The postpartum period (typically the first six weeks after delivery) may underscore physical and emotional health issues in new mothers. A structured approach to the postpartum office visit ensures that relevant conditions and concerns are discussed and appropriately addressed. Common medical complications during this period include persistent postpartum bleeding, endometritis, urinary incontinence, and thyroid disorders. Breastfeeding education and behavioral counseling may increase breastfeeding continuance. Postpartum depression can cause significant morbidity for the mother and baby; a postnatal depression screening tool may assist in diagnosing depression-related conditions. Decreased libido can affect sexual functioning after a woman gives birth. Physicians should also discuss contraception with postpartum patients, even those who are breastfeeding. Progestin-only contraceptives are recommended for breastfeeding women. The lactational amenorrhea method may be a birth control option but requires strict criteria for effectiveness. (Am Fam Physician 2005;72:2491-6, 2497-8. Copyright © 2005 American Academy of Family Physicians.)

Patient information: A handout on postpartum care, written by the authors of this article, is provided on page 2497.

See editorial on page 2443.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Key Elements of Postpartum Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six to 12 hours postpartum</td>
<td>Three to six days postpartum</td>
</tr>
<tr>
<td><strong>Baby</strong></td>
<td><strong>Six weeks postpartum</strong></td>
</tr>
<tr>
<td>Breathing</td>
<td>Feeding</td>
</tr>
<tr>
<td>Warmth</td>
<td>Infections</td>
</tr>
<tr>
<td>Feeding</td>
<td>Routine tests</td>
</tr>
<tr>
<td>Umbilical cord care</td>
<td>Weight and feeding</td>
</tr>
<tr>
<td>Immunization</td>
<td>Immunoization</td>
</tr>
<tr>
<td><strong>Mother</strong></td>
<td><strong>Six months postpartum</strong></td>
</tr>
<tr>
<td>Blood loss</td>
<td>Breast care</td>
</tr>
<tr>
<td>Pain</td>
<td>Fever</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Infection</td>
</tr>
<tr>
<td>Advice</td>
<td>Lochia</td>
</tr>
<tr>
<td>Warning signs</td>
<td>Mood</td>
</tr>
<tr>
<td></td>
<td>Recovery</td>
</tr>
<tr>
<td></td>
<td>Anemia</td>
</tr>
<tr>
<td></td>
<td>Contraception</td>
</tr>
<tr>
<td></td>
<td>Lactoide</td>
</tr>
<tr>
<td></td>
<td>Developent</td>
</tr>
<tr>
<td></td>
<td>Weaning</td>
</tr>
<tr>
<td></td>
<td>General health</td>
</tr>
<tr>
<td></td>
<td>Contraception</td>
</tr>
<tr>
<td></td>
<td>Continuing morbidity</td>
</tr>
</tbody>
</table>

Postpartum endometritis occurs after 1 to 3 percent of vaginal deliveries; chorioamnionitis and prolonged rupture of membranes increase the risk. A Cochrane meta-analysis found a 7 percent risk of endometritis after elective cesarean section. In nonelective cesarean deliveries, the average endometritis rate was 19 percent in women who received intraoperative antibiotics and 30 percent in women who did not. Clindamycin (Cleocin) and gentamicin are the drugs of choice to manage endometritis, which usually is polymicrobial and involves anaerobes. For prophylaxis during cesarean section, ampicillin and first-generation cephalosporins are the drugs of choice. Broad-spectrum agents or multiple-dose regimens do not seem to offer added benefit.

Urinary incontinence is common during the postpartum period, with a prevalence of 2.7 to 23.4 percent in the first year postpartum. Risk factors for urinary incontinence three months postpartum include higher prepregnancy body mass index, parity, urinary incontinence during pregnancy, smoking, longer duration of breastfeeding, use of forceps, and vaginal delivery (compared with cesarean delivery). Whether prior vaginal delivery is a risk factor for urinary incontinence in postmenopausal women remains unclear, because studies have produced conflicting results.

Thyroid disorders are common in postpartum women, with a prevalence of 4 to 7 percent in the first year postpartum. Incidence peaks at two to five months postpartum. Symptoms of thyroid disorders can include those of hypothyroidism or hyperthyroidism and may overlap with other common postpartum problems (e.g., fatigue, emotional lability, depression). Although thyroid screening is not generally recommended for asymptomatic postpartum patients, physicians should consider screening high-risk women (i.e., those with type 1 diabetes, a history of postpartum thyroiditis, or postpartum depression). Twenty-five percent of women with postpartum hypothyroidism develop long-term hypothyroidism.
**Breastfeeding**

Breastfeeding is beneficial for the baby and the mother. Breastfeeding reduces the baby’s risk for gastrointestinal tract infections and atopic eczema and, for at least six months, it can serve as a contraception method for lactating women who remain amenorrheic postpartum. WHO recommends at least four to six months of breastfeeding and, initially, eight or more feedings per 24 hours. Breastfeeding is a learned skill for mother and baby and can be aided by early practice and encouragement and specific coaching on the positioning and attachment of the infant to the breast. Unrestricted breastfeeding intervals and duration help reduce engorgement and sore nipples and increase the likelihood that the mother will be breastfeeding full time at one month postpartum. Women who have access to bottle supplements at the hospital or at discharge are five times more likely to stop breastfeeding in the first week following delivery and two times more likely to stop in the second week.

A systematic evidence review and meta-analysis found that educational programs were the most effective single intervention in promoting initiation and short-term duration of breastfeeding. Telephone or face-to-face support increased short- and long-term duration of breastfeeding. Written materials did not increase breastfeeding rates. The U.S. Preventive Services Task Force (USPSTF) found fair evidence that combining structured breastfeeding education and behavioral counseling programs increased initiation and continuation rates by up to three months. They also found fair evidence that ongoing support increased continuation rates at six months. The USPSTF found insufficient evidence that counseling by primary care providers during routine visits was effective and poor evidence that peer counseling alone was effective.

Evaluation should begin with a breastfeeding history (i.e., frequency and duration of feeds; nipple problems such as cracking, pain, and bleeding; and mastitis symptoms such as redness, warmth, pain, fever, and malaise). During the physical examination, the physician should ensure proper positioning and attachment of the infant during breastfeeding and assess for nipple problems and engorgement with erythema, tenderness, and induration. Physicians should also encourage the patient to increase the frequency and duration of feedings for maximal milk production, and should suggest that the mother use nipple shields, creams, and topical breast milk for nipple problems.

Early referral to a lactation service or feeding clinic should be considered if the mother is discouraged or struggling, or if infant nutrition is a concern.

Hospitals and health systems usually have lactation services, and local groups also may offer support for the breastfeeding mother. Women who return to work can best maintain breastfeeding if they plan for the challenges of this transition by learning how to use a breast pump and properly store milk.

Early mastitis usually can be managed by improving milk removal through increased nursing and expression of milk (manually or via breast pump). If the mastitis is secondary to an infection and does not improve within 12 to 24 hours, or if initial presentation is severe, antibiotics are indicated (e.g., 500 mg dicloxacillin [Dynapen] or cephalaxin [Keflex] four times daily for seven to 10 days).

**The postpartum period begins one hour after delivery of the placenta and generally lasts six weeks.**

**Postpartum Depression**

Postpartum depression has potentially serious consequences, making early recognition and screening important. Thirty to 70 percent of women experience the “blues,” sadness, and emotional instability with onset in the first week postpartum and resolution by 10 days. The blues generally is considered a physiologic phenomenon triggered by hormonal changes and augmented by sleep deprivation, nutritional deficiencies, and the stress of new motherhood. Postpartum depression is one of the most common complications after childbirth (500,000 cases occur in the United States per year, accounting for 13 percent of postpartum women). A history of postpartum depression increases the risk to 25 percent.

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), postpartum depression has its onset within four weeks postpartum, although studies often define onset up to three months postpartum. The depression usually lasts about seven months if untreated. Predisposing factors include hormonal changes, stressful life events, history of depression, and family history of depression. The mother’s education level, the child’s sex, breastfeeding, mode of delivery, and an unplanned pregnancy are not risk factors. Cultures with strong support systems for new mothers help foster a strong mother-infant bond and have lower rates of postpartum depression.

Symptoms of postpartum depression are similar to nonpostpartum depression and interfere with functioning (e.g., depressed mood; anhedonia; and disturbances

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**Postpartum Office Visit**

The postpartum period begins one hour after delivery of the placenta and generally lasts six weeks.
Postpartum Office Visit

in appetite, sleep, energy, concentration, and attachment). One study found that routine use of the Edinburgh Postnatal Depression Scale (EPDS) screening tool (Figure 1) improved diagnosis rates, facilitating appropriate treatment. The EPDS has been shown to significantly increase identification of high-risk women compared with routine care, and postpartum women residing in the inner city have a surprisingly high prevalence rate (22 percent) when screened with EPDS.

Postpartum evaluation should include screening for depression. Postpartum psychosis usually presents in the first two weeks postpartum as manic, restless behavior. The incidence rate is only 0.1 to 0.2 percent, but rapid referral to psychiatry is critical. Postpartum psychosis is usually a manifestation of bipolar affective disorder, and women with this disorder are at increased risk of recurrence following future pregnancies and stressful life events.

Management of postpartum depression may include cognitive therapy and antidepressant treatment. Identifying high-risk patients and considering starting treatment prior to delivery is appropriate. After determining safety in pregnancy and lactation, physicians should select an antidepressant that has been effective in the past.

Edinburgh Postnatal Depression Scale (EPDS)

1. I have been able to laugh and see the funny side of things:
   - As much as I always could
   - Not quite as much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things:
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason:
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason:
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me:
   - Yes, most of the time I have not been able to cope at all
   - Yes, sometimes I have not been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable:
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying:
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me:
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the 10 items. Women with scores above 12 likely have depression.

Figure 1. Screening tool for postpartum depression. Women are instructed to indicate the answer that comes closest to how they have felt in the past seven days.

Breastfeeding women also may use the lactational amenorrhea method, alone or with other forms of contraception, for the first six months postpartum. For this method to be effective, the woman must be breastfeeding exclusively on demand, be amenorrheic (no vaginal bleeding after eight weeks postpartum), and have an infant younger than six months. The failure rate is less than 2 percent if these criteria are fulfilled.18,48

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