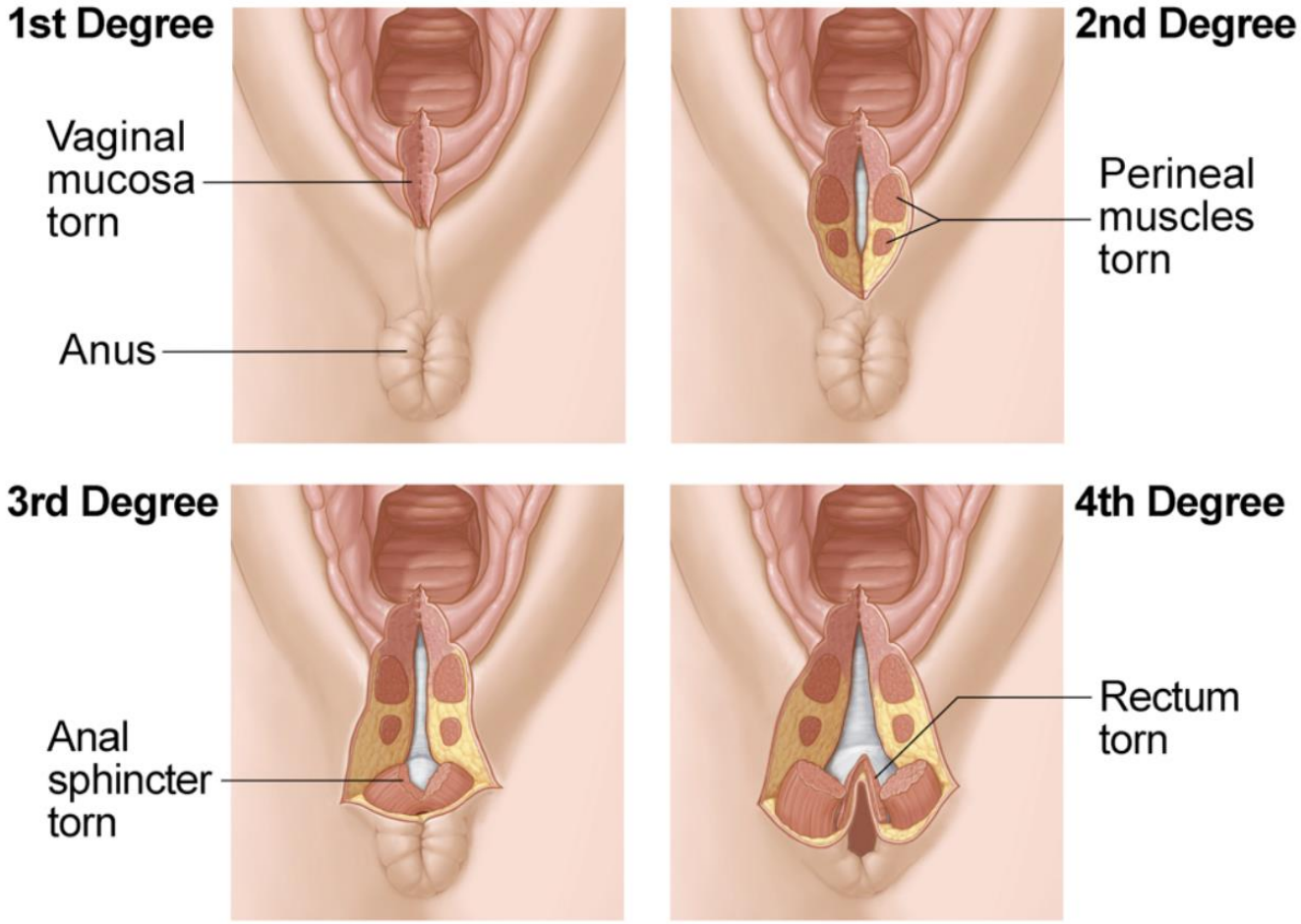
Pelvic Floor Injury

Simplistic Assessment

- Traditional 1st to 4th degree perineal

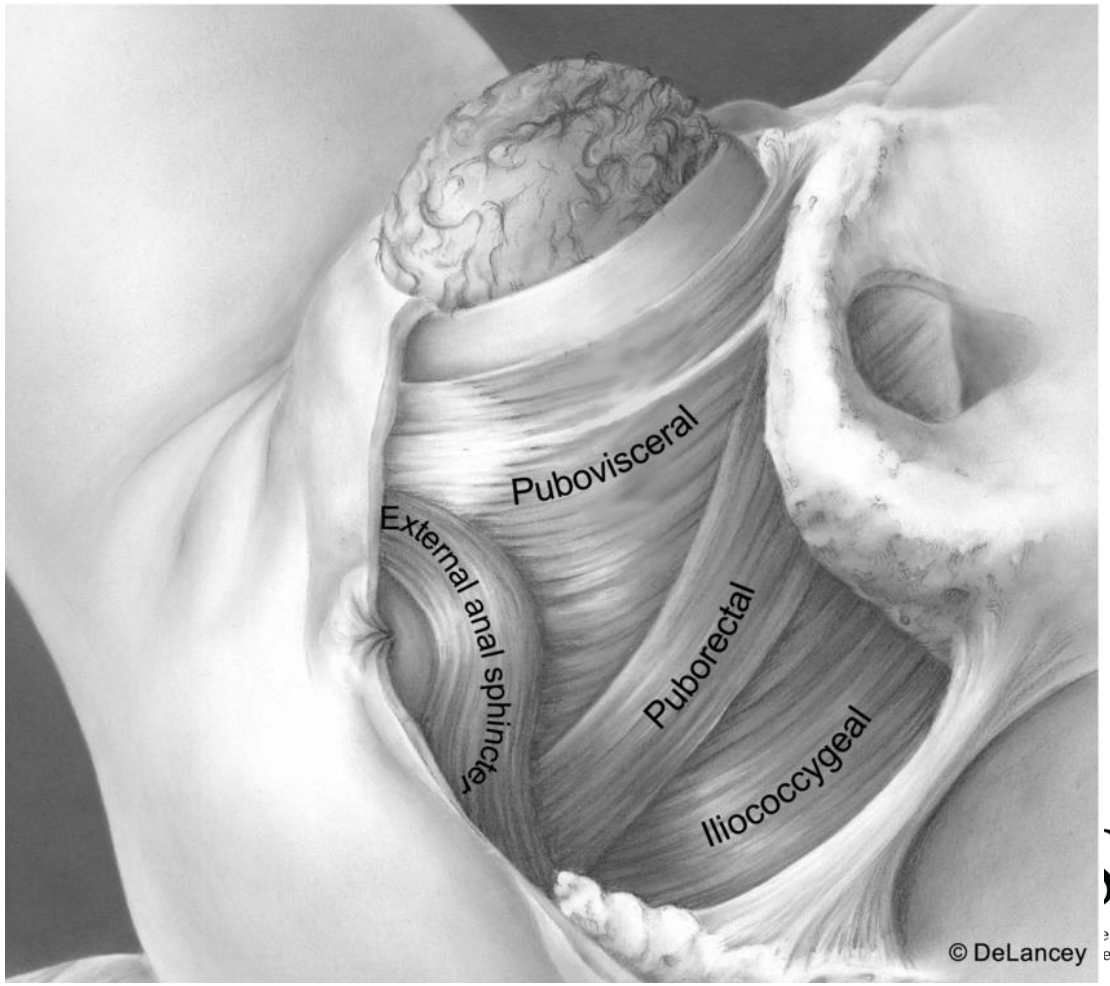
- Ignores:
  - Nerve damage
  - Levator injury / detatchment
  - Fascial deficits
  - Occult anal sphincter injury (OASIS)



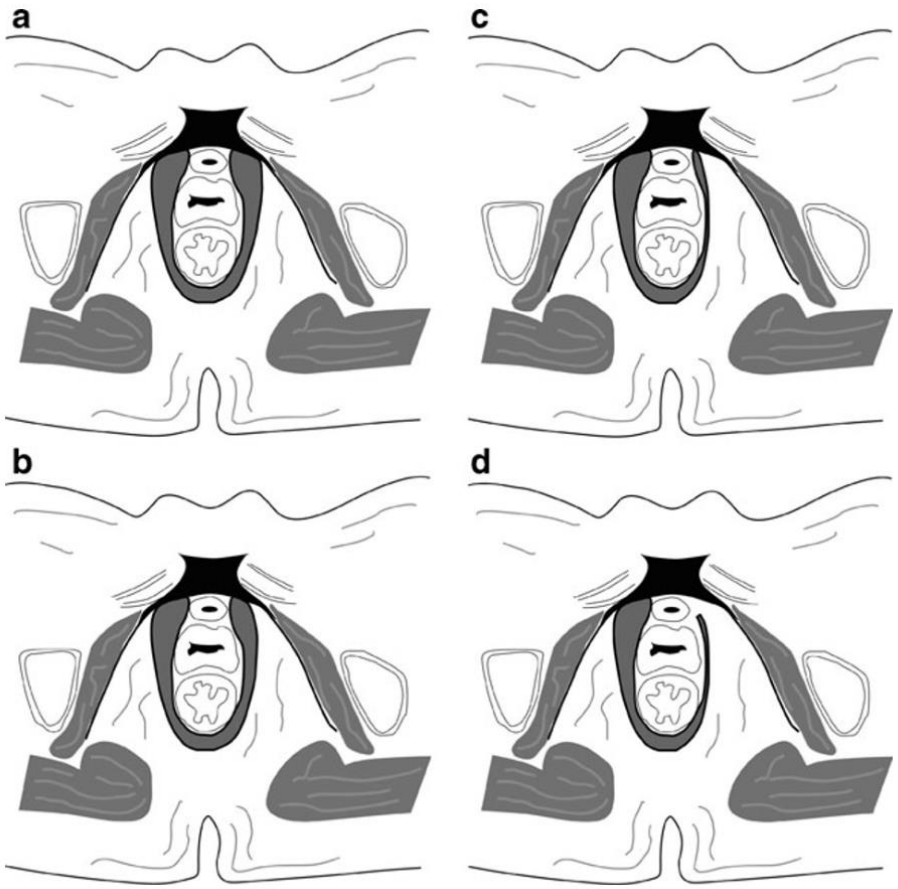
Pelvic Floor Injury

Levator Ani Injury

- Pubovisceral muscle stretches up to 3.3 times its initial length during crowning of the fetal head.
- Levator avulsion has been observed among 20-36% of women who have delivered vaginally.
- 5 fold increase risk with forceps compared to vacuum.



Pelvic Floor Injury



Varying Degrees of Levator Injury

A: Normal

B: <50% Loss

C: >50% Loss

D: Detachment from pubis

Injury results in reduced function and increased genital hiatus.

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Levator Ani Injury – Diagnosis

Physical Exam

- “Specialized” exam with considerable learning curve.
- Moderate interobserver agreement
- Moderate false positive rate:
  - Up to 20% of nulliparous women can be diagnosed with avulsion

Radiology (MRI or Pelvic USS)

- Excellent interobserver agreement
- Expensive

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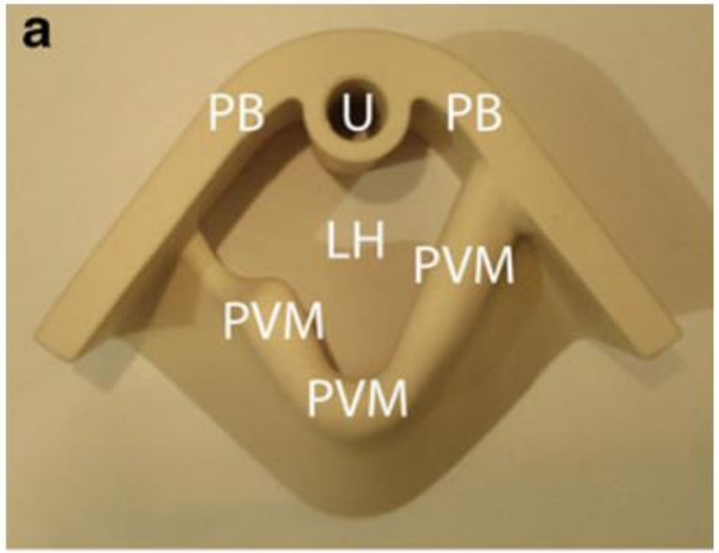
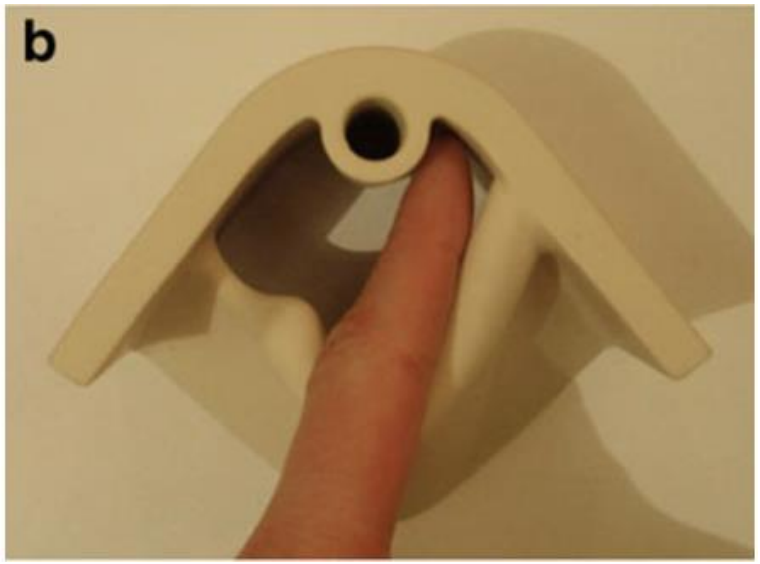
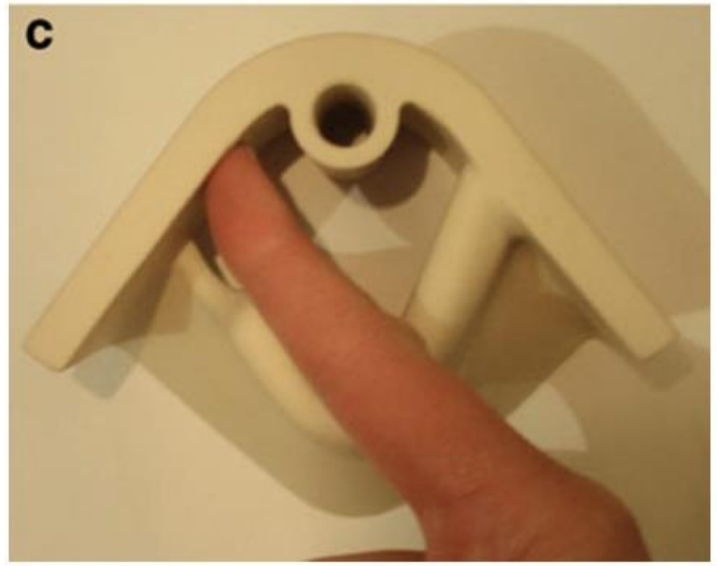
Levator Ani Injury – Physical Exam

Pubovisceral muscle assessment







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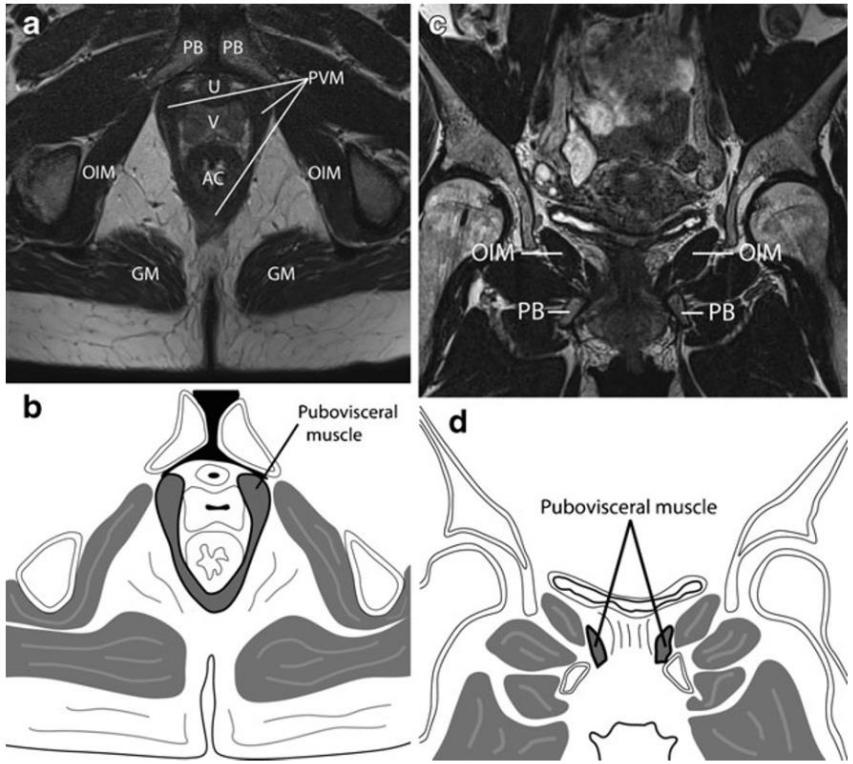
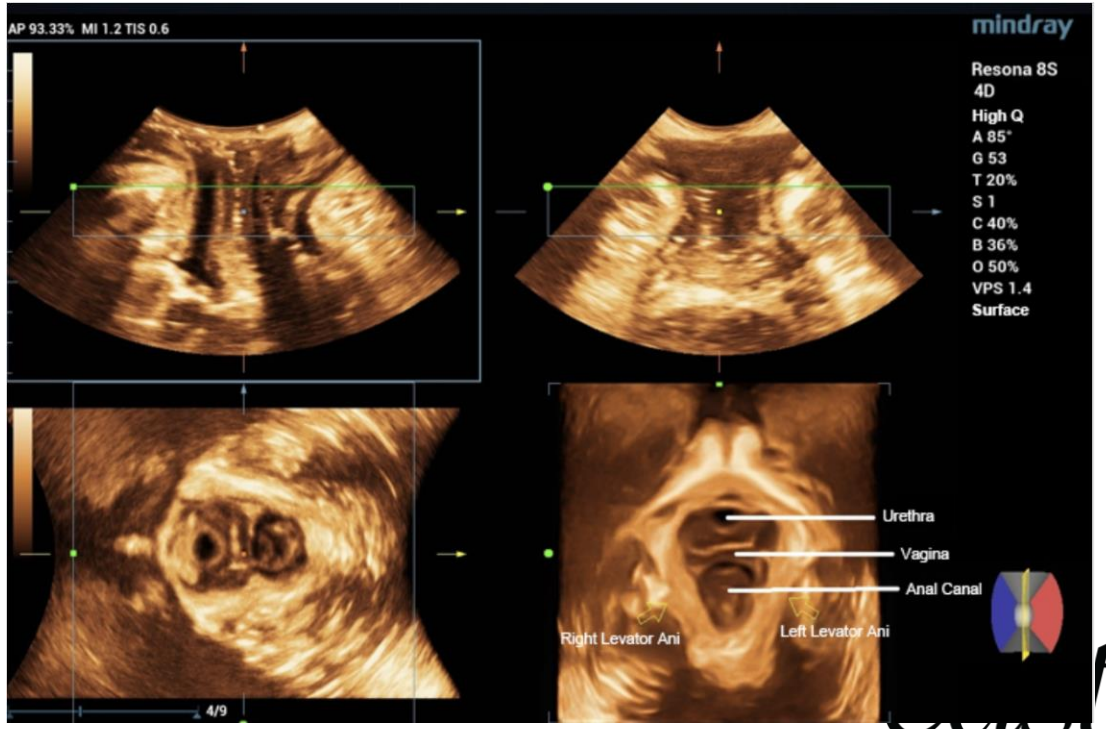
Levator Ani Injury - Radiology

MRI



Ultrasound



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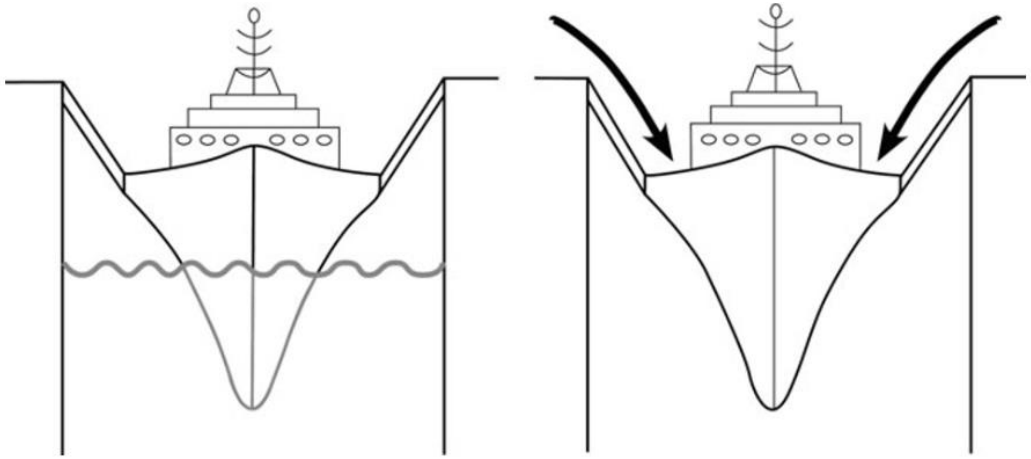
Levator Ani Injury - Consequences

Ship canal / Drydock Analogy

- Water represents pelvic floor
- Cables represent pelvic ligaments.



After injury to pelvic floor, ligaments can initially support pelvic organs, however over time leads to prolapse.

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Levator Ani Injury - Consequences

Muscle Anatomy & Function

- Weaker pelvic floor muscle
- Increase genital hiatus size

Urinary Incontinence

- Unclear whether levator injury contributes to urinary incontinence.
- Longitudinal study of 450 parous women
  - Levator injury associated with prolapse beyond hymen (odds ratio 2.7)
  - Not associated with stress urinary incontinence

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Levator Ani Injury - Summary

- Levator injuries are “hidden”
- Levator injury assessment is a relatively new concept.
  - Relies on radiological diagnosis
- Labour guidelines should incorporate levator injury.

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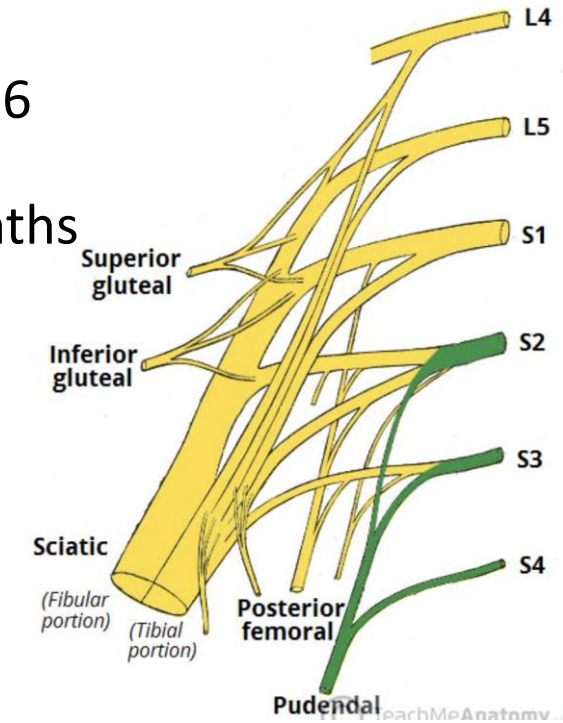
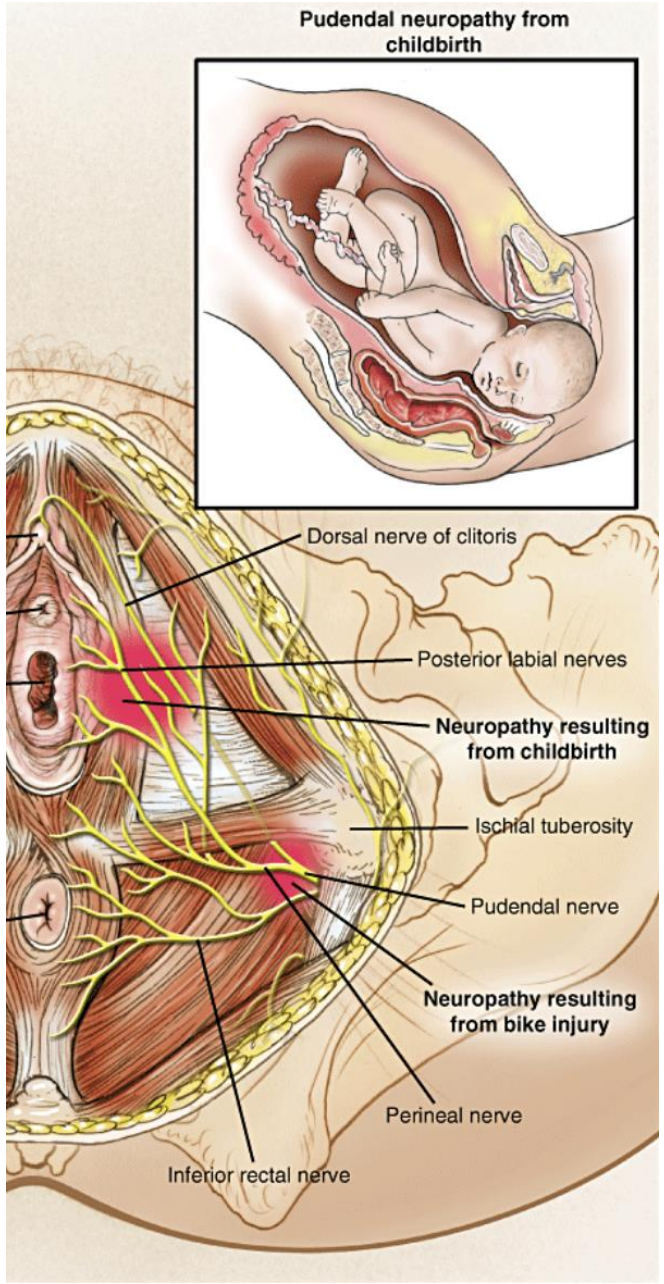
Pudendal Nerve Injury

Denervation injury

- Mechanism by stretching and compression of nerve fibers.
  - 80% of women after delivery
  - Greater with long second stage (>56 mins, large baby 3.4kg)
  - 60% will return to normal at 2 months post partum.

- Remember… innervates
  - Periurethral striated muscle.
  - External anal sphincter

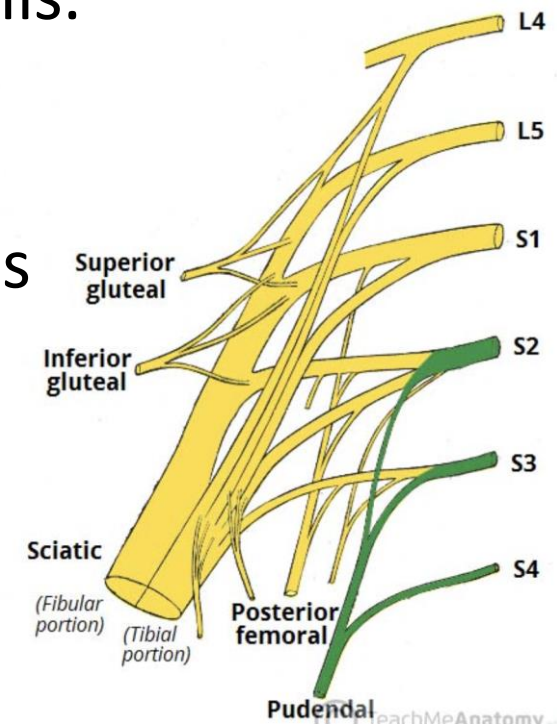


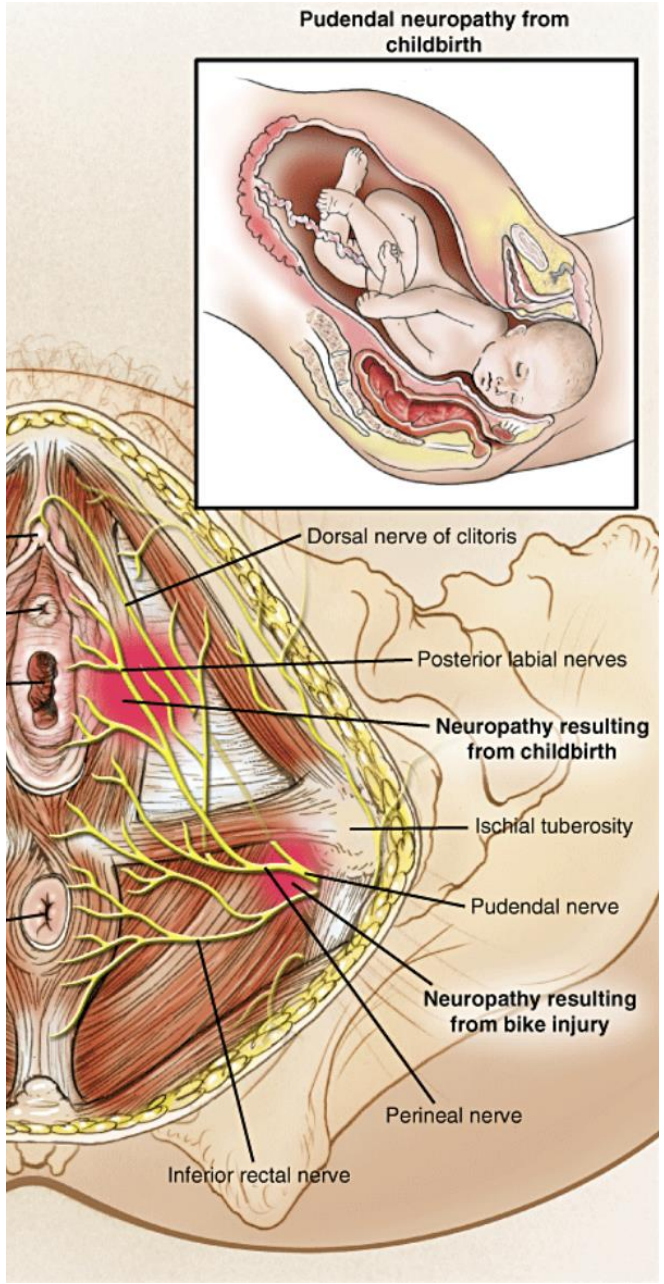


Pudendal Nerve Injury

Consequences

- Damages leads to loss of periurethral striated muscle cells.
- Animal models have demonstrated that injury to pudendal nerve results in stress incontinence.
  - Resolves with distension injury





Pudendal Nerve Injury

Note on SAPPG labour guidelines

- Upper limits for combined passive and active second stage before initiation of obstetric intervention are recommended as follows:
  - 4 hours for nulliparous
  - 3 hours for parous

Study to justify:

- They found that these adverse perinatal outcomes were only worse when second stage was extremely prolonged (≥ 5 hours)

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SAPPG – Length of second stage

Pushing the limits: perinatal outcomes beyond prolonged second stage.

- 661 women
- Examining length of second stage on perinatal outcomes.
- “Second stage ≥5 is a potential tipping point”

Taylor & Francis

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Pushing the limits: perinatal outcomes beyond prolonged second stage

Alexis C. Gimovsky, Leora Aizman, Andrew Sparks & Jordan T. Levine

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SAPPG – Length of second stage

Ignores nerve & levator injury…

Table 2. Maternal outcomes of women with epidural anesthesia ($n = 492$), multivariable analysis.

	PSS versus NSS (adjusted OR, 95% CI)	*p* Value	EPSS versus NSS (adjusted OR, 95% CI)	*p* Value	EPSS versus PSS (adjusted OR, 95% CI)	*p* Value
Total vaginal delivery	0.48 (0.15–1.60)	.2	0.07 (0.03–0.18)	<.001*	0.15 (0.39–0.87)	.005*
Spontaneous vaginal delivery	0.35 (0.16–0.77)	.009*	0.05 (0.03–0.11)	<.001*	0.15 (0.07–0.34)	<.001*
Cesarean delivery	2.07 (0.62–6.89)	.2	13.56 (5.45–33.75)	<.001*	6.54 (2.26–18.90)	.005*
Operative vaginal delivery	1.92 (0.87–4.25)	.1	4.07 (2.06–8.01)	<.001*	2.12 (0.97–4.63)	<.001*
Chorioamnionitis	1.31 (0.49–3.55)	.6	1.27 (0.50–3.25)	.6	0.97 (0.31–3.05)	1.0
Endometritis	NE	NE	NE	NE	NE	NE
Postpartum hemorrhage	1.67 (0.60–4.66)	.3	8.52 (3.99–18.19)	<.001*	5.10 (1.93–13.50)	.001*
Transfusion	NE	NE	NE	NE	NE	NE
3rd or 4th degree perineal laceration	5.24 (1.43–19.24)	.013*	5.87 (1.71–20.17)	.005*	1.12 (0.37–3.44)	.8

NSS: normal second stage; PSS: prolonged second stage; EPSS: extremely prolonged second stage; CI: confidence interval; NE: not estimable. Adjusted for maternal age, race, diabetes, gestational age, fetal position; for the adjusted analysis only cases where fetal position was documented were included.
*$p < .05$.

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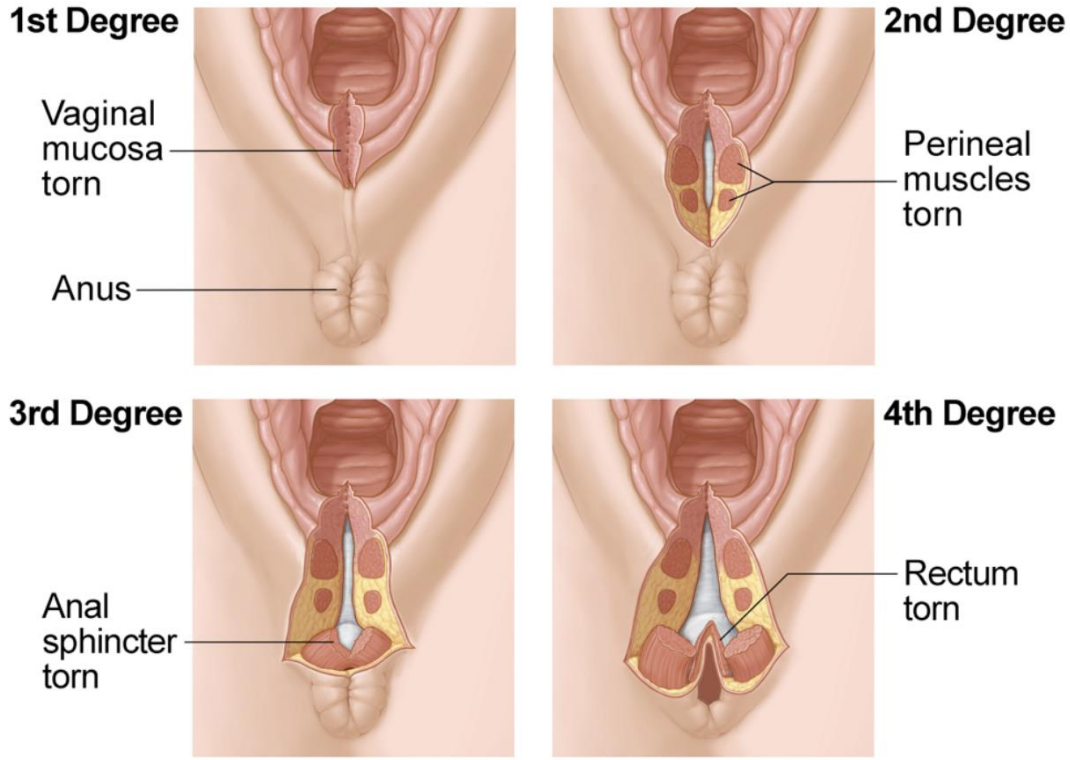
Obstetric Anal Sphincter Injury

OASIS Rates

- OASIS risk: 6.3%
- BJOG Study 25%
- Prospective studies showing that between 20% and 41% of women sustain occult sphincter injuries.



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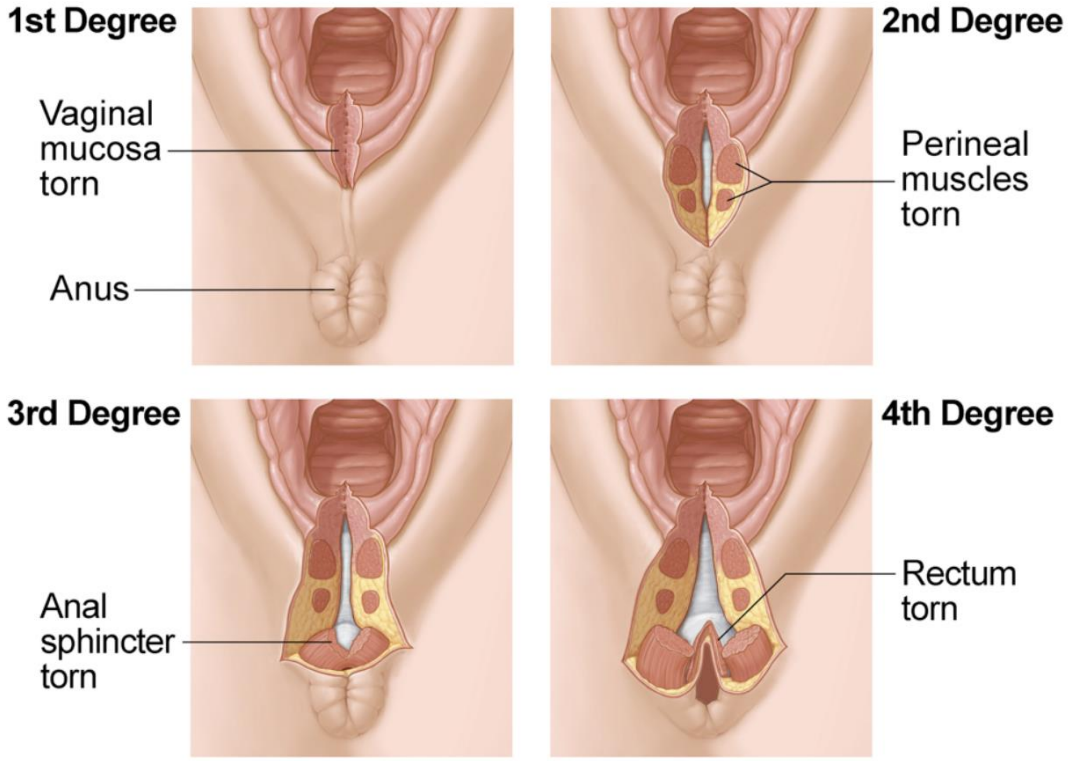
Obstetric Anal Sphincter Injury

- Up to 35 percent of women with a recognized and repaired OASIS will have persistent sonographic defects of the anal sphincter complex 6 to 12 months postpartum.



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www.blackwellpublishing.com/bjog

Occult anal sphincter injuries—myth or reality?

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Accepted 28 September 2005.

Objectives To establish the true prevalence of clinically recognisable and occult obstetric anal sphincter injuries (OASIS).

Design Prospective interventional study.

Setting Busy district general hospital.

Sample Two hundred and fifty-four women having their first vaginal delivery over a 12-month period were invited. Two hundred and forty-one (95%) participated and 208 (86%) attended follow up.

Methods Women had a clinical examination at delivery by the accoucheur and repeated by an experienced research fellow immediately after delivery. All identified OASIS were verified and repaired by the duty specialist registrar or consultant. Endoanal ultrasound was performed immediately postpartum prior to suturing and repeated seven weeks later.

Main outcome measures Prevalence of recognised and occult anal sphincter injuries.

Results Fifty-nine (24.5%) women sustained OASIS. The prevalence of OASIS increased significantly from 11% to 24.5% when women were re-examined. Of these, 30 occurred in deliveries by midwives who missed 26 (87%) and 29 following deliveries by doctors who missed 8 (28%) injuries. All clinically apparent OASIS were also identified on endoanal ultrasound. In addition, three (1.2%) women had an occult anal sphincter injury. Two of these occult sphincter injuries were isolated to the internal anal sphincter (IAS) and would not usually be clinically detectable.

Conclusions OASIS occur more frequently than previously reported. Many remain undiagnosed and are subsequently classified as occult when identified on anal endosonography. Genuine occult injuries are rare. Training in perineal anatomy and recognition of OASIS needs to be enhanced in order to increase detection of OASIS and minimise the risk of consequent anal incontinence.

Please cite this paper as: Andrews V, Sultan A, Thakar R, Jones P. Occult anal sphincter injuries—myth or reality? BJOG 2006; 113:195–200.

Obstetric Anal Sphincter Injury

Primip deliveries

- 59 out of 241 (24.5%) had OASIS on USS at time of delivery

Table 4. Endoanal ultrasound scan findings

Type of injury	No. of cases, *n* = 241 (%)	Anal endosonographic defects prior to perineal repair, *n* = 241 (%)	Anal endosonographic defects at follow up, *n* = 209 (%)
Intact perineum	29 (12)	1/29 (3.4)	1/24 (4.2)
First-degree tear	17 (7.1)	0/17 (0)	0/16 (0)
Second-degree tear	136 (56)	2/136 (1.5)	2/111 (1.8)
3a tear	28 (11.6)	28/28 (100)	0/27 (0)
3b tear	30 (12.4)	30/30 (100)	6/30 (20)
3c tear	0	0/0 (0)	0/0 (0)
Fourth-degree tear	1 (0.5)	1 (100)	0/1 (0)
All third/fourth-degree tears (OASI)	59 (24.5)	59/59 (100)	6/58 (10)

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Table 2. Rates of perineal trauma in deliveries conducted by midwives. The question mark (?) represents suspected anal sphincter injuries and details of these are given in the Results section

	Midwives diagnosis (%), *n* = 173	Research Fellow diagnosis (%), *n* = 173	
Intact perineum	32 (18.5)	Intact perineum	24 (13.9)
		First-degree tear	7 (4)
		Second-degree tear	1 (0.6)
		Third/fourth-degree tear	0
First-degree tear	20 (11.6)	Intact perineum	5 (2.9)
		First-degree tear	5 (2.9)
		Second-degree tear	9 (5.2)
		Third/fourth-degree tear	1 (0.6)
Second-degree tear	111 (64.2)	Intact perineum	0
		First-degree tear	4 (2.3)
		Second-degree tear	82 (47.4)
		Third/fourth-degree tear	25 (14.5)
Third/fourth-degree tear	8 (4.6)	Intact perineum	0
		First-degree tear	0
		Second-degree tear	4 (2.3)
		Third/fourth-degree tear	4 (2.3)
Third-degree tear*	2 (1.2)	Intact perineum	0
		First-degree tear	0
		Second-degree tear	2 (1.2)
		Third/fourth-degree tear	0

*Suspected anal sphincter injuries. See Results section for further details.

OASI Care Bundle

Summary:

1. Inform risk of OASI
2. “Hands on” birth to support perineum
   - Warm compress
   - Perineal massage
3. Episiotomy when essential
   - All instrumental deliveries
4. Examination after birth
   - Vaginal and rectal examination

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OASI Care Bundle:

Implementation guide for maternity sites in the roll-out phase

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Faecal Incontinence

Incidence

OASIS increases the risk of faecal incontinence:

- 1 to 10% without OASIS
- 0 to 28% with OASIS,

Obstetric Anal Sphincter Injury (OASI)

- Incidence 6%
- Symptoms: Faecal urgency, incontinence, perineal pain, discharge
- Beware of occult OASIS
- Refer to specialist service
    - Consider endo-anal ultrasound

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Episiotomy

- **Episiotomy and pelvic floor strength**
  - Mediolateral episiotomy, which typically involves an intentional incision of the levator ani and coccygeus muscles,
  - has been assumed to impact pelvic muscle function.
  - However, a Swedish study reported that mediolateral episiotomy was not associated with pelvic muscle strength six weeks after delivery.

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Pelvic Floor Injury

Management

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Levator Ani Injury

Management:

- No proven treatments levator avulsion with delivery.
  - Similar response to postpartum pelvic muscle exercises.
- Therefore, it is not the standard of care to assess for levator avulsion in the postpartum period.
- Until effective secondary prevention measures are identified, assessment for obstetric levator avulsion does not have clinical value.
  - However, can be useful in research.

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Urinary Incontinence

Management

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Urinary Stress Incontinence

Incidence

- Prospective study of 949 women
  - 22% prior to pregnancy (15% of nulliparous women)
  - 65% during third trimester
  - 31% after delivery

Stress Incontinence

Prognosis

- Women who develop urinary incontinence during pregnancy is generally favourable.
  - 70% experience spontaneous resolution postpartum.
  - Within 12 months postpartum, the prevalence drops to 11% to 23%.
- Women with persistent incontinence postpartum
  - Severity substantially declines in the first year after childbirth

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Urinary Retention

Incidence:

- Post partum urinary retention 1.7% - 17.9%

Causes:

- Injury to the pudendal nerve during the birth process.
  - Can last 2-3 months.
- Anaesthesia
  - Bladder can taken up to 8 hours to regain sensation from last top-up of epidural.

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Urinary Retention

Clinical findings:

- asymptomatic
- small voided volumes
- urinary frequency or urgency
- Slow or intermittent stream
- hesitancy
- bladder pain or discomfort
- urinary incontinence
- straining to void
- sense of incomplete emptying
- no sensation to void

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Urinary Retention

Management:

- Intermittent catheterization. Pharmacological therapies are not effective.

Prognosis:

- Typically a self-limited disorder that can be expected to resolve within one week in most patients (Provided diagnosed and managed)
- Urinary retention can lead to permanent detrusor dysfunction

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Pelvic Floor Injury

Preventing Pelvic Floor Injury

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Preventing Pelvic Floor Disorders

Caesarean delivery

- Associated with a lower risk compared with vaginal delivery
  - 7 to 12 women would have to deliver only by caesarean to prevent one woman from having a PFD later in life.

- Caesarean delivery does not eliminate the risk
  - Prospective cohort study of primiparous women (n = 124) who underwent cesarean delivery before labour found that 22.9 percent reported urinary incontinence at six months.

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Physical Examination

Prolapse Assessment

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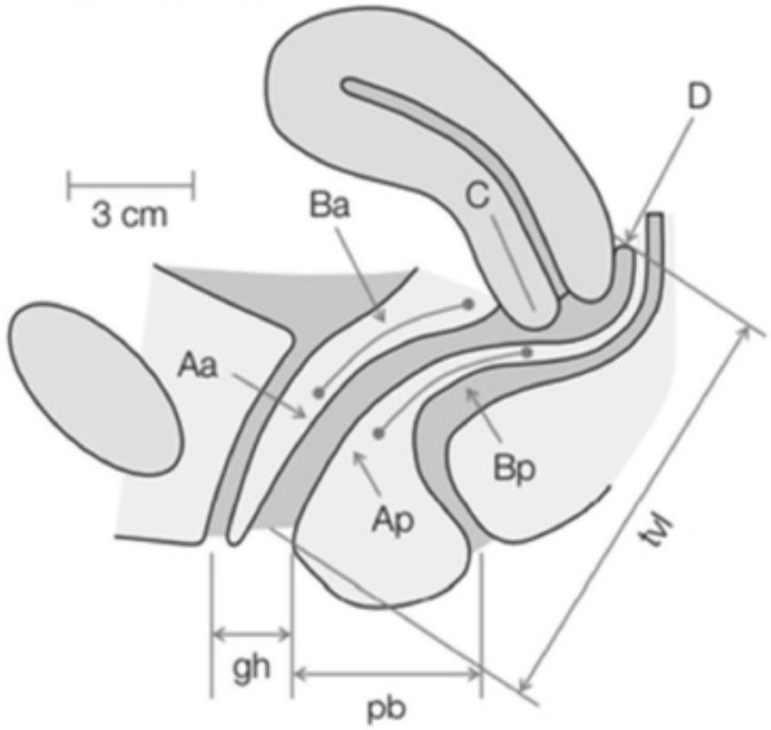
Prolapse Assessment

POP Q



Anterior wall **Aa**	Anterior wall **Ba**	Cervix or cuff **C**
Genital hiatus **gh**	Perineal body **pb**	Total vaginal length **tvl**
Posterior wall **Ap**	Posterior wall **Bp**	Posterior fornix **D**

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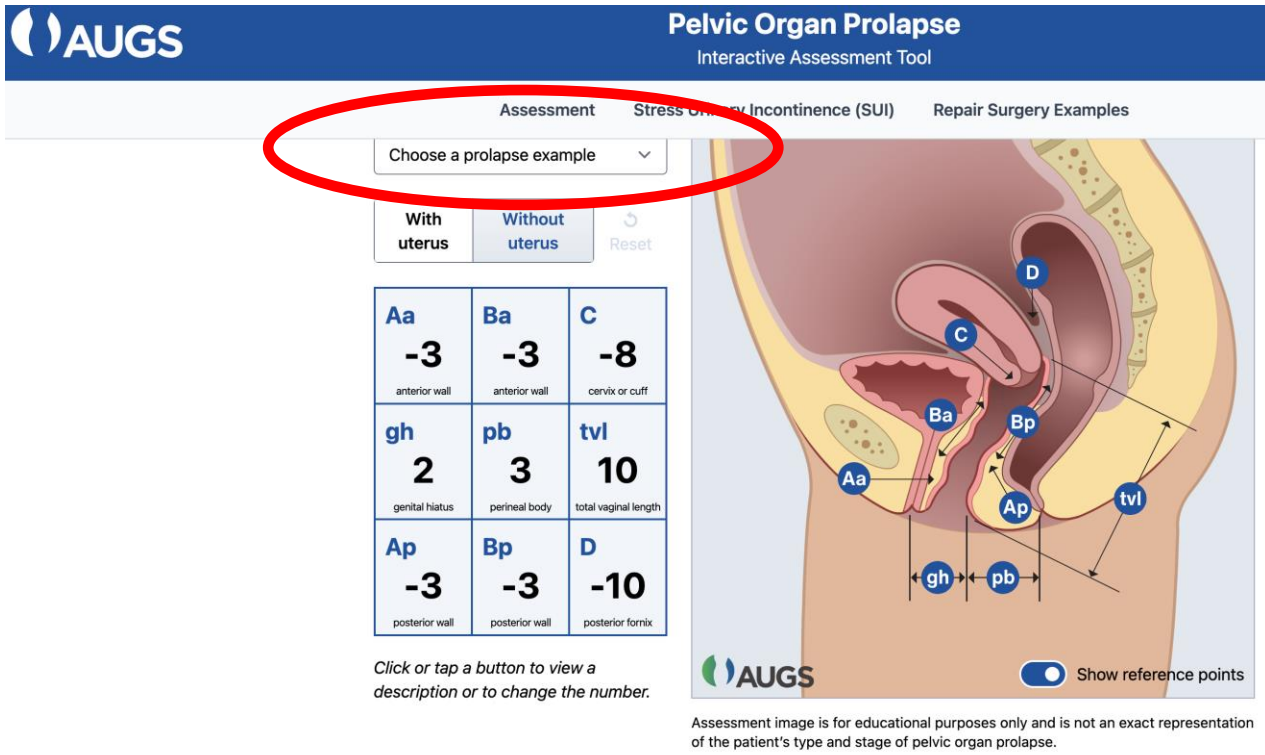
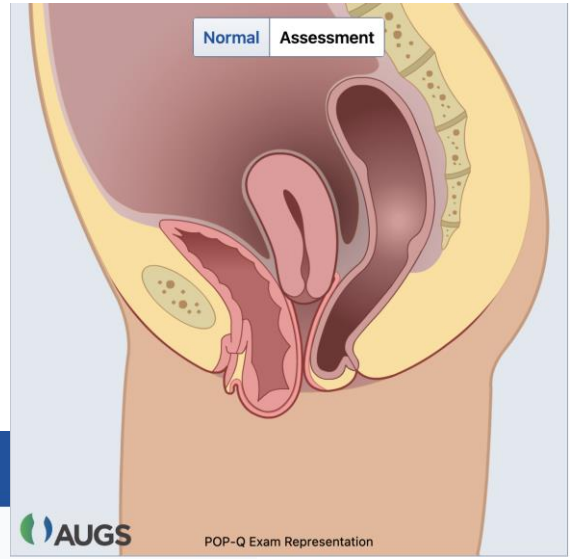
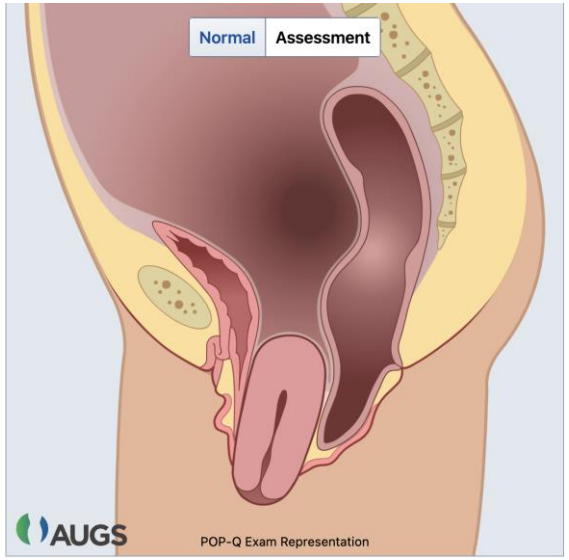
POPQ Netlify

https://pop-q.netlify.app/







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Sex and Contraception

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Resuming Intercourse post partum

- Fears / Concerns:
  - Concerned of changes to the vaginal introitus.
  - Fear that vaginal intercourse will be difficult or painful.
  - physical, emotional, and relationship considerations
- Discuss:
  - Fear is extremely common
  - Reassure pain, oedema, and bruising typically heal well.
  - Should be able to resume vaginal sexual function by approximately six to eight weeks postpartum (depending on the status of the perineum).
  - If unable to resume predelivery sexual activity by three months postpartum should prompt evaluation.

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Vaginal dryness

Evaluation

- Evaluate physical, emotional, and relationship considerations
- Breast feeding vs non-breastfeeding

Lactating

- Vaginal estrogen may be helpful.
  - Hypo-oestrogen state post partum.
  - low dose does not interfere with lactation.

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Perineal pain or dyspareunia

Incidence

- Prolonged postpartum perineal pain and dyspareunia are relatively common.
  - 20% dyspareunia six month after delivery
  - 8% of women noted persistent perineal pain at one year following vaginal delivery.
  - Greater symptoms after instrumental delivery or OASI.

Management

- Although supporting data are limited, initial treatment options include topical estrogen therapy and pelvic floor muscle therapy (PFMT).

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Emotional Wellbeing

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Emotional Wellbeing

- How do we “measure" emotional wellbeing?
  - Indirect questions:
    - Feeding and settling baby
    - Emotional and practical supports
    - Sleep patterns
    - Relationship (Ask of Partners emotional wellbeing)
    - Depressive symptoms such as dysphoria, insomnia, fatigue, and impaired concentration
  - Direct questions:
    - Edinburgh Postnatal Depression Scale (EPDS)

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Emotional Wellbeing

Edinburgh Postnatal Depression Scale

- **0-9:** Presence of some symptoms of distress that may be short-lived and are less likely to interfere with day-to-day ability to function at home or at work.

- **10-12 :** Presence of symptoms of distress that may be discomforting. Repeat the EDS in 2 weeks time and continue monitoring progress regularly.

- **13 +:** Require further assessment and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary.

Item 10: Any woman who scores 1, 2 or 3 on item 10 requires further evaluation before leaving the office to ensure her own safety and that of her baby.

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Postpartum blues vs Depression

Postpartum blues

- Incidence 40%
- No minimum number of symptoms
- Symptoms are mild and self-limited
- Develop within 2-3 days of delivery, peak over the next few days, and resolve within two weeks of onset.

Postnatal Depressions

- Incidence 10-15%
- Minimum of five symptoms
- Must be present for at least two weeks
- Onset of episodes occurs before or during pregnancy in approximately 50 percent of patients.

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iCOPE – Digital EPDS

COPE
Centre of Perinatal Excellence

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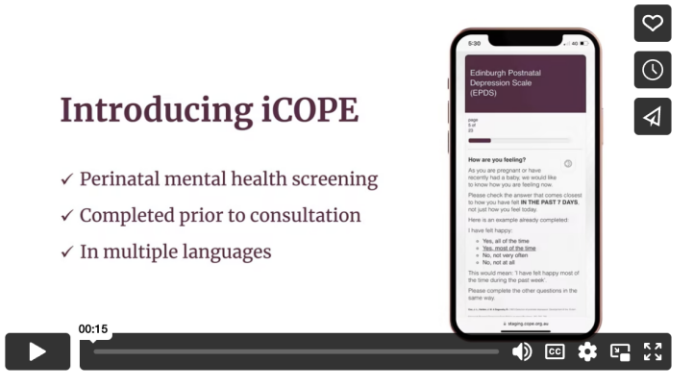
Health Professionals | COPE Online Training: Course Information | **iCOPE Digital Screening** | Health professional information hubs

- **iCOPE Digital Screening**
- iCOPE Information leaflet (Download)
- iCOPE website for information and orders
- Screening in other languages
- Adaption of iCOPE for Aboriginal and Torres Strait Islanders

iCOPE Digital Screening

iCOPE is designed to ensure every mother is provided with the right support for mental health during the perinatal period.

The digital platform screens for symptoms of depression and anxiety and assesses psychosocial risk factors. iCOPE ensures 100% accuracy in scoring, provides automated tailored clinician and patient reports and resources, and facilitates efficient, cost-effective and private screening.



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Where to get help

SAPPG Resource List

- Mental Health Telephone Triage Service (previously ACIS)
- Beyondblue
- Centre of Perinatal Excellence (COPE)
- Perinatal Anxiety and Depression Australia (PANDA)
- Helen Mayo House (Statewide Service)
- Perinatal and Infant Mental Health Services at Metropolitan Hospitals:
- General Practitioner (+/- referral to Mental Health Practitioner)
- Rural and Remote Telemedicine/Tele-Psychiatry Unit
- Child and Family Health Services (CaFHS)

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Birth Debrief

- Invite mother to debrief about birth… do not force it.
  - How did you feel about the birth?
  - Do you have any questions about your birth?

- Give a space to debrief if she needs
  - Positives: gratitude / happiness / high five
  - Negatives: trauma / disappointment / confusion

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