Postpartum Care: A Beginning not The End

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Who are we?
A. I care for mothers postpartum in the hospital
B. I see mothers for the “6 wk postpartum visit”
C. I care for women of childbearing age in the outpatient setting
D. Both A and B
E. All of the above

So much to do!
• Contraception
• Breastfeeding/Infant Care
• Mood
• Medical/physical issues

In-hospital postpartum care often brief
6 wk postpartum visits poorly attended
Focus is on the BABY
What more could we be doing?

- Focus on longer term maternal health issues in addition to short term issues
- Realize that postpartum care has larger implications for women and their families
- Redefine postpartum period as the beginning of interconception care

Maximizing the Post-partum Visit

- Interconception Care Project for California
- March of Dimes and ACOG District IX Project with Preconception Health Council of California (PHCC)
- Goal: Produce post-partum care guidelines for obstetric providers that incorporate risk assessment based on the previous pregnancy and develop recommendations for future care

Preconception Health and the Life Course Perspective

ICPC Guidelines Content Areas

- Alcohol Use
- Anemia
- Domestic Violence
- Gestational Diabetes
- Gonorrhea and Chlamydia
- Hepatitis
- HIV
- Hypertension
- Migraine
- Obesity
- Postpartum Depression
- Preclampsia
- Preterm Birth
- Cesarean Section
- Seizure
- Substance Abuse
- Syphilis
- Thrombocytopenia
- Thyroid Disorder
- Tobacco Use
- Vaccinations
Rubella

- Do not give during pregnancy and avoid pregnancy x 28 days
- Not an indication for termination
- If lab evidence of immunity, no need to repeat
- If neg or equivocal titer after 1-2 doses, give third dose and stop checking titer
- Ok for children of pregnant women to get
- May give with Rhogam, check titer in 3 months

Varicella

- Lab evidence of immunity or disease
- Birth in US before 1980 is not sufficient for pregnant women
- Diagnosis or verification of history of varicella or zoster by health care provider
  - Should have link to a typical case or lab confirmation if testing done during acute infection

Mary is 36 yo G2P2 delivered 2 days ago via cesarean delivery. She had declined the Tdap and flu shot pregnancy because she was afraid of it hurting the baby. Now she is willing to accept these two immunizations if you still recommend them. She got the flu shot last season and got a Tdap after her last pregnancy in 2011.
What immunizations should she get?

A. Tdap only  
B. Influenza only  
C. Both  
D. Neither

![Bar chart showing percentages of Tdap and influenza vaccinations.]

**Tdap**

- If not given prenatally between 27-36 weeks, no need to give postpartum if up to date
- Immunize other family members

**Answer B**

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**Short Interpregnancy Interval**

- Preterm birth, SGA, LBW and perinatal death
  - IPI <3 months: 60% LBW c/w 13-14 months
  - IPI <6 months: 30% LBW c/w 18-23 months
  - IPI < 5 mo: 15% SGA c/w 12-23 months
- PPROM, cardiovascular defect, autism
- Anemia, placental abruption, endometritis, placenta previa, uterine rupture

Shachar BZ, Lyell DJ. *Obstet Gynecol Surv* 2012;67:584-96
Zhu BP et al. *NEJM* 1999
Grisaru-Granovsky S *Contraception* 2009

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**Contraception**

worth talking about
What is the causal factor?

- Maternal depletion
  - protein, macro and micronutrients
  - evidence not clear

- Folate depletion
  - Low 3-4 months PP; improve w supplementation
  - Strong evidence

- Cervical insufficiency
  - collagen concentration in cervix not normalized until 12 months PP

- Inflammation


Is there an ideal IPI?

- WHO and US Agency for International Development
  - Recommend IPI > 2 years after a live term birth
  - IPI > 5 years increased risk for adverse outcomes
  - Aligns with WHO breastfeeding recommendation

- Studies support IPI 18-24 months
  - birth to conception
  - 12 months for moms >35 yo

Wendt A, Gibbs CM, Peters S, Hogue CJ. *Paediatr Perinat Epidemiol* 2012

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**California Unintended Pregnancies**

Almost half of live births in California result from unintended pregnancies

- 64.8
- 49.4
- 37.1
- 33.0

<table>
<thead>
<tr>
<th>Percent (%)</th>
<th>Black</th>
<th>Hispanic</th>
<th>White</th>
<th>Asian/Pacific Islander</th>
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<tbody>
<tr>
<td>State Total</td>
<td>44.6</td>
<td></td>
<td></td>
<td></td>
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</table>

- 64.8
- 49.4
- 37.1
- 33.0

Percent of mothers in California with a recent live birth by race/ethnicity, 2007

Data Source: Maternal and Infant Health Assessment Survey
**Nonbreastfeeding**

- Mean day 1st ovulation 45-94 day
- Mean 1st menstruation 45-64
- 20-71% first menses preceded by ovulation but more than half abnormal (30-100%) (compromised fertility)
- Earliest day of ovulation day 25

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**Lactation Amenorrheic Method**

- Fully breastfeeding or nearly full breastfeeding and amenorrhea
  - 98% effective x first 6 months
- Exclusively breastfeeding
  - Total contraception x 10 weeks


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**Not fully breastfeeding**

- Ovulation returns 6 wk after supplementation
- Half of women not fully breastfeeding resume menses by 6 weeks

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**Rule of 3s**

- Fully Breastfeeding
  - Initiate contraception at 3 months postpartum
- Not breastfeeding
  - Initiate contraception at 3 weeks postpartum
Mary (36 yo G2P2 s/p CS; BMI 35) was discharged on POD #4. She was certain she was not going to have intercourse but promised that she would use condoms if it happened. She left the hospital breastfeeding and was breastfeeding well when you saw her a week later for her baby’s first visit.

She comes in for a 3 week postpartum visit. She found it too difficult to breastfeed with all her other responsibilities. She is interested in taking “the pill”. She wants to wait at least 2 years before getting pregnant again. She suspects that she may be having intercourse in the next week.

What would you offer her?
A. Progestin only pill (POP) because you hope she will go back to breastfeeding
B. POP because her risk of DVT right now is too high postpartum to start on COC
C. COC because she has stopped breastfeeding and it is more effective than POP
D. Talk her into using a LARC (implant, IUD)

Kind of a trick question…
Answer: NOT C

Progestins
- Considered safe even immediately postpartum
- Progestins are transferred via breastmilk
- Theoretical concerns but no harms seen

<table>
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<tr>
<th>WHO</th>
<th>3</th>
<th>&lt;6 weeks</th>
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<tbody>
<tr>
<td>US Med Eligibility Criteria</td>
<td>2</td>
<td>&lt;1 month breast</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>No breast</td>
</tr>
<tr>
<td>UK Medical Eligibility Criteria</td>
<td>1</td>
<td></td>
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</table>
**OCPs and breastfeeding**

- COCs decreases quality and quantity of breastmilk but no difference in infant growth or supplementation in well nourished moms
- COC associated with decreased rate of breastfeeding after 6 months
- POP modest increase in milk production; breastfeed longer and later time to supplementation

**Initiating COC postpartum**

- VTE risk increases by 2-5x postpartum
- Risk declines by more than half second week postpartum
- Returns to baseline at 4-6 weeks
- Exogenous estrogens increase hepatic synthesis of several clotting factors 3x-7x

Jackson, Emily Obstet Gynec 2011

**WHO classification for COC**

- No one should get COC < 21 days pp (4)
- If risk factors, don't start prior to 42 days (3)
  - Age >35, prev VTE, thrombophilia, immobility, transfusion at delivery, BMI >30, PPH, post CS, preeclampsia, smoking
- If no risk factors, can start 21-42 days (2)

MMWR July 8, 2011 60(26);878-883
Breastfeeding – good for baby

• Breastfed babies
  o less otitis media, gastroenteritis, atopic dermatitis

• NOT Breastfed
  o Higher risk for asthma, obesity, DM, childhood leukemia

…good for mom too!

• Increased weight loss immediately PP
• Decreased risk of pp depression
• Decreased risk of Type 2 DM
• Decreased risk of breast and ovarian CA
• Breastfeeding at least 3 months with lower risk of vascular changes associated with CVD
• Breastfeeding for lifetime >2 years
  o 37% lower CHD, 23% lower risk of CHD than those who never BF


Maternal depression and their children

• Lower on cognitive, emotional and behavioral assessments
• At risk for mental health problems
• Social adjustment problems
• Difficulties at school
• Employment and health as adults
• EEG findings similar to adults with depression
• Increase child’s stress response system, exposure to maternal depression during infancy– higher stress hormones in adolescence

Postpartum mood disorders

<table>
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<tr>
<th>Disorder</th>
<th>Prevalence</th>
<th>Duration</th>
<th>Management</th>
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<tbody>
<tr>
<td>Blues</td>
<td>30-75%</td>
<td>Day 3-4, resolves within 2 weeks</td>
<td>Reassurance</td>
</tr>
<tr>
<td>Depression</td>
<td>10-15%</td>
<td>*Within 1st year</td>
<td>Outpatient treatment/support</td>
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<tr>
<td>Psychosis</td>
<td>0.1-0.2%</td>
<td>Within 2 weeks</td>
<td>Hospitalization</td>
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</table>

*DSM V (May 2013)

PP Depression=Major depression episode with onset in pregnancy or within 4 weeks

Screening for PP depression

- USPTF recommends screening for depression in adults if adequate resources in place to address depression (B)
- Best timing for screening is unknown
- Don’t know how to prevent PP depression

Depression varies with SES

% Depression in mothers with 9 month olds

Screening Tests

<table>
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<tr>
<th>TEST</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>SOE</th>
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<tbody>
<tr>
<td>EDPS</td>
<td>80-90%</td>
<td>80-90%</td>
<td>Mod</td>
</tr>
<tr>
<td>PDSS</td>
<td>80-90%</td>
<td>80-90%</td>
<td>Mod</td>
</tr>
<tr>
<td>PHQ 9</td>
<td>75-89%</td>
<td>83-91%</td>
<td>Low</td>
</tr>
<tr>
<td>PHQ 2*</td>
<td>100%</td>
<td>44-65%</td>
<td>Mod</td>
</tr>
</tbody>
</table>

*In the last two weeks how often have you Felt down, depressed, or hopeless? Lost interest or pleasure in doing things? Efficacy and Safety of Screening for Postpartum Depression. Comparative Effectiveness Review AHRQ evidenced based practice April 2013

Antidepressant Treatment of Depression during Pregnancy and the Postpartum Period AHRQ evidenced based practice July 2014
Edinburgh Depression Scale

1. I have been able to laugh and see the funny side of things
2. I have looked forward with enjoyment to things
3. I have blamed myself unnecessarily when things went wrong
4. I have been anxious or worried for no good reason
5. I have felt scared or panicky for no good reason
6. Things have been getting on top of me
7. I have been so unhappy that I have had trouble sleeping
8. I have felt sad or miserable
9. I have been so unhappy that I have been crying
10. The thought of harming myself has occurred to me

Treatment

- Need for further research
- Extrapolate treatment for adult depression
  - Meds (SSRI)
  - Cognitive Behavioral Therapy
  - Interpersonal Behavioral therapy
  - Group psychotherapy
- Effect of treatment on child development?
  - IPV, Anxiety, substance abuse, finances

Antidepressant Treatment of Depression during Pregnancy and the Postpartum Period
AHRQ evidenced based practice July 2014

Possibilities…

- Weekly parent-toddler psychotherapy
- Education for moms
- Massage therapy
- Mother-infant interaction coaching
- Home visits
Summary

• Provide interconception care and educate our patient about the importance of this
• Let go of the 6 week postpartum visit and provide individualized timing of care
• Beware of additional risk factors for VTE
• Encourage breastfeeding for mothers health
• Screen and treat for postpartum depression

www.everywomancalifornia.org
http://www.cdc.gov/breastfeeding/resources/guide.htm