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Postpartum practice: guidelines for clinical practice from the French College of Gynaecologists and Obstetricians (CNGOF)

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ABSTRACT

Objective: To make evidence-based recommendations for the postpartum management of women and their newborns, regardless of the mode of delivery.
Material and methods: Systematic review of articles from the PubMed database and the Cochrane Library and of recommendations from the French and foreign societies or colleges of obstetricians.
Results: Because breast-feeding is associated with reductions in neonatal, infantile, and childhood morbidity (lower frequency of cardiovascular, infectious, and atopic diseases and infantile obesity) (LE2) and improved cognitive development in children (LE2), exclusive and extended breastfeeding is recommended (grade B) for at least 4–6 months (professional consensus). Pharmacological treatments for inhibition of lactation should not be given routinely to women who do not wish to breastfeed (professional consensus). Because of potentially serious adverse effects, bromocriptine is contra-indicated in inhibiting lactation (professional consensus). For women aware of the risks of pharmacological treatments to inhibit lactation but choose to take them, lisuride and cabergoline are the preferred drugs (professional consensus). Regardless of the mode of delivery, only women with bleeding or symptoms of anemia should be tested for it (professional consensus). Immediate

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postoperative monitoring after cesarean delivery should be performed in the postanesthesia care unit (PACU). An analgesic multimodal protocol for analgesia, preferring oral administration, should be developed by the medical team and be available for all staff (professional consensus) (grade B). Thromboprophylaxis with compression stockings should begin the morning of all cesarean deliveries and maintained for at least 7 postoperative days (professional consensus) with or without the addition of LMWH, depending on the presence and severity (major or minor) of additional risk factors. It is recommended that women be informed of the dangers of closely spaced pregnancies (LE3), that effective contraception begin no later than 21 days post partum for women who do not want such a pregnancy (grade B), and that it be prescribed at the maternity ward (professional consensus). In view of the postpartum risk of venous thromboembolism, use of combination hormonal contraception is not recommended before six weeks post partum (grade B).

Pelvic floor rehabilitation in asymptomatic women to prevent urinary or anal incontinence in the medium or long term is not recommended (professional consensus). Rehabilitation using pelvic floor muscle contraction exercises is recommended to treat persistent urinary incontinence at 3 months post partum (grade A), regardless of the type of incontinence. Postpartum pelvic floor rehabilitation is recommended to treat anal incontinence (grade C), but not to treat or prevent prolapse (grade C) or dyspareunia (grade C). The months following the birth are a period of transition and of psychological changes for all parents (LE2) and are still more difficult for those with psychosocial risk factors (LE2). Situations of evident psychological difficulties can have a significant effect on the child's psychological and emotional development (LE3). Among these difficulties, postpartum depression is most common, but the risk of all mental disorders is generally higher in the perinatal period (LE3).

Conclusion: The postpartum period presents clinicians with a unique and privileged opportunity to address the physical, psychological, social, and somatic health of women and babies.

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Introduction and methods [1–3]

The sponsor (the French College of Gynecologists and Obstetricians (CNGOF)) appointed a steering committee (Appendix A) to define the exact questions to be put to the experts, to choose them, follow their work and draft the synthesis of recommendations resulting from this work [1]. The experts analyzed the scientific literature on the subject to answer the questions raised. A literature review identified the relevant articles through mid-2015 by a search of the MEDLINE database and the Cochrane Library. The search was restricted to articles published in English and French [2,3]. Priority was given to articles reporting results of original research, although review articles and commentaries were also consulted. For each question, each overview of validated scientific data was assigned a level of evidence based on the quality of its data, in accordance with the framework defined by the HAS (French Health Authority) [3], summarized below.

Quality of evidence assessment

LE1: very powerful randomized comparative trials, meta-analyses of randomized comparative trials;

LE2: not very powerful randomized trials, well-run non-randomized comparative studies, cohort studies;

LE3: case–control studies;

LE4: non-randomized comparative studies with notable biases, retrospective studies, cross-sectional studies, and case series.

A synthesis of recommendations was drafted by the organizing committee based on the replies given by the expert authors. Each recommendation for practice was allocated a grade, defined by the HAS as follows:

Classification of recommendations

Grade A: Recommendations are based on good and consistent scientific evidence

Grade B: Recommendations are based on limited or inconsistent scientific evidence

Grade C: Recommendations are based primarily on consensus and expert opinion

Professional consensus: In the absence of any conclusive scientific evidence, some practices have nevertheless been recommended on the basis of agreement between the members of the working group (professional consensus).

All texts were reviewed by persons not involved in the work, i.e., practitioners in the various specialties (Appendix) concerned and working in different situations (public, private, university, or non-university establishments). Once the review was completed, changes were made, if appropriate, considering the assessment of the quality of the evidence.

The original long texts in French are cited [4–15], but their individual references are not included here in view of the enormous space they would occupy in this article intended to summarize the guidelines.

Breast-feeding (part I): frequency, benefits and drawbacks, optimal duration, and factors influencing its initiation and continuation

At birth, nearly 70% of French children are breastfed (LE2). Breast-feeding continues for a median of 15 weeks and is the exclusive method of feeding for a median of 3.5 weeks. At 3 months, only a third of the children breastfed at birth remain unweaned (LE2). Breast-feeding is associated with better cognitive development in children (LE2); this outcome may be explained by the composition of breast milk, the mother's interaction with the child, sociocultural level, or even by all three of these factors simultaneously. The duration of breast-feeding and of its exclusivity enhances this effect (LE2). Exclusive and prolonged breast-feeding (grade B) for 4–6 months (professional consensus) is recommended to prevent many short- and long-term diseases (such as otitis, gastrointestinal infections, atopic disorders, obesity, and cardiovascular disease). Breast-feeding does not prevent postpartum depression (professional consensus). Prolonged-breast feeding is also recommended to reduce the incidence of breast cancer (grade B). Recommendations intended to increase the rate of breastfeeding initiation and its duration include: healthcare professionals should support mothers in this project (grade A), and messages promoting breast-feeding should promote breast-feeding on demand, without regular intervals between

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