Postnatal care

The general practitioner visit

CPD

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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 postpartum concerns, follow-up management of antenatal comorbidities and contraceptive choices are outlined, along with management of early parenting issues.

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 care recommend the timing of the postnatal visit be individualised and flexible to reflect the woman's needs.[4] The importance of primary care providers delivering postnatal care is emphasised,[5,6] with women reporting they value the identification of health issues, facilitating disclosure regarding concerns and providing support and reassurance where necessary.[7] The postnatal visit includes the physical, emotional and social assessment of both mother and baby; however, this article considers only issues pertaining to the mother.

A mother and newborn commonly present together, and a systematic approach to the consultation allows adequate 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.

Maternal assessment

History, physical examination, education and counselling regarding ongoing general and reproductive healthcare are all considered important. Box 1 outlines aspects of the history. Asking about labour and birth, including delivery complications, provides an opportunity for the mother to debrief about the birth experience or unexpected outcomes and allows assessment for ongoing or future concerns. Women may require counselling regarding the birth outcome if there were unrealised hopes and expectations and will appreciate considered empathic responses to their concerns.

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Box 1. History-taking in the postnatal period

- Pregnancy complications
- Labour and mode of delivery
- Perineal tears
- Bowel and bladder issues
- Immediate postnatal complications
- Length of hospital stay
- Breast concerns – pain with feeding, infant attachment, nipple damage
- Sleep
- Home situation/relationship concerns
- Maternal concerns about the infant
- Mental health assessment
- Sexual health, contraception and future pregnancy planning
- Immunisation status: enquire if antenatal pertussis was given; check rubella immunity status (measles, mumps and rubella vaccine should be offered if the patient is not immune)
- Resus status: if rhesus negative, ask whether Anti-D was recommended or given

Follow-up of antenatal comorbidity

Appropriate medical record documentation and follow-up of antenatal comorbidity is key to improving long-term health outcomes of women after childbirth. Hypertensive diseases in pregnancy are known to lead to consequences of cardiovascular[8] and renal disease.[9] Similarly, women diagnosed with gestational diabetes mellitus are at 10 times progressive risk of developing type 2 diabetes in their lifetimes.[10] Management of postpartum thyroid disease is detailed elsewhere; however, postpartum thyroiditis is common, affecting one in 20 women.[11] Monitoring is required, and consideration is important given that postnatal thyroid disorders increase the risk of postnatal depression.[12] Table 1 outlines the recommended follow-up of common comorbidities.

Perinatal mental health

Mother–infant emotional attachment begins antenatally and continues to grow in the immediate postnatal period, and it can be supported in primary care postnatal visits.[13] Enquiry about feeding and settling the baby, alongside assessment of emotional and practical supports, will gain insight into a woman's home situation and infant and maternal wellbeing. If the woman is in a relationship, it is good practice to ask about the partner's adjustment to parenthood, particularly if the mother appears to be struggling with her mental health. Research indicates fathers are at significant risk of depression and anxiety in this scenario.[14] In addition, the diversity of family structures should be acknowledged, with mothers in same-sex or separated relationships facing unique parenting challenges that may require specific support, resource provision and communication strategies.[15]

Issues of perinatal mental health are addressed in separate *Australian Journal of General Practice* (*AJGP*) articles[16,17] and current guidelines;[18] however, it is important to remember that suicide is one

Table 1. Follow-up of antenatal comorbidities

Antenatal condition	Follow-up advice	Useful resources
Gestational diabetes mellitus	OGTT at six weeks postpartum[2] OGTT every three years[10]	The Royal Australian College of General Practitioners – *Guidelines for preventive activities in general practice*, www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition.pdf The Royal Australian College of General Practitioners – *Management of type 2 diabetes: A handbook for general practice*, www.racgp.org.au/getattachment/41fee8dc-7f97-4f87-9d90-b7af337af778/Management-of-type-2-diabetes-A-handbook-for-general-practice.aspx
Hypertensive disease of pregnancy/pre-eclampsia	Blood pressure check within seven days of delivery and evaluation for signs of end organ damage and the need for antihypertensive medication[2] Recheck at 6–8-week postnatal review Annual blood pressure check and regular (every five years, or more frequent if indicated) assessment of other cardiovascular risk factors including serum lipids and blood glucose[8]	Society of Obstetric Medicine of Australia and New Zealand – *Guideline for the management of hypertensive disorders of pregnancy*, https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/SOMANZ-Hypertension-Pregnancy-Guideline-April-2014.pdf?ext=.pdf
Hypothyroidism	Reduce thyroxine dose to pre-pregnancy levels Regular monitoring of TFTs	'Thyroid disease in the perinatal period'[11] NPS MedicineWise – Thyroid disorders in pregnancy and postpartum, www.nps.org.au/australian-prescriber/articles/thyroid-disorders-in-pregnancy-and-postpartum[12]
Hyperthyroidism	Regular monitoring of TFTs as dose reduction of anti-thyroid medication may be required Consider infant monitoring	

OGTT, oral glucose tolerance test; TFTs, thyroid function tests

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of the leading causes of maternal mortality in Australia.[19] Screening for past or current maternal mental health problems, using the Edinburgh Postnatal Depression Scale alongside a biopsychosocial assessment, is useful. While recognising and counselling women regarding the natural response to a highly anxiety-provoking adjustment to motherhood, it is important to identify those women at significant risk due to pre-existing mental health disorders, not just mood disorder,[19] as well as those with complex biopsychosocial needs such as relationship, domestic violence or trauma issues.

Physical examination and investigations

Suggested physical examinations are listed in Box 2. There are essential physical examinations to be performed; others should be offered or performed if there are specific individual or delivery concerns. There are limited evidence and guidelines recommending routine postnatal investigations. Table 2 lists investigations to consider on the basis of individual presentations.

Management of common conditions

Common postnatal concerns arising within the first 6–7 months postpartum are listed in Box 3,[5] and it is important that general practitioners (GPs) are attuned to indications for referral back to the obstetric unit responsible for the birth, especially in the first two weeks postpartum.

Blood loss

Postnatal vaginal blood loss is variable and difficult to measure[13] but lasts 24 days on average.[20] Antenatally and immediately postnatally, women should receive education regarding the expected pattern of loss and be instructed to seek medical review if lochia becomes heavy, bright red or offensive, or if clots are passed.[5] Secondary postpartum haemorrhage (PPH) is defined as blood loss of >500 mL more than 24 hours after birth and up to 12 weeks postnatally.[21] The differential diagnosis includes retained products, endometritis, uterine atony, haematoma or a coagulation disorder. The clinician should be alert to risk factors including operative delivery, bleeding or coagulation disorders and prolonged or precipitous labour.[21] It is important to examine for abdominal tenderness, uterine involution and signs of shock suggesting the need for emergency assessment.[4] Secondary PPH is usually associated with endometritis. If the patient is haemodynamically stable, management may consist of empirical antibiotics and ultrasonographic assessment for retained products.[22] Suitable empirical antibiotics may include amoxicillin plus metronidazole, but local guidelines should be consulted,[23] and cervical and high vaginal swabs should be sent for culture to direct antibiotic treatment. Clinicians may opt for inpatient management because of the need for frequent monitoring; however, if outpatient management is chosen, regular and close follow-up is required, and patients should be promptly referred

Box 2. Postnatal physical examination[4,5,13]

Essential examinations

- Vital signs – particular focus on blood pressure if there was a history of hypertensive disease in pregnancy
- Temperature
- Breasts – nipple damage, breast lumps, areas that are firm/red/hot
- Fundal height and position/uterine involution
- Abdominal examination – caesarean section wound, tenderness, divarication of rectus sheath
- Cervical screening test, if due

Optional examinations depending on concerns/presentation

- Pallor/signs of anaemia
- Pelvic floor or perineal assessment if issues or complications – check for bruising, suture healing and oedema

Box 3. Common postnatal concerns in the first six months[2,4,16]

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

Table 2. Postnatal investigations according to presentation[2,4]

Postnatal presentation	Possible investigations
Follow-up of pregnancy complication: gestational diabetes mellitus, hypertension or thyroid dysfunction	Refer to Table 1
Iron deficiency or anaemia in pregnancy Heavy uterine bleeding/postpartum haemorrhage	Full blood examination Ferritin
Suspected caesarean section wound infection	Wound swabs
Suspected retained products of conception or endometritis	Pelvic ultrasonography Cervical or high vaginal swabs for culture
If overdue: cervical screen	Cervical screening test
Dysuria, dyspareunia, pelvic pain or urinary incontinence	Midstream urine microscopy, culture and sensitivity

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Table 3. Contraceptive options[32–36]

Contraceptive type	Notes	Contraindications
Options for all women, including those breastfeeding		
Levonorgestrel intrauterine device	• Lasts up to five years • Frequent spotting or bleeding in the first 3–5 months is common; thereafter, the device significantly reduces menstrual bleeding • High level of effectiveness • Can be inserted <48 hours postpartum/immediately after delivery if desired (MEC category 2)	• Insertion 48 hours to four weeks post delivery • Current breast cancer, or breast cancer within the past five years • Ischaemic heart disease or stroke • Unexplained vaginal bleeding • Gestational trophoblastic disease • Cervical, endometrial or ovarian cancer • Distortion of uterine cavity (eg large fibroids) • Current pelvic inflammatory disease • Chlamydial or gonorrhoeal infection • Severe liver disease
Contraceptive implant	• Can be inserted immediately postnatally • Unpredictable bleeding patterns are common; one in five women may experience amenorrhoea • Lasts up to three years • High level of effectiveness, especially if inserted immediately after delivery	• Personal history of, or current, breast cancer • Development of ischaemic heart disease, stroke or transient ischaemic attack during use • Unexplained vaginal bleeding • Severe liver disease
Copper intrauterine device	• Can be inserted <48 hours postpartum/immediately after delivery if desired • After 48 hours, insertion should be delayed until 28 days after childbirth • Can last up to 10 years • Increased risk of pelvic infection in the three weeks after insertion	• Structural uterine abnormalities • Caution in those with a history of dysmenorrhoea or high risk of sexually transmissible infections
Progesterone-only oral contraceptive pill	• Does not reduce breastmilk production • Can be started immediately postnatally • Counsel women on strict dosing timing to improve efficacy and that the pills are taken continuously (no sugar pills)	• Breast cancer • Unexplained vaginal bleeding • Severe liver disease
Depot contraceptive injection	• Can be used in the immediate postnatal period • Administered intramuscularly every 12 weeks • Not recommended as first line for women aged <18 years or >45 years • May be associated with weight gain • May have delayed return to fertility of 12–18 months • Up to 70% of women develop amenorrhoea by 12 months	• Personal history of, or current, breast cancer • Past/current history of ischaemic heart disease, stroke or transient ischaemic attack • Multiple risk factors for cardiovascular disease • Hypertension with vascular disease • Unexplained vaginal bleeding • Severe liver disease
Barrier methods: male or female condoms, diaphragm	• Can be safely used immediately postpartum • Condoms, with typical use, have a high failure rate • Women choosing to use a diaphragm should be advised to wait at least six weeks after childbirth before having it fitted because the size of the diaphragm required may change as the uterus returns to normal size	• Diaphragm: <6 weeks postpartum

Table continues on the next page.

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Table 3. Contraceptive options[32–36] (Cont'd)

Contraceptive type	Notes	Contraindications
Options for those exclusively formula feeding		
Combined oral contraceptive pill	• Counsel women on risks and signs of venous thromboembolism, missed pills management and factors affecting efficacy • Generally safe to use if >6 months postpartum and breastfeeding (MEC category 2)	• Breastfeeding or immediate postnatal period (first 21 days) • Significant risk factors for arterial disease • Migraine with aura • Diabetes with vascular complications • Uncontrolled hypertension • Smoker and aged >35 years
Etonogestrel with ethyinylestradiol-releasing vaginal ring	• Can be used once the mother feels comfortable inserting it from >4 weeks postpartum • Common side effects include vaginitis, change in vaginal discharge or irregular bleeding • Women should check for the ring regularly to ensure it has not been expelled	• <4 weeks postpartum • Anatomical deformation of uterus

MEC, medical eligibility category

to the emergency department if there are additional or ongoing concerns.

Pain

Afterpains following birth are common, as is pain associated with perineal repairs or caesarean section. Women are generally given analgesic advice in hospital and should not require any regular analgesia at review. However, women may present earlier specifically for management of pain. Ibuprofen and paracetamol are appropriate, effective first-line options for postnatal pain, and women should be counselled about their safety in breastfeeding.[24] Aspirin should be avoided in women who are breastfeeding because of the increased infant risk and absorption, and opioids are generally inappropriate in the primary care and postnatal setting because of their established risks.[24] It is prudent to optimise the use of first-line oral analgesics with local pain relief options such as perineal icepacks, nonsteroidal anti-inflammatory drug (NSAID) gels, haemorrhoid creams and heat packs.

Tiredness and fatigue

Tiredness and fatigue are the most common problems identified by new mothers and can be a source of stress affecting mood and cognitive function.[25] Consideration of screening for common postnatal conditions such as anaemia, postpartum depression and thyroid disorders is essential. However, the time taken for infants to establish regular circadian rhythms is variable, and new parents require realistic expectations about sleep disruption and self-management of their own sleep needs.[25] Several strategies may help, including close maternal attachment and exposure to light and dark cues to assist with establishing infant sleep patterns, with no evidence supporting the use of formula feeding to improve sleep.[25] In addition to self-care techniques, daytime naps, exercise and early bedtimes may be useful suggestions for some new parents in coping.[25] Getting help with managing workload, though sometimes difficult for new mothers,[26] is ideal. General advice regarding adequate dietary and fluid intake, encouraging use of social and professional supports – such as Maternal and Child Health nurses and parenting groups – and identifying underlying anxieties and stress are important.

Breastfeeding

Although this issue is discussed in separate *AJGP* articles,[27–29] it is important to remember the vital role of GPs in providing education and promoting and supporting women in their choices to breastfeed or not. It is appropriate to discuss drug and alcohol use while breastfeeding. Although no alcohol use is recommended when breastfeeding, apps such as Feed Safe can be downloaded to reduce harm to infants from alcohol exposure. LactMed can also be a valuable resource for GPs when considering the risk of medication exposure to breastfeeding mothers.

Sexual health, contraception and future pregnancy planning

Relationships and changes in libido and intimacy are important, with women wanting information, support and reassurance from primary care professionals regarding intimacy and sexual satisfaction following childbirth.[30] Sexual morbidity – in the form of dyspareunia, loss of libido and vaginal dryness – is especially common in the first three months postpartum, and the type of delivery, instrumentation and perineal damage contribute significantly.[31] Information regarding expectations of perineal healing and altered continence is often appreciated, especially if women are embarrassed to raise the issue themselves. Recommendations regarding vaginal lubricants or prescription of vaginal oestrogen, graduated resumption of sexual activity, advice for coping with changes in intimate relationships and pelvic floor physiotherapy referral are often welcomed,

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recognising there may be geographical or financial barriers to this.

There are many options for contraception, and a summary of these is provided in Table 3. The timing of ovulation postnatally varies significantly and may occur before menstruation, making unplanned pregnancy in the postnatal period possible. Discussion and commencement of contraception should occur early. Women may be clear regarding future pregnancy planning, and if a pregnancy is being considered early, preconception counselling will need to occur. Extremes of interpregnancy intervals are associated with adverse outcomes, with research suggesting an interval minimum of 12 months as ideal.[32]

Conclusion

The postnatal period is a time of increased physical, emotional and social change for new parents. GPs may want to reconsider the traditional timing of the first postnatal visit to provide earlier intervention as needed. The postnatal period should be viewed as occurring over several months and visits. It encompasses acute medical and chronic disease management and preventive care.

Key points

- 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 as well as necessary counselling, advice and management.
- Antenatal comorbidities should be managed according to current guidelines.
- The postnatal visit is an opportune time to discuss ongoing family planning and provide contraceptive advice.

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