

An Approach to the Postpartum Office Visit

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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.

The postpartum period is an exciting, dynamic time in a woman's life, and the family physician plays an important role in promoting a smooth transition through this period. Physicians can ensure quality postpartum care through a thorough and consistent approach to medical and psychologic conditions. The postpartum period begins

one hour after delivery of the placenta and generally lasts six weeks. After this period, the new mother is in a nonpregnant physiologic state, and lactation—if occurring—is usually well established. The World Health Organization (WHO) points out that although there is no official definition, the traditional six-week duration is consistent with the 40-day period commonly observed in many countries.¹ WHO also recommends a schedule of postpartum care for mother and child (Table 1).² Oversight of four general categories (i.e., medical complications, breastfeeding, postpartum depression, and sexuality and contraception) is vital to a mother's healthy recovery and her baby's healthy start.

Medical Complications

Women with heavy, persistent postpartum bleeding should be evaluated for complications such as retained placenta, uterine atony, laceration, hematoma, or coagulation disorders (e.g., disseminated intravascular coagulopathy, von Willebrand's disease).³ A Cochrane review⁴ found insufficient evidence to recommend specific treatment of secondary postpartum hemorrhage. However, physicians traditionally base their treatment decisions on whether they suspect retained placental fragments.³ No evidence shows that vaginal examination to detect uterine involution is a beneficial part of the routine postpartum visit.⁵

TABLE 1
Key Elements of Postpartum Care

Six to 12 hours postpartum	Three to six days postpartum	Six weeks postpartum	Six months postpartum
Baby			
Breathing	Feeding	Weight and feeding	Development
Warmth	Infections	Immunization	Weaning
Feeding	Routine tests		
Umbilical cord care			
Immunization			
Mother			
Blood loss	Breast care	Recovery	General health
Pain	Fever	Anemia	Contraception
Blood pressure	Infection	Contraception	Continuing morbidity
Advice	Lochia	Libido	
Warning signs	Mood		

Adapted with permission from *Care and service provision in the postpartum period*. In: Department of Reproductive Health and Research, World Health Organization. *Postpartum care of the mother and newborn: a practical guide*. 1998. Accessed online July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.

SORT: KEY RECOMMENDATIONS FOR PRACTICE

<i>Clinical recommendation</i>	<i>Evidence rating</i>	<i>References</i>
Women with heavy, persistent postpartum bleeding should be evaluated for complications (e.g., retained placenta, hematoma, laceration, uterine atony, involution of the uterus, coagulation disorder), and treated accordingly.	C	4
Prophylactic intrapartum ampicillin or first-generation cephalosporins reduce the risk of postpartum endometritis in women undergoing elective and nonelective cesarean section.	A	7, 8
The lactational amenorrhea method of contraception should be used only if the mother is exclusively breastfeeding, amenorrhea is present, and the infant is younger than six months.	B	18, 48
During the early weeks of breastfeeding, mothers should be encouraged to breastfeed eight to 12 times per day on demand.	C	19, 25
Patients should receive structured breastfeeding education and behavioral counseling to promote breastfeeding. Written materials are insufficient.	C	20, 21, 24
Progestin-only contraceptive use should start no earlier than six weeks postpartum in women who are breastfeeding unless, in the physician's judgement, the risk of unintended pregnancy outweigh the risk to the baby.	C	42-45
Progestin-only contraceptives are recommended for breastfeeding women who wish to use hormonal contraception.	C	47
Combination hormonal contraceptive use should not start until three weeks postpartum because of the increased risk of thromboembolism.	C	47

A = consistent, good quality patient-oriented evidence; B = inconsistent or limited quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For more information about the SORT evidence rating system, see page 2416 or <http://www.aafp.org/afpsort.xml>.

Postpartum endometritis occurs after 1 to 3 percent of vaginal deliveries; chorioamnionitis and prolonged rupture of membranes increase the risk.⁶ A Cochrane meta-analysis⁷ 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.⁷ Clindamycin (Cleocin) and gentamicin are the drugs of choice to man-

age endometritis, which usually is polymicrobial and involves anaerobes.⁶ 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.⁸

Urinary incontinence is common during the postpartum period, with a prevalence of 2.7 to 23.4 percent in the first year postpartum.^{9,10} 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).^{9,10} Whether prior vaginal delivery is a risk factor for urinary incontinence in postmenopausal women remains unclear, because studies^{11,12} have produced conflicting results.

Thyroid disorders are common in postpartum women, with a prevalence of 4 to 7 percent in the first year postpartum.¹³ 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).¹⁴ 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).¹⁵ Twenty-five percent of women with postpartum hypothyroidism develop long-term hypothyroidism.¹⁶

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Breastfeeding

Breastfeeding is beneficial for the baby and the mother. Breastfeeding reduces the baby's risk for gastrointestinal tract infections and atopic eczema¹⁷ and, for at least six months, it can serve as a contraception method for lactating women who remain amenorrheic postpartum.¹⁸ WHO recommends at least four to six months of breastfeeding and, initially, eight or more feedings per 24 hours.¹⁹ 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.¹⁹ 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.¹⁹

A systematic evidence review and meta-analysis²⁰ found that educational programs were the most effective single intervention in promoting initiation and short-term duration of breastfeeding.²⁰ 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)²¹ 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.²¹

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).²² 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.²³

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.^{24,25}

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.²⁶

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 bacterial 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 cephalexin [Keflex] four times daily for seven to 10 days).²⁷ Breast abscesses usually require incision and drainage.²⁷

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 postpartum.²⁸ 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.^{28,29} 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).²⁹ A history of postpartum depression increases the risk to 25 percent.²⁹

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.²⁹ The depression usually lasts about seven months if untreated.²⁹ 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.²⁹ Cultures with strong support systems for new mothers help foster a strong mother-infant bond and have lower rates of postpartum depression.³⁰

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

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 so 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.

Reprinted from Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1987;150:785.

in appetite, sleep, energy, concentration, and attachment). One study³¹ found that routine use of the Edinburgh Postnatal Depression Scale (EPDS) screening tool (Figure 1³²) improved diagnosis rates, facilitating appropriate treatment.³¹ The EPDS has been shown to significantly increase identification of high-risk women compared with routine care,³³ and postpartum women residing in the inner city have a surprisingly high prevalence rate (22 percent) when screened with EPDS.³⁴ Postpartum evaluation should include screening for depression.^{33,34}

Postpartum psychosis usually presents in the first two weeks postpartum as manic, restless behavior. The inci-

dence rate is only 0.1 to 0.2 percent, but rapid referral to psychiatry is critical.²⁸ 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.²⁹

Management of postpartum depression may include cognitive therapy and antidepressant treatment. Identifying high-risk patients and considering starting treatment prior to delivery is appropriate.²⁹ After determining safety in pregnancy and lactation, physicians should select an antidepressant that has been effective in the past. Antidepressants and emotional support during and after labor can help prevent postpartum depression

in at-risk women.²⁹ See the accompanying patient education handout for useful self-help networks.

Sexuality and Contraception

Libido and sexuality are common concerns during the postpartum period.³⁵ Libido may decrease after delivery, possibly because of decreased estrogen levels. Some surveys³⁶ have shown that prepregnancy estrogen levels may not return for as long as one year postpartum. The length of time for women to wait to have intercourse following delivery is variable; the average is six to eight weeks in the United States, but it may be shorter or much longer.^{35,36} No consistent correlation exists between delivery complications (e.g., vaginal lacerations) and a delay in resuming intercourse.³⁵⁻³⁷ However, the majority of patients report some type of sexual problem postpartum.³⁷ Breastfeeding can delay the return to intercourse, possibly because estrogen levels remain low in these women.³⁵ Other significant factors affecting postpartum sexual function include body image changes, fatigue, and fear of pregnancy.³⁵

Breastfeeding or not, postpartum women have unique contraceptive needs. Although evidence suggests a delay in resumption of ovulation in breastfeeding women,³⁸ contraception should be addressed before the traditional six-week postpartum office visit to prevent unintended closely spaced pregnancies. The prenatal period is the best time to discuss postpartum contraception; many women feel that these discussions are too brief when held in the hospital after delivery and are crowded by additional postpartum information.³⁹ Written materials also have been shown to improve a woman's ability to make an informed choice about her method of birth control.⁴⁰

Both breastfeeding and nonbreastfeeding women can use barrier contraceptives, intrauterine devices (IUDs; copper-releasing [ParaGard] and hormone-releasing [Mirena]), and progestin-only contraception. Diaphragms and cervical caps must be refitted, usually six weeks after delivery.³ Although IUDs may be inserted immediately after delivery of the placenta, the usual practice in the United States is to wait until six weeks postpartum because of an increased risk of expulsion.⁴¹ WHO recommends breastfeeding women wait six weeks postpartum before starting progestin-only contraceptives (e.g., depot-medroxyprogesterone acetate [Depo-Provera], progestin-only pills). Several studies⁴²⁻⁴⁵ have failed to show that progestin-only contraceptives affect the growth or development of breastfed babies; however, evidence is limited.

Combination estrogen-progestin contraceptives (e.g., oral pills, the patch [Ortho Evra], the vaginal ring

[NuvaRing]) interfere with breast milk production.⁴⁶ The American College of Obstetricians and Gynecologists (ACOG) says that progestin-only contraceptives are the best hormonal contraceptive choice for breastfeeding women.⁴⁷ ACOG also recommends that women wait at least six weeks before starting combination hormonal contraceptives but acknowledges that this may depend on the clinical situation.⁴⁷ Nonbreastfeeding women should wait three weeks before starting estrogen-containing contraceptives because of the increased risk of thromboembolism.⁴⁷

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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REFERENCES

1. Defining the postpartum period. In: Department of Reproductive Health and Research, World Health Organization. Postpartum care of the mother and newborn: a practical guide. 1998. Accessed online July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.
2. Care and service provision in the postpartum period. In: Department of Reproductive Health and Research, World Health Organization. Postpartum care of the mother and newborn: a practical guide. 1998. Accessed online, July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.
3. Bowes WA, Katz VL. Postpartum Care. In: Gabbe SG, Niebyl JR, Simpson JL, eds. *Obstetrics: normal and problem pregnancies*. 4th ed. New York: Churchill Livingstone, 2002:702-8.
4. Alexander J, Thomas P, Sanghera J. Treatments for secondary postpartum haemorrhage. *Cochrane Database Syst Rev* 2002;(1):CD002867.
5. Sharif K, Clarke P, Whittle M. Routine six-week postnatal vaginal examination: to do or not to do? *J Obstet Gynecol* 1993;13:251-2.
6. French LM, Smaill LM. Antibiotic regimens for endometritis after delivery. *Cochrane Database Syst Rev* 2004;(4):CD001067.
7. Smaill F, Hofmeyr GJ. Antibiotic prophylaxis for cesarean section. *Cochrane Database Syst Rev* 2002;(3):CD000933.
8. Hopkins L, Smaill F. Antibiotic prophylaxis regimens and drugs for cesarean section. *Cochrane Database Syst Rev* 1999;(1):CD001136.
9. Wilson PD, Herbison RM, Herbison GP. Obstetric practice and the prevalence of urinary incontinence three months after delivery. *Br J Obstet Gynaecol* 1996;103:154-61.
10. Burgio KL, Zyczynski H, Locher JL, Richter HE, Redden DT, Wright KC. Urinary incontinence in the 12-month postpartum period. *Obstet Gynecol* 2003;102:1291-8.

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11. Brown JS, Grady D, Ouslander JG, Herzog AR, Varner RE, Posner SF; for the Heart & Estrogen/Progestin Replacement Study (HERS) Research Group. Prevalence of urinary incontinence and associated risk factors in postmenopausal women. *Obstet Gynecol* 1999;94:66-70.
12. Thom DH, Brown JS. Reproductive and hormonal risk factors for urinary incontinence in later life: a review of the clinical and epidemiologic literature. *J Am Geriatr Soc* 1998;46:1411-7.
13. Gerstein HC. How common is postpartum thyroiditis? A methodologic overview of the literature. *Arch Intern Med* 1990;150:1397-400.
14. Stagnaro-Green A. Postpartum thyroiditis. *J Clin Endocrinol Metab* 2002;87:4042-7.
15. Amino N, Tada H, Hidaka Y, Crapo LM, Stagnaro-Green A. Therapeutic controversy: screening for postpartum thyroiditis. *J Clin Endocrinol Metab* 1999;84:1813-21.
16. Othman S, Phillips DI, Parkes AB, Richards CJ, Harris B, Fung H, et al. A long-term follow-up of postpartum thyroiditis. *Clin Endocrinol (Oxf)* 1990;32:559-64.
17. Kramer MS, Chalmers B, Hodnett ED, Sevkovskaya Z, Dzikovich I, Shapiro S, et al, for the PROBIT Study Group. Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the Republic of Belarus. *JAMA* 2001;285:413-20.
18. Kennedy KI, Visness CM. Contraceptive efficacy of lactational amenorrhoea. *Lancet* 1992;339:227-30.
19. Breastfeeding. In: Department of Reproductive Health and Research, World Health Organization. Postpartum care of the mother and newborn: a practical guide. 1998. Accessed online July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.
20. Guise JM, Palda V, Westhoff C, Chan BK, Helfand M, Lieu TA. The effectiveness of primary care-based interventions to promote breastfeeding: systematic evidence review and meta-analysis for the U.S. Preventive Services Task Force. *Ann Fam Med* 2003;1:70-8.
21. U.S. Preventive Services Task Force. Behavioral interventions to promote breastfeeding: recommendations and rationale. *Ann Fam Med* 2003;1:79-80.
22. Andolsek KM, Copeland JA. Benign breast conditions and disease. In: Taylor RB, David AK, eds. *Family medicine: principles and practice*. 6th ed. New York: Springer, 2003:898.
23. Gjerdingen DK. Postpartum care. In: Taylor RB, David AK, eds. *Family medicine: principles and practice*. 6th ed. New York: Springer, 2003:135.
24. Palda VA, Guise JM, Wathen CN, for the Canadian Task Force on Preventive Health Care. Interventions to promote breast-feeding: applying the evidence in clinical practice. *CMAJ* 2004;170:976-8.
25. Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, et al. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics* 2005;115:496-506.
26. Biagioli F. Returning to work while breastfeeding. *Am Fam Physician* 2003;68:2201-8.
27. Puerperal mastitis. In: Department of Reproductive Health and Research, World Health Organization. Postpartum care of the mother and newborn: a practical guide. 1998. Accessed online July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.
28. Psychological problems in the postpartum period. In: Department of Reproductive Health and Research, World Health Organization. Postpartum care of the mother and newborn: a practical guide. 1998. Accessed online July 29, 2005, at: http://www.who.int/reproductive-health/publications/msm_98_3/.
29. Wisner KL, Parry BL, Piontek CM. Clinical practice. Postpartum depression. *N Engl J Med* 2002;347:194-9.
30. Miller LJ. Postpartum depression. *JAMA* 2002;287:762-5.
31. Georgiopoulos AM, Bryan TL, Wollan P, Yawn BP. Routine screening for postpartum depression [published correction appears in *J Fam Pract* 2001;50:470]. *J Fam Pract* 2001;50:117-22.
32. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1987;150:782-6.
33. Ferguson SS, Jamieson DJ, Lindsay M. Diagnosing postpartum depression: can we do better? *Am J Obstet Gynecol* 2002;186:899-902.
34. Morris-Rush JK, Freda MC, Bernstein PS. Screening for postpartum depression in an inner-city population. *Am J Obstet Gynecol* 2003;188:1217-9.
35. Glazener CM. Sexual function after childbirth: women's experiences, persistent morbidity and lack of professional recognition. *Br J Obstet Gynaecol* 1997;104:330-5.
36. Von Sydow K. Sexuality during pregnancy and after childbirth: a meta-content analysis of 59 studies. *J Psychosom Res* 1999;47:27-49.
37. Byrd JE, Hyde JS, DeLamater JD, Plant EA. Sexuality during pregnancy and the year postpartum. *J Fam Pract* 1998;47:305-8.
38. Campbell OM, Gray RH. Characteristics and determinants of postpartum ovarian function in women in the United States. *Am J Obstet Gynecol* 1993;169:55-60.
39. Hiller JE, Griffith E, Jenner F. Education for contraceptive use by women after childbirth. *Cochrane Database Syst Rev* 2002;(3):CD001863.
40. Johnson LK, Edelman A, Jensen J. Patient satisfaction and the impact of written material about postpartum contraceptive decisions. *Am J Obstet Gynecol* 2003;188:1202-4.
41. Grimes D, Schulz K, Van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices. *Cochrane Database Syst Rev* 2003;(1):CD003036.
42. World Health Organization Task Force for Epidemiological Research on Reproductive Health. Special Programme of Research, Development, and Research Training in Human Reproduction. Progestogen-only contraceptives during lactation: I. Infant growth. *Contraception* 1994;50:35-53.
43. World Health Organization Task Force for Epidemiological Research on Reproductive Health. Special Programme of Research, Development, and Research Training in Human Reproduction. Progestogen-only contraceptives during lactation: II. Infant development. *Contraception* 1994;50:55-68.
44. World Health Organization Task Force on Oral Contraceptives. Effects of hormonal contraceptives on breast milk composition and infant growth. *Stud Fam Plann* 1988;19(6 pt 1):361-9.
45. Jimenez J, Ochoa M, Soler MP, Portales P. Long-term follow-up of children breast-fed by mothers receiving depot-medroxyprogesterone acetate. *Contraception* 1984;30:523-33.
46. Truitt ST, Fraser AB, Grimes DA, Gallo MF, Schulz KF. Combined hormonal versus nonhormonal versus progestin-only contraception in lactation. *Cochrane Database Syst Rev* 2003;(2):CD003988.
47. American College of Obstetricians and Gynecologists. ACOG Educational Bulletin. No. 258, July 2000. Breastfeeding: maternal and infant aspects. *Obstet Gynecol* 2000;96:1-16.
48. World Health Organization Task Force on Methods for the Natural Regulation of Fertility. The World Health Organization multinational study of breast-feeding and lactational amenorrhoea. III. Pregnancy during breast-feeding. *Fertil Steril* 1999;72:431-40.