Practice Guidelines

Interpregnancy Care: Guidelines from ACOG and SMFM

Key Points for Practice

- Clinicians should review women's prescription and nonprescription medications and environmental exposures for potential teratogens before the next pregnancy.
- During the interpregnancy period, all women should be asked about their use of tobacco, alcohol, and drugs.
- Women should be advised to avoid interpregnancy intervals shorter than six months and counseled about the risks and benefits of intervals shorter than 18 months.

From the *AFP* Editors

Interpregnancy care is the care provided to women of childbearing age who are between pregnancies. The interpregnancy period provides an opportunity to address complications or medical issues that developed during pregnancy, to assess women's mental and physical well-being, and to optimize long-term health. The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) have published guidelines focusing on interpregnancy care to improve outcomes of future pregnancies and the overall health of women, regardless of their future pregnancy plans.

Anticipatory guidance should begin during pregnancy and include the development of a postpartum care plan that addresses the transition to parenthood and interpregnancy or well-woman care. Family planning counseling should also begin during the prenatal period, with conversations about the woman's desire to have more children. In women with chronic medical conditions, the interpregnancy period is an opportune time to optimize health before a subsequent pregnancy and to promote future health.

Breastfeeding and Maternal Health

HIGH-QUALITY EVIDENCE

Clinicians should routinely provide guidance and support to enable women to breastfeed. Multiple studies have shown that longer duration of breastfeeding is associated with improved maternal health. Benefits include a lower risk of diabetes mellitus, hypertension, myocardial infarction, ovarian cancer, and breast cancer. Although exclusive breastfeeding is recommended for the first six months of life, clinicians should support each woman's informed decision about whether to initiate or continue breastfeeding.

Congenital Abnormalities

HIGH-QUALITY EVIDENCE

Women who are planning to become pregnant or are capable of becoming pregnant should take 400 mcg of folic acid daily, beginning at least one month before fertilization and continuing through the first 12 weeks of pregnancy. Those who have had a child with a neural tube defect should take 4 mg of folic acid daily, beginning at least three months before fertilization and continuing through the first 12 weeks of pregnancy.

Clinicians should review women's prescription and nonprescription medications and environmental exposures for potential teratogens before the next pregnancy.

MODERATE-QUALITY EVIDENCE

The interpregnancy period is an ideal time for clinicians to provide genetic counseling and carrier screening. A genetic and family history of the patient and her partner should be obtained (e.g., genetic disorders; birth defects; mental disorders; breast, ovarian, uterine, and colon cancers).

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

This series is coordinated by Sumi Sexton, MD, Editor-in-Chief.

A collection of Practice Guidelines published in *AFP* is available at https://www.aafp.org/afp/practguide.

CME **This clinical content** conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 79.

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LOWER-QUALITY EVIDENCE

Clinicians should review postnatal or pathologic information with women who have a history of pregnancies affected by congenital abnormalities or genetic disorders. Genetic counseling should be offered, if appropriate, to estimate the risk to subsequent pregnancies.

Substance Use, Weight, and Nutrition

HIGH-QUALITY EVIDENCE

Smokers should be offered smoking cessation support before pregnancy through behavioral interventions, pharmacotherapy, or both. Tobacco use should be reassessed at the postpartum visit, with continued assistance for ongoing cessation efforts.

During the interpregnancy period, all women should be asked about their use of alcohol and drugs (e.g., prescription opioids, marijuana, other medications or substances used for nonmedical reasons) and referred for substance use disorder and relapse prevention programs when appropriate. Women who are planning to become pregnant in the immediate future should be encouraged to discontinue recreational substance use. Women should be counseled that no amount of alcohol use is safe during pregnancy.

Actionable advice about nutrition and physical activity should be provided using proven behavioral techniques. Although the most effective method for achieving weight loss goals is unclear, it most likely includes diet or diet plus exercise. Because bariatric surgery is associated with improved metabolic health, it should be considered in women with a body mass index of 40 kg per m^2 or greater or a body mass index greater than 35 kg per m^2 and at least one serious obesity-related morbidity.

LOWER-QUALITY EVIDENCE

Women should be encouraged to reach their prepregnancy weight by six to 12 months postpartum and achieve a normal body mass index (19 to 25 kg per m^2). Lowering body mass index between pregnancies is associated with improved perinatal outcomes, making it an important topic during interpregnancy care.

Interpregnancy Interval

MODERATE-QUALITY EVIDENCE

Women should be advised to avoid interpregnancy intervals (the time between birth and the start of the next pregnancy) shorter than six months and counseled about the risks and benefits of intervals shorter than 18 months. Although most data from observational studies in the United States suggest an increase in risks with short interpregnancy intervals, this has become less clear with more recent research. However, because interpregnancy interval is a modifiable risk factor, it may be beneficial to educate mothers about the potential benefits of interpregnancy intervals longer than six months.

LOW-QUALITY EVIDENCE

Interpregnancy interval recommendations should not be any different for women with a history of infertility.

Depression

MODERATE-QUALITY EVIDENCE

One in seven women experiences perinatal depression and anxiety. All women should be screened for depression in the postpartum period and again as part of well-woman care during the interpregnancy period, with systems in place to ensure accurate diagnosis and appropriate treatment and follow-up. Screening may also occur at well-child visits as long as there are procedures for communicating accurate information to the maternal care clinician. Use of a validated screening instrument, such as the Patient Health Questionnaire-9 or Edinburgh Postnatal Depression Scale, is recommended.

Preterm Birth

MODERATE-QUALITY EVIDENCE

Women with a history of preterm birth are at increased risk of subsequent preterm births. The discussion of ideal interpregnancy intervals is especially important in these women. There is insufficient evidence to recommend screening for and treating asymptomatic genitourinary infections in the interpregnancy period in women at high risk of preterm birth.

History of Cesarean Delivery

MODERATE-QUALITY EVIDENCE

Women with prior cesarean deliveries, particularly those who are considering a trial of labor in future pregnancies, should be counseled that a shorter interpregnancy interval increases their risk of uterine rupture (interval of 18 to 24 months or less) and their maternal morbidity and need for transfusion (interval less than six months).

Other Medical Concerns

HIGH-QUALITY EVIDENCE

Women with a history of sexually transmitted infection should be assessed to determine risk of repeat infection or current or subsequent infection with HIV or viral hepatitis. Women at high risk of sexually transmitted infections should be offered appropriate screening following guidelines from the Centers for Disease Control and Prevention. All women should be counseled about safe sex practices. Partners should be screened and treated as appropriate.

MODERATE-QUALITY EVIDENCE

Women of childbearing age should be screened for intimate partner violence (e.g., domestic violence, sexual coercion, rape) and referred for appropriate intervention services. Because of the high incidence of intimate partner violence, screening is recommended at all clinician encounters, including postpartum visits, well-woman visits, and the first prenatal visit and at least once per trimester.

LOWER-QUALITY EVIDENCE

To improve interpregnancy care of women with communication needs, such as low-health literacy or limited English proficiency, clinicians should consider using patient navigators, trained medical interpreters, health educators, and promotoras (i.e., lay community health care workers who work in Spanish-speaking communities).

Guideline source: American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Not reported

Recommendations based on patient-oriented outcomes? Yes

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