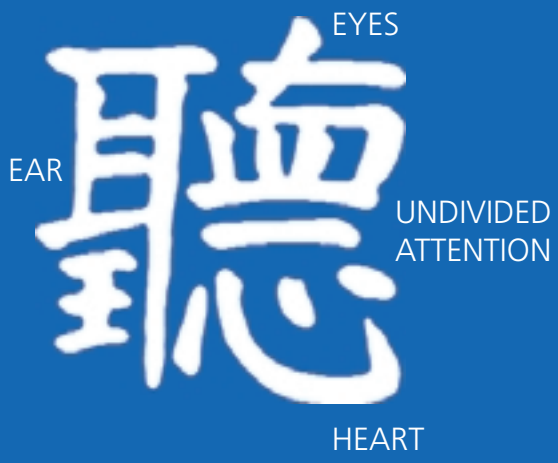
GOPP

Evidence Based Guidelines



Pregnancy and giving birth are major events in women's lives. Giving birth is the most common reason for hospital admission in Australia. Whilst the months of pregnancy are filled with check-ups and investigations the months following the birth have received little attention. Recent research in Australia and the UK has documented concerning levels of physical and emotional health problems for women. The effect of these problems on the lives of women and their families will interest all health professionals. General Practitioners, Maternal and Child Health Nurses and domiciliary nurses provide most of the primary care to mothers and babies in the first year. These guidelines have been developed by a multidisciplinary team using the best available evidence. There is an urgent need for more research and randomised trials to determine the most effective management strategies for the common postnatal problems. The column headed 'What's the evidence?' documents clearly whether the management strategies are based on observational studies, expert opinion (NHMRC level IV) or randomised controlled trials (NHMRC level I & II). Ideally, all management decisions should be supported by evidence obtained from well designed and conducted randomised controlled trials (Level I & II evidence).

Maternal Health

Physical and emotional health problems are common after childbirth.

Many women are reluctant to mention postnatal problems to health professionals despite the fact they often would like more advice and assistance in dealing with them. *(Brown and Lumley 1998)*

Review of Medicare data shows that, on average, a mother and her baby will visit a GP 8 times in the first six months. *(Gunn, Lumley et al. 1996)*

Prevalence of postnatal problems

The most common postnatal problems experienced in the first six months as reported in a recent survey of Victorian women:

69% exhaustion
44% backache
26% sexual problems
21% haemorrhoids
21% perineal pain
17% depression
17% mastitis
13% bowel problems
11% urinary incontinence
(Brown and Lumley 1998)

In a study conducted in the UK:

6% faecal incontinence
(MacArthur, Bick et al. 1997)

GAPP – a simple approach

Listen

When women were asked about their postnatal check-up and what they were 'particularly happy' about 79/181 (44%) comments were made about the communication style of the GP.

Then use ESP

Emotional

How are YOU feeling in yourself?
How do you find being a mother?

Social

How is your relationship going?
What interests do you have apart from caring for the baby?
Who shares the work of caring for the baby?
How much time do you get to yourself?

Physical

Many women experience physical problems after childbirth. Do you have any problems at the moment?
Have you had any problems with: exhaustion, back pain, sex, haemorrhoids, perineal pain, mastitis, loss of control of bowels or bladder.

GAPP Strategies

Listen

Women really value a GP who listens.
Listening may be the most important thing you can do.

Acknowledge

Women have different experiences of motherhood. Acknowledge the experience of each woman.

Suggest time-out

Being a mother can be really hard work. Giving women 'permission' to take time-out from mothering is a really valuable thing to do.

Tackle issues one by one

Just as mothering can be hard work, dealing with postnatal problems can be overwhelming for the GP. Building up a picture over time will help.

Time

Arranging time to talk about issues/problems can be therapeutic.

Active Listening – why bother?

"Am particularly comfortable with my GP and was able to talk … and get a sympathetic ear, was able to express fears and anxieties." *(Mother at 3 months postpartum)*

"The greatest single fault in interviewing is probably the failure to let patients tell their story." *(McWhinney 1989)*

"Doctors often interrupt patients after the initial concern, apparently assuming that the first complaint is the chief one, yet the order in which patients present their problems is not related to their clinical importance." *(Beckman and Frankel 1984)*

"The longer a doctor waits before interrupting at the beginning of the interview, the more likely s/he is to discover the full spread of issues that the patient wants to discuss and the less likely will it be that new complaints arise at the end of the interview." *(Beckman and Frankel 1984; Joos, Hickman et al. 1996)*

"The use of open rather than closed questions and the use of attentive listening leads to greater disclosure of patients' significant concerns." *(Cox 1989; Wissow et al. 1994)*

Problem	Prevalence
Exhaustion *"I didn't know it was possible to feel that tired"*	69% of mothers in the Survey of Recent Mothers at 6 months postpartum. *(Brown and Lumley 1998)* In the UK 59% at 8 wks postpartum and 54% at 2-18 months. *(Glazener, Abdalla et al. 1995)*
Urinary incontinence Women perceive that it is normal, and *"nothing can be done about it"* – *"it's impossible to think about finding the time for doing something about it"*	Variations in reported prevalence due to timing & method of questioning and definitions used. 11% at 6-7 months *(Brown and Lumley 1998)*, 8% at 6-7 months *(Glazener, Abdalla et al. 1995)*, 24% at 7-9 months *(LAMP)*, 34% at 3 months *(Wilson, Herbison et al. 1996)*
Sexual problems *"Sex. What's that?"*	Reported prevalence varies: 26% in the first 6-7 months postpartum. *(Brown and Lumley 1998)* 53% in the first 8 weeks, and 49% in the subsequent year. *(Glazener 1997)*
Perineal pain	**Reported prevalence varies:** 21% in the first 6-7 months postpartum. *(Brown and Lumley 1998)* 22% in the first 8 weeks, and 10% in the subsequent year. *(Glazener, Abdalla et al. 1995)* For a small % of women pain persists beyond 1 year. *(Glazener 1997; Hay-Smith 1999)*

Associated factors

NOT related to parity or method of delivery. *(Brown and Lumley 1998)*

Babies' sleep patterns vary considerably: 25% of babies <3months take more than 30mins to settle at night-time and most babies less than 3 months will wake once or twice overnight.

Some babies (~5%) wake 5 or more times overnight. 50% of babies still wake once or twice overnight at 12 months of age.

12.4% of babies aged 4-12months disturb their parents 3-4 times every night. *(Armstrong, Quinn et al. 1994)*

Tiredness is common, even among women who are not depressed: 60% of women whose scores on the Edinburgh Postnatal Depression Scale (EPDS) indicate they are not depressed report exhaustion at 7-9 months postpartum, compared with 80% of women scoring as depressed. *(Brown 1998)*

Management

Offer time to talk:

"We spoke to the local doctor who we know really well…He was really good..he always asks after both of us..he always makes a point of asking how we are doing…"

Encourage time-out:

"Many women find it helpful to have some time away from the baby – even a couple of hours every week can help."

Encourage sharing the work:

"Is there anyone who can share the work of caring for the baby? What about taking turns to get up at night or be first up in the morning?"

Encourage acceptance of invitations to help:

"Accepting help from friends and relatives can reduce the strain of caring for a new baby"

Discuss other potentially linked problems:

Haemorrhoids, back pain, perineal pain, problems with sex, relationship problems, breastfeeding problems, uncommon problems (anaemia, thyroid problems)

Operative vaginal births.

Higher birthweight.

Long second stage.

Multiparity.
(Snooks, Swash et al. 1986; Snooks, Swash et al. 1990; Glazener, Abdalla et al. 1995; Brown and Lumley 1998)

Obesity. *(Wilson 1996)*

Only 15% of the women who reported urinary incontinence in the LAMP study had discussed the problem with a health professional.

Women with stress incontinence likely to benefit from pelvic floor exercises (PFE) – especially with support and instruction.

Bo et al advised 8-12 contractions 3 times a day and exercise groups with skilled physical therapists once a week. *(Bo, Talseth et al. 1999)*

Exclude UTI & constipation.

Consider weight loss strategies.

Instrumental delivery. *(Brown and Lumley 1998)*

Perineal trauma/pain. *(Glazener 1997; Brown and Lumley 1998)*

Women who report depression or tiredness are more likely to experience problems with sex. *(Glazener 1997)*

Women who breastfeed are more likely to report loss of interest in sex. *(Glazener 1997, Alder 1986, Byrd 1998)*

In a UK study, 90% of women report having sex by 10 weeks postpartum. 2% of women had not attempted intercourse 1 year postpartum. *(Glazener 1997)*

If appropriately skilled use vacuum extraction rather than forceps, avoid unnecessary instrumental deliveries.

See perineal pain below.

Encourage time-out from mothering.

Encourage practical and social support.

Provide a listening ear:
- acknowledging the problems will help.
- reassurance that many couples have difficulties after having a baby.
- discuss changes in the relationship.

Acknowledge that couples will resume sexual activity at a time that is right for them. Discuss other ways to be close.

Establish referral networks for continuing problems.

Instrumental delivery, higher birthweight, longer labour.
(Brown and Lumley 1998).

Perineal trauma. *(Sleep, Grant et al. 1984; Klein, Gauthier et al. 1994)*

Women unlikely to raise issue -
10% of women reported perineal pain at 7-9 months postpartum. Of these women -15% had discussed this with a GP, 25% had discussed this with an obstetrician. *(LAMP study)*

Avoid elective forceps delivery. If appropriately skilled use vacuum extraction for assissted delivery.

Restricted rather than routine use of episiotomy.

Attention to perineal repair.

Use NSAID's for pain relief.

Avoid codeine containing and other constipating analgesics.

Pelvic floor exercises (PFE).

May be linked to sexual problems – discuss lubrication, position, talking to partner, other ways to be close.

What's the evidence? Level

Life as A Mother Project (LAMP) – Cross-sectional study of in-depth telephone interviews with mothers 7-9 months after the birth. Women suggested – talking with someone, time-out from baby and sharing the work as strategies used to combat exhaustion. Level IV

Limited evidence about effective treatments.
Bo et al evaluated 4 treatments: PFE with instruction/electrical stimulation/vaginal cones/no treatment. PFE were superior to other treatments, compliance greater and less side effects.
(Bo, Talseth et al. 1999) Level II

Cochrane systematic review on pelvic floor muscle training is underway. *(Hay-Smith, Bo et al. 1999)* Level I

Current evidence insufficient to advise the use of electrical stimulation, vaginal cones, biofeedback, bladder training, drug therapies, surgical repair.

Very little research about postnatal sexuality has been conducted.

See perineal pain below.

One study found that breastfeeding women who reported severe loss of interest in sex had significantly lower levels of androgens. Androgen levels were lower in breasfeeding women using the progesterone only pill. Alternative contraception may need to be considered. *(Alder 1986)* Level IV

54% of women who had a forceps delivery reported perineal pain compared with 20% who had a SVD. *(Brown and Lumley 1998)* Level IV

Liberal use of episiotomy associated with higher rates of postnatal sexual dysfunction. *(Klein, Gauthier et al. 1994)* Level II

Use of Dexon / Vicryl throughout all layers with a continuous sub-cuticular suture to the skin results in less short-term pain than other methods. *(Kettle and Johanson 1998a; Kettle and Johanson 1998b)* Level I

Mefenamic acid was better than paracetamol in relieving early postnatal pain. *(Dewan, Glazener et al. 1993)* Level IV

NSAID's have been found to be more effective analgesics.
(Windle, Brooker et al. 1989) Level I

PFE may be of benefit. *(Sleep and Grant 1987)* Level II

Cochrane review concludes insufficient evidence to demonstrate benefits or otherwise of therapeutic ultrasound. *(Hay-Smith 1999)* Level I

The use of vaginal oestrogen cream has not been studied in postnatal women.

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Problem	Prevalence	Associated factors
Faecal incontinence	More common than expected – 3% reported occasional faecal loss at 3 months postpartum. *(Sleep and Grant 1987)* 6.1% reported frank incontinence or urgency in first 9 months. *(MacArthur, Bick et al. 1997)* 16.5 % reported urgency, frank incontinence or incontinence of flatus at 6-8 weeks. *(Sultan, Kamm et al. 1993)*	Forceps / vacuum extraction. *(MacArthur, Bick et al. 1997)* Nerve injury, structural damage and ageing all play a part in the development of faecal incontinence. *(Kamm 1994)* Women very reluctant to raise the issue. *(Kamm 1994; MacArthur, Bick et al. 1997)*
Back pain	Around 50% of women experience back pain. Reported prevalences vary – 44% at 6-7 months *(Brown and Lumley 1998)*, 24% in first 8 weeks, 20% in subsequent year *(Glazener, Abdalla et al. 1995)*, 66% at 8 weeks *(Bick and MacArthur 1995a)*	Higher birthweight. *(Brown and Lumley 1998)* Epidural anaesthesia. *(MacArthur, Lewis et al. 1990; MacArthur, Lewis et al. 1991a; MacArthur, Lewis et al. 1991b; Macarthur, Macarthur et al. 1995; Brown and Lumley 1998)*
Depression *"Not that she offered any miraculous cure, but I felt she really understood what I was talking about. That was helpful."* *"Well I spoke to my doctor and he was very supportive…I didn't actually go for those sorts of reason (about depression). I went through, just – you know, like either one of the kids had a cold or something…."* *"Just talking – having someone impartial who listens.."*	Prevalence rates in the year after childbirth vary from 10-20%. *(Pitt 1968; Watson, Elliot et al. 1984; Astbury, Brown et al. 1994)* In 1989, 15.4% of Victorian women scored as depressed on the EPDS when surveyed 8-9 months after giving birth. *(Astbury, Brown et al. 1994)* In 1993, 16.9% of Victorian women scored as depressed on the EPDS when surveyed 6-7 months after giving birth. *(Brown and Lumley 1998)*	Perceived lack of social, emotional and practical support, particularly from a partner. *(Paykel, Emms et al. 1980; Kumar and Robson 1984; O'Hara, Neunaber et al. 1986; Small, Brown et al. 1994b)* Physical health problems *(Brown and Lumley 1998)* Exhaustion *(Small, Brown et al. 1994b; Brown and Lumley 1998; Currie, Thompson et al. 1999)* Infant factors: unsettled/ 'difficult' babies. *(Miller, Barr et al. 1993; Small, Brown et al. 1994a; Murray, Stanley et al. 1996)* Negative life events *(Paykel, Emms et al. 1980; Watson, Elliot et al. 1984; O'Hara, Neunaber et al. 1986; Small, Brown et al. 1994a; Brown 1998)* A previous psychiatric history, although this will only account for a small number of the women who experience depression. *(Tod 1964; Watson, Elliot et al. 1984)* There is little or no evidence of any direct association between depression after birth and hormonal factors *(Kendell 1985; Adler, Cook et al. 1986; O'Hara, Schlechte et al. 1991)*, breastfeeding, age, parity or education. *(Astbury, Brown et al. 1994)* There have been inconclusive findings about the link between type of delivery and socioeconomic status and the development of depression. *(Paykel, Emms et al. 1980; Watson, Elliot et al. 1984; Astbury, Brown et al. 1994)* In an Australian case-control study only 2 in 5 women who were depressed sought professional help. *(Small, Brown et al. 1994b)* Only 50/228 (29%) women were very confident that their GP would know if they were feeling depressed. *(Gunn 1997)*

Management	What's the evidence?	Level
Ask women whether they have experienced any incontinence of flatus or faeces. Any problems with soiling of the underwear?	The current evidence suggests that all measures should be taken to avoid anal sphincter damage during childbirth by avoiding elective instrumental deliveries and when damage does occur using the best surgical techniques to repair the anal sphincter. *(Kamm 1994)*	Level IV
Inconclusive evidence regarding effective strategies: Pelvic floor exercises, electrical stimulation with or without biofeedback may be useful yet further research is required. *(Hosker, Norton et al. 1999; Norton, Hosker et al. 1999)*	How long it persists and whether it resolves and later recurs have not been studied. *(MacArthur, Bick et al. 1997)*	
Consider high fibre diet, fluid intake and exercise. The use of constipating agents may need to be considered.	More research is needed.	
Avoid bed rest.	Cochrane Reviews in progress: No good scientific evidence to support the use of exercise therapies during the acute phase or the use of spinal manipulation. *(Assendelft, Shekelle et al. 1995; Tulder, Malmivaara et al. 1997)*	
NSAID's may provide short-term benefits. *Avoid codeine containing and other constipating analgesics.*	A randomised controlled trial of a community based exercise program led by a physiotherapist, and based on cognitive behavioural principles, helped patients to cope better with their pain, and function better one year later than patients receiving traditional GP care. *(Klaber Moffett et al. 1999)*	Level II
Provide emotional support. Suggest practical help. Encourage socialisation. Resume normal daily activites as soon as possible.		
Preventive approach to protect back may be useful – advice on changing baby, lifting, carrying, capsules, slings.		
	Few population based studies that use consistent, clinically meaningful definitions of depression.	
Support and encourage women to speak about their experiences of motherhood in terms of their own emotional well-being.	UK trial of 'listening visits' by Health Visitors resulted in less depression.*(Holden, Sagovsky et al. 1989)*	Level II
Simple techniques such as active listening and non-directive counselling are effective strategies.	Swedish randomised trial found that non-directive counselling by a nurse was effective in reducing the number of women depressed – 12/15 women in the treatment group were not depressed after 6 counselling sessions compared with 4/16 in the control group. *(Wickberg and Hwang 1996)*	Level II
Offer time to talk about concerns and feelings.		
Non-professional support/befriending may be effective strategies for women who agree to become involved. *(Harris, Brown et al. 1999)*	UK randomised trial of volunteer befriending was effective in producing remission in a group of chronically depressed women – remission occurred in 28/43 (65%) women in the befriended group compared with 17/43 (39%) in the control group. *(Harris, Brown et al. 1999)*	Level II
Suggest sharing the work of caring for the child/ren.	Women who have experienced depression suggest that finding someone to talk to, sharing the work and having time to oneself can help to reduce depression. *(Brown, Lumley et al. 1994)*	Level IV
Suggest time-out or doing something for oneself.		
The use of medication needs to be made taking into account the preferences of the woman.	Cognitive behavioural therapy is as effective as fluoxetine in reducing postnatal depression. The choice of treatment can be made by women themselves. *(Appleby, Warner et al. 1997)*	Level II
Prescription of an antidepressant for a breastfeeding woman is a case-specific risk-benefit decision. *(Wisner, Perel et al. 1996)*	Lack of published research. Often small numbers of babies included in studies (1-7) and lack of long-term follow-up. *(Wisner,Perel et al. 1996)*	Level IV
	Antidepressants concentrate in the central nervous system; therefore, serum concentrations and breastmilk:plasma ratios may not accurately predict infant drug exposure. *(Hatzopoulos and Albrecht 1996)*	Level IV

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This document is a general guide to appropriate practice, to be followed only subject to the practitioner's judgement in each individual case. The guidelines are designed to provide information to assist decision making and are based on the best information available at the date of publication.

THE UNIVERSITY OF MELBOURNE Australia

M&C Centre for the Study of Mothers' and Children's Health

PRISM

GAPP Evidence Based Guidelines

Problem	Prevalence	Associated factors	Management	What's the evidence? Level
Faecal incontinence	More common than expected – 3% reported occasional faecal loss at 3 months postpartum. *(Sleep and Grant 1987)* 6.1% reported frank incontinence or urgency in first 9 months. *(MacArthur, Bick et al. 1997)* 16.5 % reported urgency, frank incontinence or incontinence of flatus at 6-8 weeks. *(Sultan, Kamm et al. 1992)*	Forceps / vacuum extraction. *(MacArthur, Bick et al. 1997)* Nerve injury, structural damage and ageing all play a part in the development of faecal incontinence. *(Kamm 1994)* Women very reluctant to raise the issue. *(Kamm 1994; MacArthur, Bick et al. 1997)*	Ask women whether they have experienced any incontinence of flatus or faeces. Any problems with soiling of the underwear? Inconclusive evidence regarding effective strategies. Pelvic floor exercises, electrical stimulation with or without biofeedback may be useful yet further research is required. *(Hosker, Norton et al. 1989; Norton, Hosker et al. 1990)* Consider high fibre diet, fluid intake and exercise. The use of constipating agents may need to be considered.	The current evidence suggests that all measures should be taken to avoid anal sphincter damage during childbirth by avoiding elective instrumental deliveries and when damage does occur using the best surgical techniques to repair the anal sphincter. *(Kamm 1994)* Level IV How long it persists and whether it resolves and later recurs have not been studied. *(MacArthur, Bick et al. 1997)* More research is needed.
Back pain	Around 50% of women experience back pain. Reported prevalences vary – 44% at 6-7 months *(Brown and Lumley 1998)*, 24% in first 8 weeks, 20% in subsequent year *(Gazerec, Abdalla et al. 1995)*, 66% at 8 weeks *(Bick and MacArthur 1995a)*	Higher birthweight. *(Brown and Lumley 1998)* Epidural anaesthesia. *(MacArthur, Lewis et al. 1990; MacArthur, Lewis et al. 1991a; MacArthur, Lewis et al. 1991b; Macarthur, Macarthur et al. 1995; Brown and Lumley 1998)*	Avoid bed rest. NSAID's may provide short-term benefits. *Avoid codeine containing and other constipating analgesics.* Provide emotional support. Suggest practical help. Encourage socialisation. Resume normal daily activities as soon as possible. Preventive approach to protect back may be useful – advice on changing baby, lifting, carrying, capsules, slings.	Cochrane Reviews in progress: No good scientific evidence to support the use of exercise therapies during the acute phase or the use of spinal manipulation. *(Assendelft, Bouter et al. 1995; Tulder, Malmivaara et al. 1997)* A randomised controlled trial of a community based exercise program led by a physiotherapist, and based on cognitive behavioural principles, helped patients to cope better with their pain, and function better one year later than patients receiving traditional GP care. *(Klaber Moffett et al. 1999)* Level II
Depression *"Not that the offered any miraculous cure, but I felt she really understood what I was talking about. That was helpful."* *"Well I spoke to my doctor and he was very supportive…I didn't actually go for those sorts of reason (about depression). I went through, just – you know, like either one of the kids had a cold or something…."* *"Just talking – having someone impartial who listens.."*	Prevalence rates in the year after childbirth vary from 10-20%. *(Pitt 1968; Watson, Elliot et al. 1984; Astbury, Brown et al. 1994)* In 1989, 15.4% of Victorian women scored as depressed on the EPDS when surveyed 8-9 months after giving birth. *(Astbury, Brown et al. 1994)* In 1993, 16.9% of Victorian women scored as depressed on the EPDS when surveyed 6-7 months after giving birth. *(Brown and Lumley 1998)*	Perceived lack of social, emotional and practical support, particularly from a partner. *(Paykel, Emms et al. 1980; Kumar and Robson 1984; O'Hara, Neunaber et al. 1986; Small, Brown et al. 1994b)* Physical health problems *(Brown and Lumley 1998)* Exhaustion *(Small, Brown et al. 1994b; Brown and Lumley 1998; Currie, Thompson et al. 1999)* Infant factors: unsettled/ 'difficult' babies. *(Miller, Barr et al. 1993; Small, Brown et al. 1994a; Murray, Stanley et al. 1996)* Negative life events. *(Paykel, Emms et al. 1980; Watson, Elliot et al. 1984; O'Hara, Neunaber et al. 1986; Small, Brown et al. 1994a; Brown 1998)* A previous psychiatric history, although this will only account for a small number of the women who experience depression. *(Tod 1964; Watson, Elliot et al. 1984)* There is little or no evidence of any direct association between depression after birth and hormonal factors *(Kendell 1985; Adler, Cook et al. 1986; O'Hara, Schlechte et al. 1991)*, breastfeeding, age, parity or education. *(Astbury, Brown et al. 1994)* There have been inconclusive findings about the link between type of delivery and socioeconomic status and the development of depression. *(Paykel, Emms et al. 1980; Watson, Elliot et al. 1984; Astbury, Brown et al. 1994)* In an Australian case-control study only 2 in 5 women who were depressed sought professional help. *(Small, Brown et al. 1994b)* Only 50/228 (29%) women were very confident that their GP would know if they were feeling depressed. *(Gunn 1997)*	Support and encourage women to speak about their experiences of motherhood in terms of their own emotional well-being. Simple techniques such as active listening and non-directive counselling are effective strategies. Offer time to talk about concerns and feelings. Non-professional support/befriending may be effective strategies for women who agree to become involved. *(Harris, Brown et al. 1999)* Suggest sharing the work of caring for the children. Suggest time-out or doing something for oneself. The use of medication needs to be made taking into account the preferences of the woman. Prescription of an antidepressant for a breastfeeding woman is a case-specific risk-benefit decision. *(Wisner, Perel et al. 1996)*	Few population based studies that use consistent, clinically meaningful definitions of depression. UK trial of 'listening visits' by Health Visitors resulted in less depression. *(Holden, Sagovsky et al. 1989)* Level II Swedish randomised trial found that non-directive counselling by a nurse was effective in reducing the number of women depressed – 12/15 women in the treatment group were not depressed after 6 counselling sessions compared with 4/16 in the control group. *(Wickberg and Hwang 1996)* Level II UK randomised trial of volunteer befriending was effective in producing remission in a group of chronically depressed women – remission occurred in 28/43 (65%) women in the befriended group compared with 17/43 (39%) in the control group. *(Harris, Brown et al. 1999)* Level II Women who have experienced depression suggest that finding someone to talk to, sharing the work and having time to oneself can help to reduce depression. *(Brown, Lumley et al. 1994)* Level IV Cognitive behavioural therapy is as effective as fluoxetine in reducing postnatal depression. The choice of treatment can be made by women themselves. *(Appleby, Warner et al. 1997)* Level II Lack of published research. Often small numbers of babies included in studies (1-7) and lack of long-term follow-up. *(Wisner,Perel et al. 1996)* Level IV Antidepressants concentrate in the central nervous system; therefore, serum concentrations and breastmilk:plasma ratios may not accurately predict infant drug exposure. *(Hatsoupoulos and Albrecht 1996)* Level IV

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This document is a general guide to appropriate practice, to be followed only subject to the practitioner's judgement in each individual case. The guidelines are designed to provide information to assist decision making and are based on the best information available at the date of publication.

GAPP

Evidence Based Guidelines

Pregnancy and giving birth are major events in women's lives. Giving birth is the most common reason for hospital admission in Australia. Whilst the months of pregnancy are filled with check-ups and investigations the months following the birth have received little attention. Recent research in Australia and the UK has documented concerning levels of physical and emotional health problems for women. The effect of these problems on the lives of women and their families will interest all health professionals. General Practitioners, Maternal and Child Health Nurses and domiciliary nurses provide most of the primary care to mothers and babies in the first year. These guidelines have been developed by a multidisciplinary team using the best available evidence. There is an urgent need for more research and randomised trials to determine the most effective management strategies for the common postnatal problems. The column headed "What's the evidence?" documents clearly whether the management strategies are based on observational studies, expert opinion (NHMRC level IV) or randomised controlled trials (NHMRC level I & II). Ideally, all management decisions should be supported by evidence obtained from well designed and conducted randomised controlled trials (Level I & II evidence).

Maternal Health

Physical and emotional health problems are common after hildbirth.

Many women are reluctant to mention postnatal problems to health professionals despite the act they often would like more advice and assistance in dealing with them. *(Brown and Lumley 998)*

Review of Medicare data shows hat, on average, a mother and her baby will visit a GP 8 times n the first six months. *(Gunn, umley et al. 1996)*

Prevalence of postnatal problems

The most common postnatal problems experienced in he first six months as eported in a recent survey of Victorian women:

69% exhaustion
44% backache
26% sexual problems
21% haemorrhoids
21% perineal pain
17% depression
17% mastitis
13% bowel problems
11% urinary incontinence
Brown and Lumley 1998)

n a study conducted in he UK:
6% faecal incontinence
MacArthur, Bick et al. 1997)

GAPP – a simple approach

Listen
When women were asked about their postnatal check-up and what they were 'particularly happy' about 79/181 (44%) omments were made about the ommunication style of the GP.

Then use ESP

Emotional
How are YOU feeling in yourself?
How do you find being a mother?

Social
How is your relationship going?
What interests do you have apart from caring for the baby?
Who shares the work of caring or the baby?
How much time do you get to ourself?

Physical
Many women experience physical problems after hildbirth. Do you have any problems at the moment?
Have you had any problems with: exhaustion, back pain, ex, haemorrhoids, perineal pain, mastitis, loss of control of bowels or bladder.

GAPP Strategies

Listen
Women really value a GP who listens.
Listening may be the most important thing you can do.

Acknowledge
Women have different experiences of motherhood. Acknowledge the experience of each woman.

Suggest time-out
Being a mother can be really hard work. Giving women 'permission' to take time-out from mothering is a really valuable thing to do.

Tackle issues one by one
Just as mothering can be hard work, dealing with postnatal problems can be overwhelming for the GP. Building up a picture over time will help.

Time
Arranging time to talk about issues/problems can be therapeutic.

Active Listening – why bother?

"Am particularly comfortable with my GP and was able to talk … and get a sympathetic ear, was able to express fears and anxieties." (Mother at 3 months postpartum)

"The greatest single fault in interviewing is probably the failure to let patients tell their story." (McWhinney 1989)

"Doctors often interrupt patients after the initial concern, apparently assuming that the first complaint is the chief one, yet the order in which patients present their problems is not related to their clinical importance." (Beckman and Frankel 1984)

"The longer a doctor waits before interrupting at the beginning of the interview, the more likely s/he is to discover the full spread of issues that the patient wants to discuss and the less likely will it be that new complaints arise at the end of the interview." (Beckman and Frankel 1984; Joos, Hickman et al. 1996)

"The use of open rather than closed questions and the use of attentive listening leads to greater disclosure of patients' significant concerns." (Cox 1989; Wissow et al. 1994)

GAPP Evidence Based Guidelines

Problem	Prevalence	Associated factors	Management	What's the evidence?	Level
Exhaustion *"I didn't know it was possible to feel that tired"*	69% of mothers in the Survey of Recent Mothers at 6 months postpartum. *(Brown and Lumley 1998)* In the UK 59% at 8 wks postpartum and 54% at 2-18 months. *(Glazener, Abdalla et al. 1995)*	NOT related to parity or method of delivery. *(Brown and Lumley 1998)* Babies' sleep patterns vary considerably: 25% of babies <3months take more than 30mins to settle at night-time and most babies less than 3 months will wake once or twice overnight. Some babies (~5%) wake 5 or more times overnight. 50% of babies still wake once or twice overnight at 12 months of age. 12.4% of babies aged 4-12months disturb their parents 3-4 times every night. *(Armstrong, Quinn et al. 1994)* **Tiredness is common, even among women who are not depressed:** 60% of women whose scores on the Edinburgh Postnatal Depression Scale (EPDS) indicate they are not depressed report exhaustion at 7-9 months postpartum, compared with 80% of women scoring as depressed. *(Brown 1998)*	**Offer time to talk:** *"We spoke to the local doctor who we know really well…He was really good..he always asks after both of us..he always makes a point of asking how we are doing…"* **Encourage time-out:** *"Many women find it helpful to have some time away from the baby – even a couple of hours every week can help."* **Encourage sharing the work:** *"Is there anyone who can share the work of caring for the baby? What about taking turns to get up at night or be first up in the morning?"* **Encourage acceptance of invitations to help:** *"Accepting help from friends and relatives can reduce the strain of caring for a new baby"* **Discuss other potentially linked problems:** Haemorrhoids, back pain, perineal pain, problems with sex, relationship problems, breastfeeding problems, uncommon problems (anaemia, thyroid problems)	Life as A Mother Project (LAMP) – Cross-sectional study of in-depth telephone interviews with mothers 7-9 months after the birth. Women suggested – talking with someone, time-out from baby and sharing the work as strategies used to combat exhaustion.	Level IV
Urinary incontinence Women perceive that it is normal, and *"nothing can be done about it" – "it's impossible to think about finding the time for doing something about it"*	Variations in reported prevalence due to timing & method of questioning and definitions used. 11% at 6-7 months *(Brown and Lumley 1998)*, 8% at 6-7 months *(Glazener, Abdalla et al. 1995)*, 24% at 7-9 months *(LAMP)*, 34% at 3 months *(Wilson, Herbison et al. 1996)*	Operative vaginal births. Higher birthweight. Long second stage. Multiparity. *(Snooks, Swash et al. 1986; Snooks, Swash et al. 1990; Glazener, Abdalla et al. 1995; Brown and Lumley 1998)* Obesity. *(Wilson 1996)* Only 15% of the women who reported urinary incontinence in the LAMP study had discussed the problem with a health professional.	Women with stress incontinence likely to benefit from pelvic floor exercises (PFE) – especially with support and instruction. Bo et al advised 8-12 contractions 3 times a day and exercise groups with skilled physical therapists once a week. *(Bo, Talseth et al. 1999)* *Exclude UTI & constipation.* Consider weight loss strategies.	Limited evidence about effective treatments. Bo et al evaluated 4 treatments: PFE with instruction/electrical stimulation/vaginal cones/no treatment. PFE were superior to other treatments, compliance greater and less side effects. *(Bo, Talseth et al. 1999)* Level II Cochrane systematic review on pelvic floor muscle training is underway. *(Hay-Smith, Bo et al. 1999)* Level I Current evidence insufficient to advise the use of electrical stimulation, vaginal cones, biofeedback, bladder training, drug therapies, surgical repair.	Level II Level I
Sexual problems *"Sex. What's that?"*	Reported prevalence varies: 26% in the first 6-7 months postpartum. *(Brown and Lumley 1998)* 53% in the first 8 weeks, and 49% in the subsequent year. *(Glazener 1997)*	Instrumental delivery. *(Brown and Lumley 1998)* Perineal trauma/pain. *(Glazener 1997; Brown and Lumley 1998)* Women who report depression or tiredness are more likely to experience problems with sex. *(Glazener 1997)* Women who breastfeed are more likely to report loss of interest in sex. *(Glazener 1997, Alder 1986, Byrd 1998)* In a UK study, 90% of women report having sex by 10 weeks postpartum. 2% of women had not attempted intercourse 1 year postpartum. *(Glazener 1997)*	If appropriately skilled use vacuum extraction rather than forceps, avoid unnecessary instrumental deliveries. See perineal pain below. **Encourage time-out from mothering.** **Encourage practical and social support.** **Provide a listening ear:** – acknowledging the problems will help. – reassurance that many couples have difficulties after having a baby. – discuss changes in the relationship. Acknowledge that couples will resume sexual activity at a time that is right for them. Discuss other ways to be close. Establish referral networks for continuing problems.	Very little research about postnatal sexuality has been conducted. See perineal pain below. One study found that breastfeeding women who reported severe loss of interest in sex had significantly lower levels of androgens. Androgen levels were lower in breasfeeding women using the progesterone only pill. Alternative contraception may need to be considered. *(Alder 1986)*	Level IV
Perineal pain	**Reported prevalence varies:** 21% in the first 6-7 months postpartum. *(Brown and Lumley 1998)* 22% in the first 8 weeks, and 10% in the subsequent year. *(Glazener, Abdalla et al. 1995)* For a small % of women pain persists beyond 1 year. *(Glazener 1997; Hay-Smith 1999)*	Instrumental delivery, higher birthweight, longer labour. *(Brown and Lumley 1998)*. Perineal trauma. *(Sleep, Grant et al. 1984; Klein, Gauthier et al. 1994)* **Women unlikely to raise issue -** 10% of women reported perineal pain at 7-9 months postpartum. Of these women -15% had discussed this with a GP, 25% had discussed this with an obstetrician. *(LAMP study)*	Avoid elective forceps delivery. If appropriately skilled use vacuum extraction for assisted delivery. Restricted rather than routine use of episiotomy. Attention to perineal repair. Use NSAID's for pain relief. Avoid codeine containing and other constipating analgesics. Pelvic floor exercises (PFE). May be linked to sexual problems – discuss lubrication, position, talking to partner, other ways to be close.	54% of women who had a forceps delivery reported perineal pain compared with 20% who had a SVD. *(Brown and Lumley 1998)* Level IV Liberal use of episiotomy associated with higher rates of postnatal sexual dysfunction. *(Klein, Gauthier et al. 1994)* Level II Use of Dexon / Vicryl throughout all layers with a continuous sub-cuticular suture to the skin results in less short-term pain than other methods. *(Kettle and Johanson 1998a; Kettle and Johanson 1998b)* Level I Mefenamic acid was better than paracetamol in relieving early postnatal pain. *(Dewan, Glazener et al. 1993)* Level IV NSAID's have been found to be more effective analgesics. *(Windle, Brooker et al. 1989)* Level I PFE may be of benefit. *(Sleep and Grant 1987)* Level II Cochrane review concludes insufficient evidence to demonstrate benefits or otherwise of therapeutic ultrasound. *(Hay-Smith 1999)* Level I The use of vaginal oestrogen cream has not been studied in postnatal women.	Level IV Level II Level I Level IV Level I Level II Level I

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