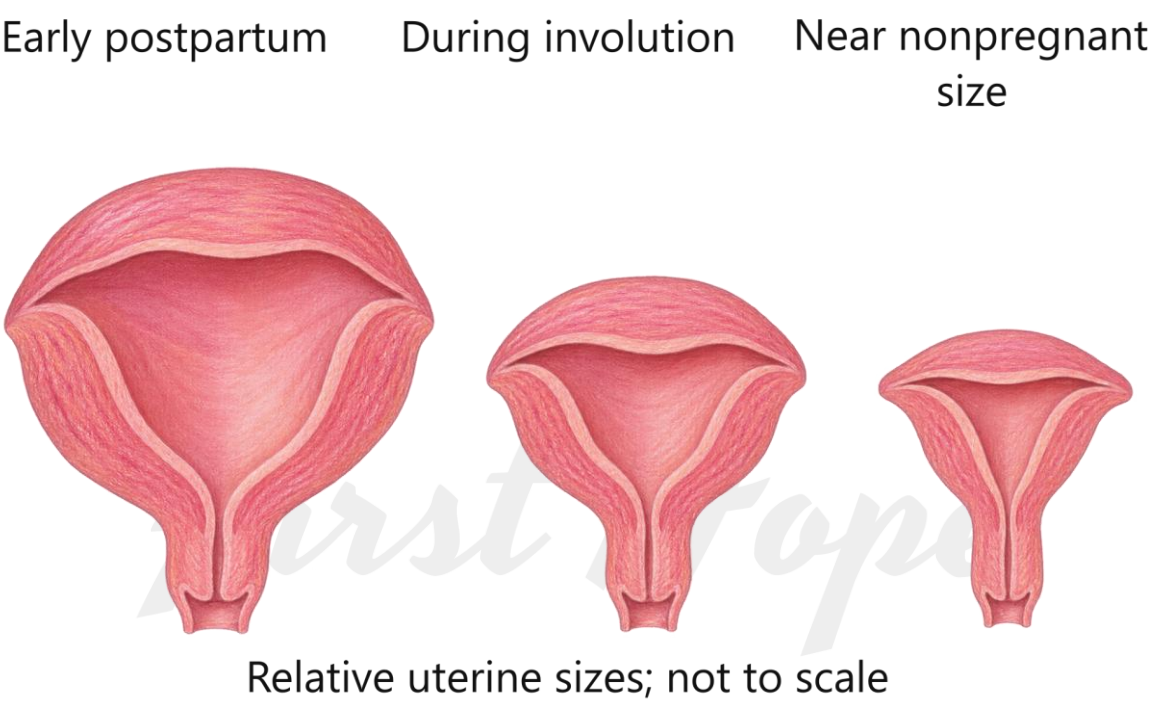
Obstetrics & Gynaecology - Topic 19 - Normal and abnormal puerperium

Normal Puerperium

Definition

- The puerperium begins after placental delivery and conventionally covers the first six weeks, although some physical and psychological recovery takes longer.

Physiological Recovery



The uterus progressively decreases in size during postpartum involution

- The uterus contracts, the placental site heals and many pregnancy-related changes gradually return towards the non-pregnant state.
- Recovery varies with the birth, blood loss, illness, sleep, nutrition and available support, so a fixed timetable should not replace individual assessment.

Components of Postpartum Recovery

A. Uterine Involution

- Contraction and reduction in the size of uterine muscle cells make the uterus progressively smaller after birth.
- The fundus is initially palpable near the umbilicus and descends over the following days, usually becoming no longer palpable abdominally by about two weeks.
- The uterus approaches its non-pregnant size over approximately six weeks, with normal variation between women.

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- After-pains are intermittent uterine cramps that may be stronger in multiparous women and during breastfeeding because of oxytocin release.
- A persistently enlarged, tender uterus or renewed heavy bleeding suggests delayed involution and needs assessment for retained tissue or infection.

B. Lochia and Genital-Tract Recovery

- Lochia is the discharge of blood, mucus and healing uterine tissue after delivery.
- It is initially red, becomes more pink or brown and then lighter or whitish as recovery progresses.
- These phases are called lochia rubra, serosa and alba, but the exact day of transition varies.

Phase	Approximate usual period	Main appearance
Rubra	First few days.	Predominantly red discharge containing blood.
Serosa	Following days, often through about the second week.	Pinkish or brownish fluid with less blood.
Alba	Later weeks.	Pale or whitish discharge with more leucocytes and mucus.

- The amount should generally decrease, and a renewed heavy flow or offensive smell requires evaluation regardless of the expected phase.
- Increasing bleeding, large clots, offensive discharge, fever or severe pain is not explained safely by normal lochia alone.
- The cervix and vagina recover gradually, while perineal wounds and pelvic-floor muscles require healing and progressive rehabilitation.

C. Circulation and Elimination

Circulatory Changes

- Mobilisation of retained pregnancy fluid can increase urine output and sweating during the early days after birth.
- The tendency to form blood clots remains increased after delivery, especially with surgery, immobility, obesity or previous thrombosis.

Bladder Function

- Bladder sensation may be reduced after labour or regional anaesthesia, so urinary retention must be recognised before overdistension causes injury.

Bowel Function

- Constipation and haemorrhoids are common, and hydration, appropriate fibre, movement and suitable medicines can help.

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D. Lactation and Fertility

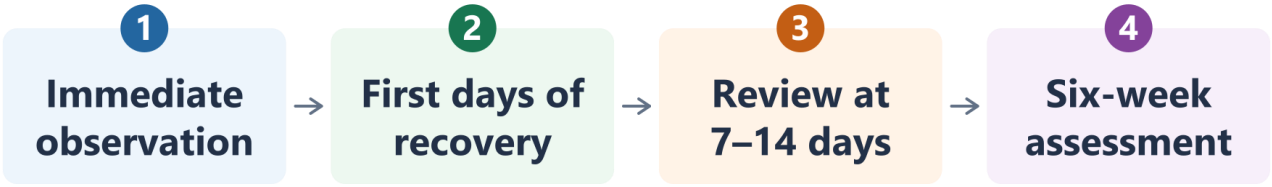
Lactation

- Falling placental hormone levels permit milk production, while suckling supports prolactin and oxytocin release.

Return of Fertility

- Frequent breastfeeding often delays ovulation, but ovulation may occur before the first menstrual period.
- Amenorrhoea alone is therefore not reliable contraception unless all lactational amenorrhoea method criteria are met.

Routine Postnatal Assessment



Clinical Assessment and Individual Risks

- Check pulse, blood pressure, temperature, uterine tone, bleeding and general condition regularly in the immediate period after birth.
- Ask about pain, bladder and bowel function, breast comfort, sleep, mood, feeding difficulties and support at home.
- Assess the perineum or caesarean wound when indicated and with consent, privacy and appropriate explanation.
- Review anaemia, blood pressure, diabetes, thrombosis risk and any other antenatal or delivery complication rather than assuming that delivery has cured it.

Observation and Scheduled Contacts

- Healthy women and babies need observation in the facility for at least 24 hours after an uncomplicated birth, with a longer stay when their condition requires it.
- Plan further contacts around 48 to 72 hours, seven to fourteen days and six weeks, adapted to the Indian service schedule and individual risk.

Support Recovery

Nutrition, Mobilisation and Pain Care

- Provide adequate food, fluids, rest and continued prescribed iron or other supplements, without imposing unnecessary food restrictions.
- Encourage early safe mobilisation, pelvic-floor exercises when comfortable and gradual return to activity according to recovery.
- Use breastfeeding-compatible analgesia when appropriate and investigate persistent or worsening pain instead of simply increasing painkillers.

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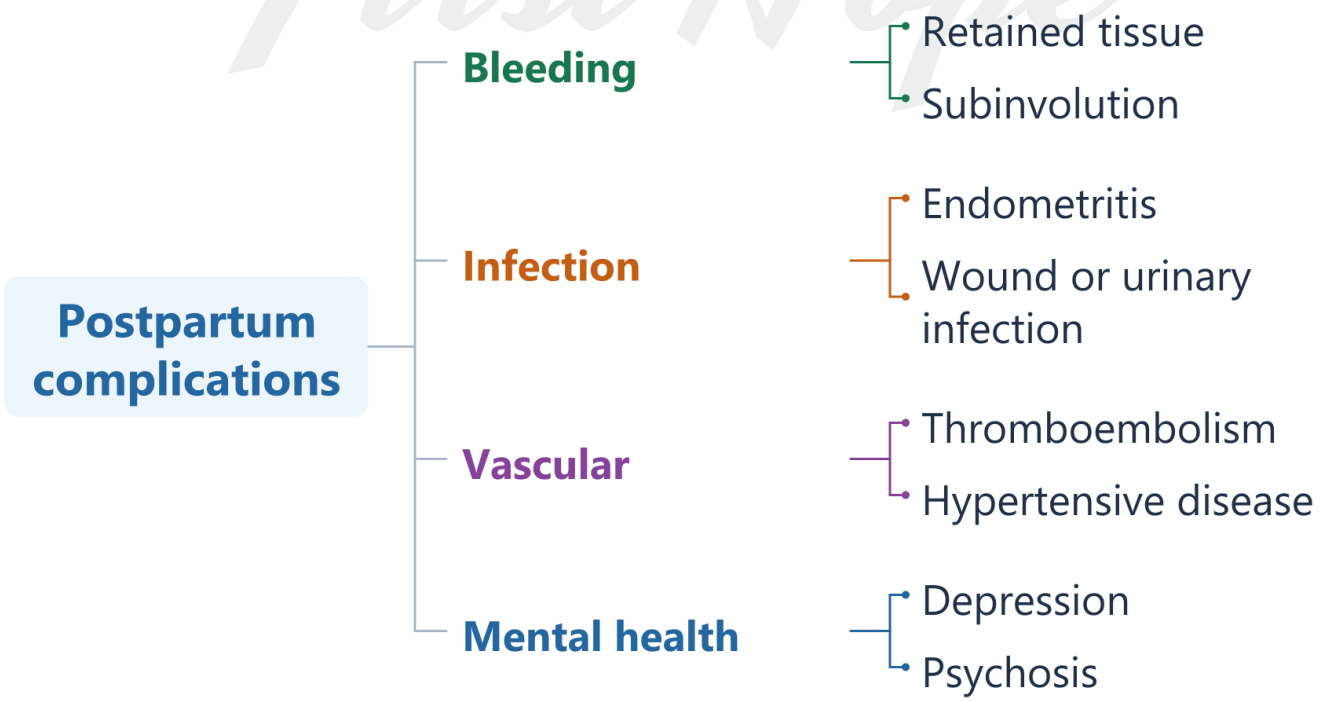
Hygiene, Sexual Health and Emotional Safety

- Explain perineal hygiene, pad changes, wound care and when to seek help, while avoiding routine vaginal douching or antiseptic insertion.
- Discuss sexual activity without pressure; comfort, healing, consent and contraception matter more than an arbitrary compulsory date.
- Ask about emotional wellbeing and safety privately, including possible domestic violence, coercion and practical support needs.

Abnormal Puerperium

Assess a Postpartum Woman Who Is Unwell

- Start with airway, breathing, circulation, mental state and vital signs, and call for urgent help when there is shock, severe breathlessness, seizure or altered consciousness.
- Ask when symptoms began, how the birth occurred, whether the placenta was complete and whether there were prolonged membranes, procedures or heavy bleeding.
- Examine the likely source while keeping a broad differential, because fever or tachycardia may arise from infection, bleeding, thrombosis or another illness.
- Investigations may include blood count, cultures, renal and liver function, coagulation tests, lactate, urine tests and targeted imaging according to severity.



Secondary Postpartum Haemorrhage

- Abnormal heavy bleeding beginning after the first 24 hours can result from retained placental tissue, endometritis, subinvolution or less common vascular and coagulation causes.

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Urgent Assessment and Cause-Directed Care

- Resuscitate significant bleeding immediately, obtain intravenous access and blood tests, and involve the obstetric team without waiting for a scan.
- Assess uterine size and tenderness, inspect for trauma when appropriate and use ultrasound with Doppler selectively to clarify the cause.
- Treat infection when suspected and arrange carefully planned evacuation or another definitive procedure when indicated.
- Avoid blind repeated instrumentation when a vascular lesion or abnormal placental adherence is possible, because this can worsen bleeding.

Puerperal Infection and Sepsis

- Infections after childbirth may involve the genital tract, urinary tract, breasts or an operative wound.
- Maternal sepsis occurs when infection causes life-threatening organ dysfunction.

Recognition and Source Control

Clinical Recognition, Organ Dysfunction and Risks

- Endometritis commonly presents with fever, uterine tenderness, lower abdominal pain and offensive lochia, but severe sepsis may occur without all these findings.
- Maternal sepsis is infection that produces life-threatening organ dysfunction during pregnancy, childbirth, after abortion or in the postpartum period.
- New confusion, oliguria, hypotension or respiratory deterioration can indicate organ dysfunction and require immediate escalation even without a high fever.
- Risk rises after caesarean birth, prolonged rupture of membranes, repeated examinations, retained tissue and poor infection-prevention practice.

Antibiotics, Source Control and Reassessment

- Start prompt broad-spectrum intravenous antibiotics for serious infection, obtain cultures without delaying treatment and provide monitored resuscitation.
- Clindamycin with gentamicin is one established endometritis regimen, while local resistance, renal function, allergy and the suspected source guide the actual prescription.
- Retained infected tissue, an abscess or necrotic wound may require source control in addition to antibiotics.
- Persistent fever despite treatment requires reassessment for an undrained focus, resistant infection, urinary disease, thrombosis or another cause.

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