The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Postpartum Complications

Introduction

- The effects of pregnancy on many organ systems begin to resolve spontaneously after birth of the infant and delivery of the placenta. The timeline for resolution is not necessarily linear and not the same for all organs or tissues. Women in the postpartum period should be monitored for postpartum complications. Frequency of follow-up depends on specific issues encountered during childbirth and the immediate postpartum period.
- A thorough understanding of the labor and delivery process, including procedures (eg, perineal lacerations repair, episiotomies, operative vaginal deliveries, and cesarean deliveries) used for specific circumstances, is especially helpful when caring for the patient who develops a postpartum complication. Box 1 provides sample guidance for patients on how to perform pelvic floor exercises that will strengthen the muscles that surround the openings of the urethra, vagina, and rectum.
- Comprehensive prenatal care incorporates key elements of the postpartum phase into patient counseling. Anticipatory counseling in the prenatal period guides patient expectations regarding routine procedures and postpartum changes, both normal and abnormal. Equipping women with knowledge of the childbirth process and the postpartum period empowers them to understand what to expect, recognize changes, and be able to advocate for their health care needs.

Urinary Incontinence

Background

- The prevalence of urinary incontinence (UI) varies widely in the postpartum period, ranging from 3% to 40%.
- For many women, urinary incontinence resolves spontaneously during the first 3 months of the postpartum period and the prevalence decreases to a range of 11–23% in the 3–12 months of the postpartum period.
- Risk factors include vaginal delivery, increased duration of second stage of labor, older age, greater parity, increased body mass index, excess maternal weight gain during pregnancy, fetal weight (more than 4 kg), family history, and UI during pregnancy.

Screening and Diagnosis

- Women's health care providers should routinely discuss incontinence at the postpartum visit to confirm spontaneous resolution or evaluate the need for further therapy in those with persistent UI symptoms.
- A urine culture should be obtained to rule out urinary tract infection.

Treatment

- Pelvic floor muscle (Kegel) exercises are effective at strengthening the muscles that surround the urethra, vagina, and anus and should be recommended for women with symptoms of UI who are in the postpartum period.
- Health care providers can instruct and coach women on Kegel exercises (see Box 1).
- Health care providers should consider focusing on modifiable risk factors, such as obesity and smoking, to decrease the incidence of UI.
- Current data are conflicting, but physical therapy with pelvic floor muscle training may be used to treat women with persistent postpartum UI at 3 months after delivery.

Anticipatory Guidance and Follow-up

- Anticipatory counseling in the antepartum period is necessary to educate patients and set expectations.
- Consider referral to urogynecology if UI is persistent and disturbing to the patient.
- Urogynecology assessment
  - helps to identify issues that require more immediate action (eg, revision of an obstetric laceration breakdown)
  - affords an opportunity to educate patients about the pelvic floor, the role of Kegel exercises, and biofeedback training or pelvic floor physical therapy, or both, if deemed appropriate
  - provides reassurance to the patient
  - The American College of Obstetricians and Gynecologists has developed a Patient FAQ on Urinary Incontinence.
- Long-term follow-up is necessary to assess stability of results

Box 1. Kegel Exercises

Patient Education FAQ-012
https://www.acog.org/Patients/FAQs/Pelvic-Support-Problems

- With an empty bladder, squeeze muscles used to stop flow of urine
- Hold for 3 seconds, then relax for 3 seconds
- Do 10 contractions at least three times a day
- Increase hold by 1 second each week up to 10-second holds
- Breathe normally through these exercises

Fecal Incontinence

Background

Up to 10% of women report fecal incontinence during pregnancy.

- Obstetric anal sphincter injuries (OASIS) occurs in 18% of vaginal deliveries, and 13–25% of women experience fecal incontinence or flatus incontinence after childbirth.
- Significant improvement occurs in women by 3–6 months in the postpartum period; some women may experience fecal incontinence 2 or more years after delivery.
- Risk factors for fecal incontinence include vaginal delivery, length of second stage of labor, large birth weight, increasing maternal age, forceps delivery, OASIS by anal sphincter laceration or episiotomy, and maternal position during childbirth.
- The lateral position affords a slightly protective effect from OASIS in the nulliparous woman, compared with standing, squatting, or lithotomy.

Screening and Diagnosis

- Studies reveal that women are not asked about incontinence by their health care providers at the postpartum visit. Women may not seek treatment because of embarrassment and shame.
- Health care providers should routinely discuss fecal incontinence at the postpartum visit to confirm spontaneous resolution or evaluate the need for further therapy in those with persistent fecal incontinence symptoms.
- Anal sphincter injury that is not apparent immediately after delivery is referred to as an occult sphincter laceration, and physical examination can identify the disrupted anal sphincter complex in most women.
- Endoanal ultrasonography is the gold standard tool used by the urogynecologist to evaluate anal sphincter pathology in the investigation of fecal incontinence. Anal sphincter disruption can be identified on sonogram because external and internal sphincters can be visualized on ultrasonography.

Treatment

- Anal sphincter repair immediately after delivery reduces the risk of fecal incontinence.
- A fiber-rich diet, adequate hydration, and use of a stool softener started immediately after childbirth can control consistency of the stool and prevent constipation and straining, which allows optimal healing.
- Pelvic floor muscle (Kegel) exercises are not only effective for stress urinary incontinence but also have been shown to improve symptoms of fecal incontinence in postpartum women. Health care providers can instruct and coach patients on the use of Kegel exercises (see Box 1).
- Inadequate anal sphincter repair immediately after delivery or break down of repair requires sphincteroplasty, which is most effective in women with moderate or severe fecal incontinence.
- Sphincteroplasty also is used in women with occult sphincter lacerations.
- A sacral nerve stimulator may be implanted in women who do not desire surgical therapy or in those in whom sphincteroplasty has failed.

Anticipatory Guidance and Follow-up

- Anticipatory counseling in the antepartum period is necessary for educating patients and setting expectations.
- For the patient with symptomatic fecal incontinence after 2 weeks in the postpartum period, refer to urogynecology or colorectal surgery.
- Early assessment
  - helps to identify issues that require more immediate action (eg, revision of an obstetric laceration breakdown or repair of an occult sphincter laceration)
  - affords an opportunity to educate patients about the pelvic floor, the role of Kegel exercises and biofeedback training or pelvic floor physical therapy, or both, if deemed appropriate
  - helps educate patients about perianal skin care and dietary changes that affect stool consistency. The American College of Obstetricians and Gynecologists has developed a patient FAQ on Accidental Bowel Leakage
  - provides reassurance to the patient
- Long-term follow-up is necessary to assess stability of results.
- The mode of delivery in subsequent pregnancies after OASIS has not been established. If fecal incontinence persists, it is reasonable to offer the patient a cesarean delivery, with a full discussion of the risks of abdominal surgery.

Perineal Pain, Dyspareunia, and Sexual Function

Background

- Perineal pain, dyspareunia, and low libido may occur after childbirth and, if persistent and not treated, may lead to long-term physical and psychological difficulties, including relationship discord.
- Prolonged postpartum perineal pain is common and has been reported in up to 10% of women 1 year after vaginal delivery. Scar tissue at the introitus from an episiotomy is a common cause.
- *Dyspareunia* is defined as genital pain that occurs just before, during, or after sexual intercourse. Physical factors, psychological factors, or both, may be involved. Postpartum dyspareunia has been reported in 50–60% of women 6–7 weeks after delivery, in 30% of women at 3 months after delivery, and in 17% of women 6 months after delivery.
- Risk factors that increase the risk of postpartum perineal pain and dyspareunia include infection, operative vaginal delivery, third- and fourth-degree laceration, wound separation of episiotomy or laceration repairs, pelvic organ prolapse, and breastfeeding.
- Vaginal atrophy secondary to the hypoestrogenic state during breastfeeding leads to inadequate lubrication and dyspareunia.
- Studies reveal no difference in the risk of dyspareunia in women with spontaneous perineal lacerations versus those women receiving episiotomies; however, avoidance or selective use of episiotomy decreases perineal trauma.

- A reduction in libido after childbirth is normal; however, many women are not aware of this. Contributors to reduced postpartum libido include hormonal alterations associated with breastfeeding, the adjustment and demands of a new infant, and fatigue. Studies have found that 50% of women at 3 months and 30% at 6 months after giving birth experience loss of libido.
- A high prevalence of postnatal sexual health issues occur during the postpartum period, and these are rarely discussed by women's health care providers at the postpartum visit.

Postpartum Test and Screening

- Women rarely discuss sexual health issues unless health care providers ask them directly.
- Given the high prevalence of postpartum perineal trauma and subsequent dyspareunia, routine and direct inquiry by women's health care providers is warranted.
- Providing questionnaires before the office visit may be helpful; however, direct inquiries during the office visit is essential.
- Consider a pelvic examination in women with severe perineal pain, or dyspareunia, or both. Topical lidocaine (jelly or spray) may be used as an anesthetic for the following:
  - Inspection of the perineum
  - Careful and gentle digital vaginal and rectal examination if warranted.
  - Use of vulvodynia and sensory mapping examination (use of moistened cotton swab to gently check for specific, localized areas of pain in the vulvar region).

Management Considerations

- The management of perinea pain, dyspareunia, and sexual function depends on the cause.
- Education and reassurance of the patient can include the following:
  - Inform the patient that it is normal for libido to decrease immediately after birth.
  - Encourage the patient to communicate openly and honestly with her partner about reasons for low libido, including physiologic changes postpartum, fatigue, and lack of time.
  - Suggest consultation with a certified therapist if or when the couple decides the issue necessitates the need to seek help or if a sexuality issue becomes problematic to the relationship.
  - Consider ablation of granulation tissue.
  - Use of a water-based lubricant for sexual relations.
  - How pelvic floor physical therapy may benefit women with persistent perineal pain and dyspareunia at 3 months after giving birth, but data are scarce and conflicting.
  - Transcutaneous electrical nerve stimulation (TENS) therapy and ultrasound therapy have been shown to decrease perineal pain and dyspareunia. However, consistent evidence is lacking, trials are of variable quality, and some studies lack adequate controls.
  - Consider revision of perineoplasty as a treatment in women with persistent and severe perineal pain or dyspareunia unresponsive to physical therapy.

Follow-up Goals

- Anticipatory counseling in the antepartum period is necessary to educate patients and set expectations.
- Because perineal laceration and dyspareunia are common, particularly in the primiparous woman, routine inquiry is warranted.
- Long-term follow-up and counseling are needed for persistent issues with dyspareunia and sexual health.

References

1. American College of Obstetricians and Gynecologists. Accidental bowel leakage. ACOG FAQ 139. Washington, DC: American College of Obstetricians and Gynecologists; 2014. Available at: https://www.acog.org/Patients/FAQs/Accidental-Bowel-Leakage.
2. American College of Obstetricians and Gynecologists. Pelvic support problems. ACOG FAQ 012. Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: https://www.acog.org/Patients/FAQs/Pelvic-Support-Problems.
3. American College of Obstetricians and Gynecologists. Urinary incontinence. ACOG FAQ 081. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: https://www.acog.org/Patients/FAQs/Urinary-Incontinence.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- Prevention and management of obstetric lacerations at vaginal delivery. Practice Bulletin No. 198. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e87–102.

  Provides evidence-based guidelines for the prevention, identification, and repair of obstetric lacerations and for episiotomy.

- Urinary incontinence in women. Practice Bulletin No. 155. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e66–81.

  Reviews information on the current understanding of urinary incontinence in women and includes guidelines for diagnosis and management that are consistent with the best available scientific evidence.

Health Care Provider Resources for Patient Care

- 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.

  Describes prevalence and severity of urinary incontinence in the 12-month postpartum period and relates this incontinence to several potential risk factors including body mass index, smoking, oral contraceptives, breastfeeding, and pelvic floor muscle exercise.

Coding

See Coding for Postpartum Complications