



Bladder and Bowel Community

Factsheet: After a Baby

Most Women accept that they might get a vaginal tear during childbirth, but having a bladder or bowel problem after giving birth to their baby is rarely in the minds of expectant mothers.

This factsheet aims to cover some possible problems that might occur and the treatments. The main thing to remember is that most of these problems are usually treatable and some, perhaps, can even be avoided by following the health professional's advice.

Pelvic Floor

The pelvic floor is made of layers of muscles, which act like a hammock, holding the bladder, bowel and uterus in place. These muscles can be weakened during pregnancy by the extra weight and natural hormonal changes. Childbirth can cause more problems especially if delivery is prolonged or the baby is large or if delivery is quick. Forceps and ventouse assisted deliveries may increase the risk of damage; muscle tearing or episiotomies (where the muscle is cut to allow an easier birth) can cause further damage. Research has shown that antenatal and postnatal pelvic floor exercises can help to prevent these problems and also improve recovery.

Urinary Problems

Stress urinary incontinence (SUI) is defined as a sudden loss of urine during normal day to day activities. It is also commonly referred to as bladder weakness and weak bladder. If you have this problem you may notice leakage if you laugh, cough, sneeze, walk, exercise, or lift something.

A weak bladder usually occurs when the muscles in the pelvic floor or sphincter have been damaged or weakened. The sphincter is a circular muscle that goes around the urethra (the tube that urine comes out of) and squeezes as the bladder fills up to create a seal so that urine can't leak out.

Stress urinary incontinence is common both during the late stages of pregnancy and also postnatally. Pelvic floor exercises usually resolve symptoms but if leakage persists you are encouraged to seek support from your local continence service. If you'd like to find out more about stress urinary incontinence, please visit our [bladder problems](#) section.

Episiotomies and Tears

Tearing of the perineal tissues can be localised to small lacerations around the vagina to more complex tears involving the perineum and anal canal.

A third degree tear may involve damage to one or both of the circular muscles and a fourth degree tear will also include the lining of the anus. When this occurs, it is necessary for the tear to be stitched in theatre and that an epidural or spinal anaesthetic will be required.

At Home

At the time of discharge the following advice will be given to help with the healing process and reduce the risk of problems:

- Shower or bath at least once a day to keep the area clean and dry.
- Drink 2-3 litres of fluid every day and eat a healthy well balanced diet, including breakfast, to achieve a normal consistency stool.
- Do pelvic floor muscle exercises as soon as you can after birth. This will increase the circulation of blood to the area, reduce the swelling and ease discomfort. Establishing a routine of practicing pelvic floor muscle exercises whilst sitting feeding the baby and having a glass of fluid at hand to satisfy thirst, makes the most of the time available.
- Follow the programme of pelvic floor muscle exercises given to you by your midwife or physiotherapist to strengthen the muscles which will have been affected during pregnancy and delivery.
- Many women find that they have to rush to the toilet to have their bowels open or have problems controlling wind from the bowel during the first few weeks after delivery, but this control gradually improves. It can be helped by practicing anal sphincter exercises and bowel habit training will help to resist urgency and gradually increase the time between feeling sensation and the need to empty the bowel.
- Whilst the area is healing it may be necessary to take laxatives to make it easier to empty the bowel and to prevent constipation.

The next clinic appointment is usually 6-12 weeks after delivery. During this appointment the doctor/ midwife will check on the woman's recovery, but most importantly it allows the woman to discuss any concerns that she has. Most women report no problems at this stage, those that do benefit from seeing a specialist physiotherapist who will help the woman to regain pelvic floor strength. Most women are able to have further vaginal delivery following a 3rd or 4th degree tear, if the tear has healed and there are no bowel control problems.

Urinary Retention

Difficulty passing urine is a common problem in the first day or two following childbirth, but with careful management this should resolve without long term consequences. The small numbers of women, who are unable to pass urine, experience the discomfort of a very full bladder and need to be catheterised. Urinary retention may also present itself as having to pass small amounts of urine frequently - but only in very small amounts.

What Causes Urinary Retention?

Hormonal changes in pregnancy cause the bladder muscle to lose some of its tone and so bladder capacity increases from the third month of pregnancy. This increase may not be obvious to the pregnant woman apart from experiencing an increased number of visits to the toilet to empty her bladder. After delivery, the loss of tone of the bladder muscle can cause difficulties in emptying out.

There are procedures that may contribute to the development of difficulties in passing urine, such as: epidural for pain relief, long labour, prolonged second stage of labour, forceps or ventouse delivery and extensive vaginal lacerations. An effect of epidural or spinal anaesthetic is that it blocks normal sensation from the bladder and interferes with the normal bladder filling and emptying function. Bladder function should be closely monitored if an epidural is used.

Bladder Management

There are certain actions that can be taken to avoid urinary retention - however providing proactive management starts during pregnancy. For a successful bladder management routine to be established it is important for midwives to identify:

- The small number of women who have pre-existing difficulties with bladder emptying and use intermittent catheterisation. An intermittent catheter is a small tube which is inserted into the bladder to drain the urine and then taken out.
- Women with a large capacity bladder who pass urine infrequently, four or less times a day, and pass large volumes of urine, in excess of 600mls.
- Women who have experienced problems with bladder emptying following a previous delivery.

Bladder Management during Labour

In labour women should be encouraged to pass urine at regular intervals, 2 hourly or before top-up of their epidural, if they have one in place. If the woman cannot pass urine after a second attempt, an intermittent catheter should be used to empty the bladder. If labour is long, a temporary indwelling urethral catheter connected to a urine drainage bag on continuous drainage can be used.

Bladder Management Following C-Section or Vaginal Delivery with Epidural

The number of caesarean sections has increased over the years and approximately 1 in 4 women will have a section.

Bladder sensation may take over 10 hours to return after caesarean section under spinal analgesia and over 6 hours following vaginal delivery with or without epidural.

Retention of urine following caesarean section does occur; even though women will have been catheterised for 12 – 24 hours after delivery. Women most at risk are those who have undergone emergency caesarean section for lack of progress in labour.

Bladder Management Following Vaginal Delivery

It is recommended that women who deliver without epidural pass urine within 6 hours of delivery. Encouragement after 4 hours allows time for simple measures to be tried, such as; pain relief, getting out of bed and walking about or a warm bath. The recommended action after 6 hours, for women, who either cannot pass urine or only pass small amounts of urine, is either an ultrasound bladder scan to estimate the amount of urine within the bladder or catheterisation.

Indwelling urethral catheterisation is the main method of choice in most maternity units. The catheter allows urine to drain in a bag, so preventing the bladder from filling and allowing it to rest, or intermittent drainage via a catheter valve, so as to allow the bladder to fill and empty in a normal cycle. The catheter will be removed after approximately 24 hours to check if normal bladder emptying is achieved. If not women may be sent home with a catheter in place and an appointment given to return to the hospital for removal.

During this period of time women are advised to drink approximately 2 litres in 24 hours. Excessive fluid intake and any intravenous fluids given during labour will increase the production of urine and the speed at which the bladder fills. During the 2nd to 5th day following delivery, the body gets rid of the additional fluids which it retained as part of normal pregnancy, so more urine will be produced.

Alternative Methods of Management

Another option to manage a bladder which does not empty is suprapubic catheterisation, a catheter which enters the bladder through the abdominal wall, which may be left in place for up to 6 weeks. Once removed the catheter hole will soon heal up - probably in 48 hrs. A benefit of suprapubic catheterisation with intermittent drainage is that the woman can try to pass urine in the normal manner.

Women can be taught to intermittently self-catheterise to empty the bladder, so as to prevent delayed discharge from hospital. Support and advice at home can be provided by community midwives or local

continence nurse specialists. The advantage of this method is that the woman only needs to continue until her bladder resumes a normal pattern of emptying.

Early discharge from hospital may result in women returning to hospital with problems passing urine that were not apparent during the first 48 hours following delivery. It is often found that constipation is the underlying cause and resolving that problem improves bladder emptying. Normal bowel movements can vary from 3 times a day to 3 times a week with a well formed stool.

Further Information

If you are experiencing any of the problems mentioned in this factsheet, you may wish to seek advice from your GP or local continence clinic. The continence clinics are run by the NHS and you don't always need to be referred to a clinic by your GP, as some clinics will allow you to book an appointment yourself.

Pelvic floor muscle exercises are also very useful for strengthening the muscles that support the bladder and bowel. Performing these exercises can help alleviate symptoms and can often prevent the problem from worsening.

For more information about Pelvic floor muscle exercises, please see our Pelvic Floor for Women factsheet in the Downloads section of our website, or you can obtain a copy from our office by telephoning 01926 357220.

The Bladder and Bowel Community provides information and support for people with bladder and bowel issues. We publish a wide range of user friendly booklets and factsheets.

For more information please call us on 01926 357220, email help@bladderandbowel.org or write to us at The Bladder and Bowel Community, 7 The Court, Holywell Business Park, Northfield Road, Southam, CV47 0FS.

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