**BMJ 10-minute consultation: The maternal six week postnatal check**

Adam D. Jakes1, Pippa Oakeshott2, Debra Bick3

1Academic Clinical Fellow in Obstetrics and Gynaecology, Guy’s & St Thomas’ Hospital NHS Trust, London, UK.

2Professor of General Practice, Population Health Research Institute, St George's, University of London, London, UK.

3Professor of Maternal Health, Warwick Clinical Trials Unit, Warwick Medical School, University of Warwick, Coventry UK.

**Word count:** 1586

**Key words:** childbirth, general practice, maternal morbidity, postnatal review

*A 29-year-old woman is seeing her GP for a 6-week postnatal check after her first baby. Her labour was induced at 41+0 weeks gestation for post-dates and she had a vaginal birth with a second-degree tear. Her baby is well, exclusively breastfed and gaining weight. Her partner has returned to work and she has no family who live in the area.*

The maternal 6-week postnatal check is a long-established part of routine postnatal care. It typically includes a review of the mother’s physical and mental health, the events of her pregnancy and birth, and discussion of future health considerations.[1] It is also an opportunity to identify the 10-15% of women who may develop postnatal depression [2-4], provide ongoing management of medical complications of pregnancy such as gestational hypertension or gestational diabetes [5, 6] and discuss post-partum contraception. This article offers an approach to the maternal 6 week (or 6-8 week) postnatal check.

**What you should cover**

If available, check the woman’s maternity care discharge summary before the consultation so that you are aware of her medical and previous pregnancy history, the circumstances surrounding the birth, and the health of her baby. Although there is a lot to get through in a short 10 or 15 minute consultation it is important to identify the most pressing needs of the woman. Start by asking some open-ended questions: how is she finding parenthood? Has she any worries about her own or her baby’s health? Suggested answers to some common questions are given in Box 1.

**Psychosocial symptoms**

* *Social* *–* Explore her home circumstances and support. Does she have any family in the area, or friends with babies? Are there other children at home? Ask sensitively what support she is getting from their partner, family or friends.
* *Mood* *–* Ask about her emotional wellbeing and screen for postnatal depression using the following questions recommended by NICE[2]:
	+ During the past month, have you often been bothered by feeling down, depressed or hopeless?
	+ During the past month, have you often been bothered by having little interest or pleasure in doing things?

Take a more detailed history for possible postnatal depression if she says yes to either question, or if she is at risk of mental health problems due to personal or family history, does not seem to be bonding with her baby, or you have other clinical concerns. Consider using the Edinburgh Postnatal Depression Scale, as this is a validated tool for assessing post-partum depression [2-3]. GP and health visitor follow-up and/or referral to mental health services should be considered as appropriate.[2]

* *Lifestyle –* Ask about smoking, alcohol or illicit drugs.
* *Sleep –* Is she getting any daytime sleep to supplement loss of nighttime sleep? Sleep disturbance is, of course, normal for new parents, but can precipitate or exacerbate post-partum depression and/or anxiety. If she is struggling to cope, explore practical solutions such as whether there are family members who can help with nighttime infant care?
* *Labour and birth* *–* Is there anything she would like to discuss about her labour and birth?[1] If she has concerns, would it be helpful to arrange a consultation with her midwife or obstetrician?

 **Physical symptoms**

* *Breastfeeding –* Ask if she is breast or bottle feeding, and if so, how it is going? Consider signposting to the health visitor/lactation consultant or observing lactation and latching if the woman has ongoing concerns. Discuss symptoms of mastitis such as breast pain, redness and fever/flu like symptoms, and stress the need for an urgent GP appointment if she develops these symptoms.
* *Wound healing –* Does she feel that her perineal tear/episiotomy wound has healed?
* *Vaginal bleeding –*Lochia after childbirth should have stopped by six weeks. If ongoing or purulent consider referral to the emergency gynaecology unit for assessment.
* *Bladder function* *–* Does she leak small amounts of urine when she coughs or sneezes? Prevalence of postpartum urinary incontinence is estimated at up to 47% in the first 12 months postpartum but usually improves over time.[7] Encourage regular pelvic floor muscle exercises (Box 1). If urinary symptoms are severe and/or persist, consider referral to physiotherapy or pelvic floor therapy for further assessment.
* *Bowel function* – Ask about constipation and offer laxatives if dietary measures have not been effective. Haemorrhoids may also be an ongoing problem. Ask about problems with loss of bowel control, especially in women who had an instrumental vaginal birth and/or gave birth to a large baby.[7]
* *Venous thromboembolism –* A relatively hypercoagulable state persists for up to 12 weeks post-partum.[8] Dyspnoea or calf pain/swelling warrants further examination.

**Sexual intercourse and contraception**

* *Sex* - Has she felt interested in resuming sexual intercourse? Less than half of postnatal women had resumed sex by 6 weeks in a recent prospective study.[9] Stating that she can have sex again when she is ready can be helpful, as some women may be waiting for the ‘all clear’ from their doctor.
* *Contraception* – Discuss contraception options, taking into account whether she is breastfeeding (Table 1).[10]
* *Smear test* – If she is due for a cervical smear this should be performed around three months after the birth.[12]
* *Vaccination status* – Women who were found to be non-immune to Rubella during their pregnancy should be offered the MMR vaccine, provided there is no risk she is currently pregnant again.[1] The vaccine is safe in breast feeding women and can prevent fetal rubella syndrome in a future pregnancy.[13]

**What you should do**

Offer a focused examination, tailored to the woman’s concerns and likelihood of post-partum complications.

* *Blood pressure* (if needed for contraception or monitoring after gestational hypertension)
* *Weight and body mass index (BMI) –* If BMI >30, NICE recommendoffering referral to a structured weight management programme or dietician.[14] It is important to do this in a sensitive and non-judgemental manner.
* *Urine* – check for proteinuria if they had pre-eclampsia or a history of renal dysfunction. If there is proteinuria (1+ or more) review again at three months postpartum to assess renal function and specialist advice sought if necessary.[5]
* *Perineal tear/Episiotomy wound* – Offer to examine her perineum, particularly if she reports pain, abnormal bleeding or vaginal discharge, to assess for signs of infection or delayed/poor healing.[1]
* *Offer contraception* as appropriate (Table 1).

**Follow-up for specific pregnancy complications**

*Anaemia (haemoglobin <100g/L)*

* Women who were anaemic during pregnancy and prescribed oral iron replacement should continue this until six weeks postpartum.[15]
* Current guidance on postpartum anaemia from the British Society of Haematology is to prescribe 100–200mg elemental iron daily for three months (e.g. ferrous sulphate 200mg tablets twice daily).[15]
* Nausea, epigastric discomfort and constipation are common side effects, especially at doses above 45mg per day.[16] Taking just one iron tablet daily combined with a diet of iron-rich foods may be sufficient where higher doses are not tolerated.[17]
* Absorption of iron can be maximized by taking supplements one hour before meals and with a source of vitamin C such as orange juice. Avoid taking antacids, calcium supplements, tea and coffee at the same time as they can impair absorption.
* The British Society of Haematology recommend repeating a full blood count and ferritin at the end of treatment to ensure haemoglobin and iron stores are replete.[15] In practice this may not be necessary if the woman has no symptoms of anaemia.

*Gestational diabetes*

* Women who develop gestational diabetes in pregnancy have a seven-fold increased lifetime risk of developing type 2 diabetes.[18]
* For women with a history of gestational diabetes, recommend a fasting plasma glucose test between 6-13 weeks postpartum.[6] Annual screening using HbA1c is recommended thereafter.[6]
* Offer lifestyle advice including weight control, diet and exercise to reduce the risk of developing diabetes.

 *Gestational hypertension and pre-eclampsia*

* Gestational hypertension or pre-eclampsia may develop in a future pregnancy, and are associated with double the risk of developing high blood pressure, heart disease and stroke in later life.[5]
* Recommend a healthy diet, support for weight management (if needed), regular physical exercise and annual blood pressure checks.
* Explain that she should take aspirin 75mg daily from 12 weeks gestation in any future pregnancy to reduce their risk of pre-eclampsia.[5]

|  |
| --- |
| **Box 1: Questions women may ask at their 6 week check***When can I have sex again?* You can have sexual intercourse again when you feel emotionally and physically ready. Usually it takes a few weeks for perineal stitches to heal, and often much longer for you to feel interested in sexual intercourse. If intercourse is painful, a lubricant may help.*When can I start to do physical exercise again?* Start low-impact exercise such as brisk walking as soon as you feel ready – typically within two weeks following vaginal delivery. Try to build up exercise gradually, such as running, swimming and cycling, to your pre-pregnancy levels. Limit high-impact exercise (for example using heavy weights) until after six weeks after childbirth.*When will my periods start again?*Vaginal blood loss (lochia) following childbirth should have ceased by six weeks. If you are breastfeeding, your periods may not return until you reduce or stop breastfeeding.*How do I do pelvic floor muscle exercises?** Squeeze and draw in your back passage as if you're holding in wind.
* Squeeze around your vagina and bladder tube (urethra) as if you're stopping the flow of urine or squeezing during intercourse.

Do these exercises for up to 10 seconds or until the muscles get tired at least four times a day. Consider setting reminders on your phone, or installing an app to help: <https://www.nhs.uk/apps-library/squeezy/> |

|  |  |
| --- | --- |
| **Contraceptive method** | **Timeframe of initiation** |
| Fertility awareness methods  | Not recommended - the signs and symptoms of fertility and ovulation may be difficult to detect after childbirth and during breastfeeding |
| Lactation amenorrhoeic | If amenorrhoeic and exclusively breastfeeding may be considered up to 6 months post-partum |
| Male and female condom | Any time after childbirth (UKMEC 1) |
| Diaphragm or cap | After 6 weeks because the size of diaphragm required may change as the uterus returns to normal size |
| Progesterone-only pill (POP) | Any time after childbirth (UKMEC 1) |
| Progesterone-only implant | Any time after childbirth (UKMEC 1) |
| Progestogen-only injectable(depot medroxyprogesterone acetate)  | Any time after childbirth (UKMEC 2 due to theoretical concerns of an increased risk of VTE compared to other progestogen-only methods) |
| Combined hormonal contraption (COC)(pill, ring or patch) | *Not-breastfeeding*21 days after delivery if no other risk factors for venous thromboembolism (UKMEC 1) |
| *Breastfeeding*After 6 weeks if no other risk factors for venous thromboembolism (UKMEC 2) |
| Intrauterine contraception(Intrauterine system or copper intrauterine device) | Within 48 hours of childbirth (vaginal or Caesarean section) or after 28 days postpartum (UKMEC 1). Women should be inform that there is a small increased risk of uterine perforation up until after 36 weeks postpartum in breastfeeding women (5:1000 vs. <1:1000).[11] |
| Tubal ligation | Any time after childbirth provided she definitely does not ever want more children. |

Table 1: Contraceptive choices after childbirth[10]
*UKMEC: UK Medical Eligibility Criteria for Contraceptive Use.*

**What you need to know**

* The maternal 6 week postnatal check is an opportunity to review a woman’s physical, emotional and social wellbeing, discuss contraceptive and offer lifestyle advice.
* Pregnancy-specific conditions such as gestational hypertension, pre-eclampsia, and gestational diabetes require postnatal follow-up and education regarding the long-term risks and the risk of recurrence in future pregnancies.
* One iron tablet daily for three months, combined with an iron-rich diet, can be a more practical way to manage postpartum anaemia, where side effects of iron supplementation are a problem.

**Education into practice**

* What proportion of postnatal women at your practice attend their 6 week postnatal check?
* Do you ensure pregnancy complications such as gestational diabetes are coded in the problem summary of the patient’s health record?
* Do you have a recall system for women who have had hypertensive disorders in pregnancy to offer annual blood pressure checks, and in women who have had gestational diabetes to offer an annual HbA1C?

**How patients were involved in the creation of this article**

Twenty women who gave birth at St Thomas’ Hospital in London were approached and asked to feedback their experiences from their maternal 6 week postnatal check. They were asked about what questions they wanted answering at this review, and the top four were included in Box 1. They were also asked to read and comment on the article resulting in Box 1 and the ‘physical symptoms’ section being expanded.

**References**

1. National Institute for Health and Care Excellence. (2015). Postnatal care up to 8 weeks after birth. (NICE Clinical Guideline No. 37).
2. National Institute for Health and Care Excellence. (2018). Antenatal and postnatal mental health: clinical management and service guidance. (NICE Clinical Guideline No. 192).
3. Jones I, Shakespeare J. Postnatal depression. BMJ 2014; 349 :g4500.
4. Shorey S, Chee CYI, [Ng ED](https://www.ncbi.nlm.nih.gov/pubmed/?term=Ng%20ED%5BAuthor%5D&cauthor=true&cauthor_uid=30114665), [Chan YH](https://www.ncbi.nlm.nih.gov/pubmed/?term=Chan%20YH%5BAuthor%5D&cauthor=true&cauthor_uid=30114665), Tam WWS, Chong YS.Prevalence and incidence of postpartum depression among healthy mothers: A systematic review and meta-analysis. J Psychiatr Res. 2018 Sep;104:235-248.
5. National Institute for Health and Care Excellence. (2019). Hypertension in pregnancy: diagnosis and management. (NICE Guideline No. 133).
6. National Institute for Health and Care Excellence. (2015). Diabetes in pregnancy: management from preconception to the postnatal period. (NICE Guideline No. 3).
7. Brown S, Gartland D, Perlen S, McDonald E, Macarthur C. 2015. Consultation about urinary and faecal incontinence in the year after childbirth: a cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology,* 122**,** 954-962.
8. McDonald, E, Brown, S. Does method of birth make a difference to when women resume sex after childbirth?. *BJOG* 2013; 120: 823– 830.
9. Kamel H, Navi BB, Sriram N, Hovsepian DA, Devereux RB, Elkind MS. Risk of a thrombotic event after the 6-week postpartum period. N Engl J Med 2014;370:1307-15.
10. Faculty of Sexual & Reproductive Healthcare (FSRH). Contraception After Pregnancy. January 2017. <https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/>
11. Heinemann K, Reed S, Moehner S, Minh TD. Risk of uterine perforation with levonorgestrel-releasing and copper intrauterine devices in the European Active Surveillance Study on Intrauterine Devices. Contraception. 2015 Apr;91(4):274-9.
12. Public Health England. (2016a) NHS cervical screening programme: colposcopy and programme management. Public Health England.
13. Public Health England. Immunisation against infectious disease. Rubella: the green book, chapter 28.
14. National Institute for Health and Care Excellence. (2010). Weight management before, during and after pregnancy. (Public health guidance No. 27).
15. Pavord S, Myers B, Robinson S, Allard S, Strong J, Oppenheimer C. UK guidelines on the management of iron deficiency in pregnancy. Br J Haematol. 2012;156:588‐600.
16. Institute of Medicine. Food and Nutrition Board. Dietary Reference Intakes for Vitamin A, Vitamin K, Arsenic, Boron, Chromium, Copper, Iodine, Iron, Manganese, Molybdenum, Nickel, Silicon, Vanadium, and Zinc: a Report of the Panel on Micronutrients. Washington, DC: National Academy Press; 2001.
17. Peña-Rosas JP, De-Regil LM, Gomez Malave H, Flores-Urrutia MC, Dowswell T. Intermittent oral iron supplementation during pregnancy. Cochrane Database of Systematic Reviews 2015, Issue 10. Art. No.: CD009997.
18. Bellamy L, Casas JP, Hingorani AD, Williams D. Type 2 diabetes mellitus after gestational diabetes: a systematic review and meta-analysis. Lancet. 2009 May 23;373(9677):1773-9.

**Competing interests**
We have read and understood the BMJ policy on declaration of interests and declare the following interests: none.

**Contributors**

All authors contributed according to ICMJE guidelines. ADJ proposed the article to the BMJ. ADJ, PO and DB contributed to planning and drafting the article. All authors contributed to revising the article and approved the final version. ADJ is responsible for the overall content as the guarantor.

**Licence**

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution, iii) create any other derivative work(s) based on the Contribution, iv) to exploit all subsidiary rights in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above.