

Postpartum Endometritis and Sepsis

Infection in the uterus lining after delivery, usually from bacteria that climbed up during birth.

THE STORY IN ONE SENTENCE

Infection in the uterus lining after delivery, usually from bacteria that climbed up during birth.

“Infection of the uterus lining after childbirth. Give clindamycin plus gentamicin by vein until fever has been gone for 48 hours. Hunt for hidden pockets of pus with imaging if fever won't quit.”

Normal anatomy — the body's job

After birth, the uterus shrinks from the size of a watermelon back down to a pear, the cervix closes tight, and the raw spot where the placenta was attached heals over. The womb flushes out leftover blood and tissue for a few weeks while staying clean inside.

BODY'S JOB

The uterus is a thick muscle that holds and feeds the baby. After delivery, it clamps down hard to squeeze shut the blood vessels where the placenta was stuck and to push out leftover tissue. A healthy lining and a closed cervix keep vaginal germs from climbing up into the clean healing space inside.

1. Baby and placenta deliver — the uterus is now a big, soft, empty bag with a raw patch inside where the placenta was.
2. The uterine muscle squeezes down tight to pinch off bleeding vessels and shrink the womb back to normal size over about six weeks.
3. The cervix (the gate between vagina and uterus) closes to seal the womb off from the outside world.
4. The lining sheds old blood, clots, and tissue (lochia) for several weeks while new lining grows underneath.
5. Normally, the immune system patrols the uterus and keeps bacteria from settling in — healing happens cleanly and fever-free.

What breaks

Bacteria from the vagina climb up into the raw, open uterus and infect the lining, especially when surgery, long labor, or manual placenta removal give germs an easy highway in.

CLINICAL TERM

Polymicrobial infection (many kinds of bacteria together) of the endometrium (uterus lining) and myometrium (muscle wall), most often after cesarean delivery, prolonged rupture of membranes, prolonged labor, or manual removal of the placenta.

How the body compensates

The body cranks up heart rate, breathing, and immune signals to fight the infection and keep organs fed with oxygen. Vital signs may look okay at first even while the infection is spreading — that's the dangerous middle where you can miss how sick the patient really is.

1. {'what': 'Fever spikes (often 100.4°F / 38°C or higher within the first few days after delivery)', 'why': 'The hypothalamus (the brain's thermostat) raises body temperature because heat helps immune cells work faster and slows bacterial growth. This is the body's first alarm that infection is present.', 'cost': 'High fever drains energy, causes chills and sweating, and can push heart rate dangerously high — but it's also a key clue that infection is brewing.'}
2. {'what': 'A fast heart rate (Tachycardia) (heart beats faster than 100 per minute)', 'why': 'The heart speeds up to pump more blood (carrying oxygen and white blood cells) to the infected uterus and to carry away waste and toxins. Fever itself also makes the heart beat faster.', 'cost': 'A racing heart can look like normal post-delivery stress, so the team might not realize the patient is sliding toward sepsis until other signs pile up. The heart is already working overtime, so it has less reserve if infection spreads.'}
3. {'what': 'Increased white blood cell count (leukocytosis)', 'why': 'Bone marrow floods the bloodstream with extra white blood cells (especially neutrophils, the bacteria-eating soldiers) to swarm the infection and try to kill invaders.', 'cost': 'White count is often high after normal delivery, so mild elevation can be missed. Very high or very low counts signal the immune system is either in overdrive or exhausted — both are danger signs.'}
4. {'what': 'Uterine tenderness and pain', 'why': 'Inflammatory chemicals (like prostaglandins and cytokines) flood the infected tissue, making nerve endings fire pain signals. The uterus swells and becomes sore to touch because it's packed with immune cells fighting bacteria.', 'cost': 'Pain and tenderness warn you exactly where the infection is, but they also make it hard for the patient to move, cough, or care for her baby — and severe pain can be confused with normal after-birth cramping.'}

5. {'what': 'Foul-smelling lochia (vaginal discharge after birth)', 'why': 'Bacteria breaking down tissue and blood release smelly gases and toxins. Anaerobic bacteria (the kind that live without oxygen) are especially known for the rotten, fishy odor.', 'cost': 'The smell is a red flag for infection, but not every postpartum infection smells bad — so you can't rule it out if discharge smells normal.'}
6. {'what': 'Increased respiratory rate (breathing faster)', 'why': 'The body breathes faster to blow off carbon dioxide (acid) building up from infection and to pull in more oxygen for hard-working tissues. If sepsis starts, the lungs work even harder to balance blood chemistry.', 'cost': 'Faster breathing burns energy and can tire the patient out. It's also an early sepsis warning sign that's easy to overlook if you're not counting breaths.'}
7. {'what': 'Normal or even high blood pressure at first', 'why': 'The body tightens blood vessels (vasoconstriction) and pumps harder to keep blood flowing to the brain, heart, and kidneys even while infection steals resources. Stress hormones like adrenaline and cortisol keep pressure up.', 'cost': 'This is the dangerous middle — vital signs look stable, so the team may not realize the patient is silently marching toward septic shock. Once blood pressure drops, organs are already starving and the window to reverse course is closing fast.'}
8. {'what': 'Watch for the tipping point: persistent fever despite antibiotics, worsening pain, low blood pressure (hypotension) (low blood pressure), confusion, decreased urine output, or signs of abscess (pocket of pus)', 'why': 'These mean the infection has either spread beyond the uterus (into blood vessels, pelvis, or abdomen), formed a walled-off pocket that antibiotics can't reach, or triggered sepsis. The body's compensations are failing and organs are starting to shut down.', 'cost': 'Once you hit this point, the patient needs imaging (usually CT scan) to find abscesses, possible surgery to drain pus or remove infected tissue, ICU-level support with IV fluids and vasopressors (medicines that squeeze vessels to raise blood pressure), and sometimes even hysterectomy (removal of the uterus) to save her life.'}

Domino effect

1. Bacteria enter the uterus during or right after delivery. — The cervix opens wide during labor, membranes rupture and let vaginal bacteria float up, and the placenta leaves a raw, bloody wound inside the uterus. C-section adds a surgical cut that carries germs straight through the muscle. Manual removal of the placenta or repeated cervical exams push more bacteria in. The uterus, normally sterile, is suddenly full of germs.

2. Bacteria colonize the endometrium and myometrium and start multiplying. — The warm, blood-rich environment is perfect for bacterial growth. Common culprits include *E. coli*, group B strep, *Bacteroides* and other anaerobes, enterococcus, and sometimes staph. Because it's usually a mix of germs (polymicrobial), no single antibiotic can kill them all alone — that's why treatment uses combination therapy.
3. The immune system launches an inflammatory attack: fever, pain, swelling, and pus. — White blood cells flood the uterus, release cytokines (chemical alarm signals), and crank up body temperature. Blood vessels dilate and leak fluid into tissue, causing swelling and tenderness. Dead bacteria, dead immune cells, and tissue debris mix into thick, foul-smelling discharge. This is the body fighting hard — but the fight itself causes the symptoms you see.
4. Systemic signs appear: a fast heart rate (tachycardia), fast breathing (tachypnea), high white count, and a run-down, unwell feeling (malaise). — Inflammatory signals spill into the bloodstream. The heart races to deliver more oxygen and immune cells. Breathing speeds up to balance acid-base chemistry. The liver and bone marrow ramp up production of clotting factors and white cells. The patient feels exhausted, achy, and weak because her whole body is on high alert.
5. If untreated or if antibiotics don't penetrate well, infection spreads or walls off into abscesses. — Bacteria can burrow deeper into the uterine muscle, travel through lymphatic channels to the pelvis, seed pelvic veins (causing septic pelvic thrombophlebitis — infected blood clots), or form pockets of pus that antibiotics can't reach. Abscesses act like hidden bunkers where bacteria survive and keep the fever going even on treatment.
6. Sepsis develops if bacteria or their toxins enter the bloodstream in large amounts. — The immune system goes into overdrive body-wide. Blood vessels leak, blood pressure drops (septic shock), and organs (kidneys, lungs, liver, brain) don't get enough oxygen. The patient becomes confused, urine output falls, oxygen levels drop, and she may need ICU support with IV fluids, vasopressors (medicines like norepinephrine that tighten vessels), and sometimes breathing support.
7. Treatment with IV clindamycin plus gentamicin (and sometimes ampicillin if very sick) kills bacteria and halts the cascade. — Clindamycin covers anaerobes and many gram-positive cocci. Gentamicin hits gram-negative rods like *E. coli*. Ampicillin is added for enterococcus coverage in severe cases. Antibiotics are continued IV until the patient has been fever-free for 48 hours — that proves the infection is truly beaten, not just suppressed. If imaging shows an abscess, it must be drained surgically or with a needle, because pus pockets won't clear on antibiotics alone.

8. With effective treatment, fever resolves, pain improves, discharge clears, and the uterus heals. — Once bacteria are dead and pus is drained, the immune system can stand down. Inflammation fades, blood vessels seal back up, and the uterine lining regrows clean tissue. The patient's energy returns, vital signs normalize, and she can safely go home to recover and care for her baby.

Symptoms · what the patient feels, and why

- Fever (usually 100.4°F or higher) starting 1–3 days after delivery: Bacteria (often from the vagina or skin) climb into the uterus during labor or C-section, and the body's immune system sends white blood cells to fight the invaders, which raises your temperature—fever is the alarm bell that infection is happening.
- Lower belly pain or tenderness over the uterus: The lining of the uterus (the endometrium) is swollen and irritated by infection, so touching or pressing on the belly hurts—like pressing on a bruise.
- Foul-smelling vaginal discharge (lochia): Normal postpartum bleeding (lochia) contains tissue and blood, but when bacteria break down that tissue inside the uterus, they release gases and waste products that smell bad—like rotting garbage.
- Heavy vaginal bleeding (more than a normal period): Infection weakens the uterine lining and blood vessels, so they bleed more easily; the uterus also may not contract well when it's inflamed, letting blood pool and spill out.
- Fast heart rate (tachycardia, over 100 beats per minute): Infection triggers the release of cytokines (immune alarm signals) that tell the heart to pump faster to deliver more white blood cells and oxygen to fight the germs; fever also speeds the heart.
- Chills or shaking: When bacteria spill toxins into the bloodstream, the hypothalamus (the brain's thermostat) resets your target temperature higher, and shivering is the body's way of making heat to reach that new set point.
- Feeling very weak, confused, or short of breath: If bacteria enter the bloodstream (sepsis), they trigger a whole-body inflammatory storm that drops blood pressure and starves organs (including the brain and lungs) of oxygen, causing confusion, weakness, and trouble breathing.
- Blood pressure dropping (systolic under 90 mmHg) or very low urine output: Severe infection releases toxins that make blood vessels leak and widen, so pressure falls; the kidneys get less blood flow and make less urine—this is septic shock, a life-threatening emergency.

Focused exam

- Fever $\geq 100.4^{\circ}\text{F}$ (38°C) on two occasions at least 4 hours apart, or $\geq 102.2^{\circ}\text{F}$ (39°C) once, in the first 10 days after birth: The body cranks up its thermostat to fight bacteria that climbed into the uterus (the organ that held the baby). Fever is the first warning sign that the lining of the uterus is infected. This happens most often after a C-section (surgery to deliver the baby through a cut in the belly) because the cut gives bacteria a door into the uterus.
- Tender, boggy uterus when you press on the lower belly: The uterus should feel firm and shrinking after birth. If it feels soft and squishy (boggy) and the mom winces or says it hurts, bacteria are multiplying inside the lining and the tissue is swollen and inflamed. This tenderness tells you the infection is in the uterus, not somewhere else like the bladder or lungs.
- Foul-smelling or pus-filled (purulent) (pus-like) vaginal discharge or lochia: Normal bleeding after birth (lochia) smells like blood, not like garbage or rotten meat. A bad smell means bacteria are multiplying inside the uterus and releasing waste products as they die. Pus (thick, cloudy discharge) means white blood cells are flooding the area to fight the infection. Either one confirms postpartum endometritis.
- Heart rate ≥ 100 beats per minute (tachycardia): When bacteria spread, the heart pumps faster to send more oxygen and infection-fighting white blood cells to the infected tissue. A fast heart rate means the body is working overtime to control the infection. If the heart stays fast even when the fever comes down, bacteria may be spilling into the bloodstream (bacteremia).
- Blood pressure $< 90/60$ mmHg or cold, clammy skin: Bacteria release toxins (poisons) that make blood vessels leak fluid out into the tissues. Blood pressure drops because there is less fluid left in the vessels to push. Cold, clammy skin means blood is being pulled away from the skin to feed the brain and heart. This is septic shock, the most dangerous stage of infection, and it can kill organs fast.
- Chills or shaking (rigors): When bacteria dump toxins into the blood, the hypothalamus (the brain's thermostat) resets higher. The brain thinks the body is too cold, so it makes the muscles shake to generate heat. Shaking chills plus fever together are a strong sign of bacteria in the bloodstream, not just in the uterus.

Diagnostics · every test answers a question

- Complete blood count (CBC) with differential → Is the white blood cell count high, showing the bone marrow is pumping out extra infection fighters? Is the platelet count dropping, warning that clotting is being used up?

- Blood cultures × 2 sets from separate sites before starting antibiotics → Are bacteria growing in the bloodstream, proving the infection has spread beyond the uterus?
- Endometrial tissue culture or uterine cavity swab during manual exploration or curettage (if done) → What exact bacteria are inside the uterus, so antibiotics can be targeted if the first-line drugs fail?
- Serum lactate level → Are the tissues getting enough oxygen, or is the infection so severe that cells are switching to emergency energy-making without oxygen?
- Pelvic ultrasound (transvaginal or transabdominal) → Is there retained placental tissue, a pocket of pus (abscess), or a blood clot in the uterus or pelvis that antibiotics cannot reach?
- CT of the abdomen and pelvis with IV contrast (if ultrasound is not clear or fever persists despite 48–72 hours of antibiotics) → Is there a hidden abscess in the pelvis, infected clots in the ovarian or uterine veins, or spread of infection to the belly (peritonitis)?
- Urinalysis and urine culture → Could the fever actually be coming from a bladder or kidney infection (urinary tract infection) instead of the uterus?
- Chest X-ray (if respiratory symptoms or low oxygen saturation) → Could the fever and fast breathing be from pneumonia or a blood clot in the lungs (pulmonary a traveling clot lodging in a vessel (embolism)) rather than uterine infection?

Treatment logic

- IV clindamycin 900 mg every 8 hours PLUS IV gentamicin 5 mg/kg (based on actual body weight) once daily, OR single-agent IV ampicillin-sulbactam 3 g every 6 hours or piperacillin-tazobactam 3.375 g every 6 hours → Kills the mix of bacteria that climbed into the uterus from the vagina and lower gut. Clindamycin targets anaerobes like *Bacteroides fragilis* (bacteria that live without oxygen deep in infected tissue). Gentamicin kills aerobic gram-negative rods like *E. coli* (bacteria that need oxygen and come from the bowel). Together they cover the broad spectrum of bacteria that cause postpartum endometritis. The single-agent beta-lactam/beta-lactamase inhibitor combinations (ampicillin-sulbactam or piperacillin-tazobactam) work the same way by covering both types of bacteria in one drug.
- Continue IV antibiotics until the mom has been fever-free for at least 24–48 hours and clinical signs (uterine tenderness, a fast heart rate (tachycardia)) are improving; do NOT switch to oral antibiotics in the hospital → Keeps drug levels high in the infected uterine tissue long enough to kill all the bacteria and prevent them from bouncing back (relapse) or forming an abscess. Stopping too early or switching to pills too soon lets surviving bacteria multiply again.

- Add IV ampicillin 2 g every 4–6 hours if no improvement after 48–72 hours of clindamycin plus gentamicin, to cover *Enterococcus* species → *Enterococcus* bacteria (a type of gut bacteria) are naturally resistant to clindamycin and gentamicin. If fever persists despite those drugs, *Enterococcus* may be the culprit. Ampicillin kills *Enterococcus* and plugs that gap in coverage.
- Pelvic ultrasound (or CT if ultrasound is not clear) within 48–72 hours if fever persists despite appropriate IV antibiotics → Finds hidden problems that antibiotics cannot fix: a pocket of pus (abscess) in the pelvis or uterus, leftover placental tissue acting like a foreign body and feeding bacteria, or infected blood clots in the uterine or ovarian veins (septic pelvic thrombophlebitis). Seeing the problem lets you drain it, remove it, or thin the blood to dissolve clots.
- Percutaneous (through the skin) or transvaginal ultrasound-guided drainage of pelvic or uterine abscess if imaging shows a drainable fluid collection → Removes the pocket of pus so antibiotics can reach the remaining bacteria. Pus is full of dead white blood cells, debris, and bacterial toxins that block antibiotics from penetrating. Draining it clears the barrier and lets the immune system and drugs finish the job.
- Manual exploration of the uterus and curettage (scraping) under anesthesia if imaging or clinical suspicion points to retained placental tissue → Removes chunks of leftover placenta that act like a sponge soaked in bacteria. Dead tissue cannot heal and protects bacteria from antibiotics and white blood cells. Taking it out restores normal uterine drainage and lets the infection clear.
- IV heparin (unfractionated) or therapeutic-dose low-molecular-weight heparin (enoxaparin 1 mg/kg every 12 hours) if imaging shows septic pelvic thrombophlebitis (clots in the ovarian or uterine veins) or if fever persists > 5–7 days despite antibiotics and no abscess/retained tissue is found → Thins the blood to stop clots from growing and breaking off to travel to the lungs (pulmonary a traveling clot lodging in a vessel (embolism)). Anticoagulation also improves blood flow so immune cells and antibiotics can reach infected tissue. Infected clots (septic thrombophlebitis) are a hidden cause of persistent fever in postpartum endometritis.

- Sepsis resuscitation bundle if the mom meets sepsis criteria (fever or hypothermia, heart rate > 90, respiratory rate > 20 or PaCO₂ < 32 mmHg, white blood cell count > 12,000 or < 4,000, plus suspected infection) with organ dysfunction (lactate ≥ 2 mmol/L, systolic blood pressure < 90 mmHg, altered mental status, urine output < 0.5 mL/kg/hour): give 30 mL/kg IV crystalloid fluid bolus within the first 3 hours, measure lactate, start vasopressors (norepinephrine first) if mean arterial pressure < 65 mmHg after fluids, and obtain blood cultures before antibiotics → Restores blood pressure and tissue oxygen delivery so organs (brain, kidneys, heart) do not fail. Sepsis makes blood vessels leak and widens them, dropping pressure. Fluids refill the tank; vasopressors squeeze the vessels to raise pressure. This buys time for antibiotics and source control (drainage, curettage) to eliminate the infection.

Medications

Clindamycin plus gentamicin (or piperacillin-tazobactam as a single drug), given through an IV · Broad-spectrum antibiotics (clindamycin is a lincosamide; gentamicin is an aminoglycoside; piperacillin-tazobactam is a beta-lactam plus beta-lactamase inhibitor)

After birth, especially after a C-section, bacteria from the vagina and bowel can climb into the womb lining and multiply, causing infection. The two most common mixes of bacteria are anaerobes (bacteria that grow without oxygen, like *Bacteroides*) and aerobes (oxygen-loving bacteria, like *E. coli* and *Streptococcus*). Clindamycin stops anaerobic bacteria from building their proteins—without proteins, they cannot grow or spread. Gentamicin punches holes in the outer wall of aerobic bacteria, killing them quickly. Piperacillin-tazobactam works as a single drug by blocking the bacteria's ability to build their cell walls (piperacillin) and also stopping the enzyme many bacteria use to break down antibiotics (tazobactam), so it covers both aerobic and anaerobic bugs in one shot. You keep giving the antibiotics through the vein until the mother has had no fever for a full 48 hours—this tells you the infection is truly under control. If she is not better after 48 hours of IV antibiotics, you take pictures (ultrasound or CT scan) to look for pockets of pus (abscesses) or pieces of placenta still stuck inside. If you find a pocket of pus or leftover tissue, you drain the pus or remove the tissue with surgery. If blood clots are blocking pelvic veins (septic pelvic thrombophlebitis), you add heparin to thin the blood and break up the clots. If the mother is very sick with sepsis (the infection has spread into the bloodstream and is shutting down organs), you follow sepsis protocols—give fluids fast, check blood oxygen, support blood pressure, and switch to even stronger antibiotics if needed.

1. Bacteria from the vagina, cervix, or bowel enter the womb during or after delivery, especially if the amniotic sac was broken for a long time, labor was long, or a C-section was done.

2. The bacteria multiply in the womb lining (endometrium), releasing toxins that trigger fever, pain, and foul-smelling discharge.
3. Clindamycin enters the bacterial cell and binds to the ribosome (the protein factory), blocking it so anaerobic bacteria cannot make the proteins they need to survive.
4. Gentamicin enters aerobic bacteria and scrambles their protein-making instructions, and also damages the outer membrane, causing the bacteria to leak and die.
5. Piperacillin blocks the enzyme (transpeptidase) bacteria use to link their cell wall pieces together, so the wall falls apart; tazobactam stops the beta-lactamase enzyme that many bacteria use to destroy piperacillin, keeping the antibiotic working.
6. With fewer live bacteria, the immune system can clear the remaining germs, the fever drops, and the uterus begins to heal.
7. You keep the IV antibiotics going until the mother has been fever-free for 48 hours straight—this makes sure the infection is truly knocked out.
8. If fever continues or returns, imaging (ultrasound or CT) checks for hidden pockets of pus or leftover placenta that antibiotics alone cannot reach; those need to be drained or removed surgically.
9. If pelvic veins are clotted and infected (septic thrombophlebitis), heparin thins the blood to dissolve the clots and stop bacteria from hiding inside them.

SAFETY WATCH

Gentamicin can damage the kidneys (nephrotoxicity) and the inner ear (ototoxicity, causing hearing loss or dizziness), especially if used for more than a few days or in women with kidney disease—doctors check blood levels of gentamicin and kidney function (creatinine) every 1–2 days. · Clindamycin can cause severe diarrhea from *Clostridioides difficile* (C. diff), a bacteria that overgrows when normal gut bacteria are killed—if watery diarrhea starts, stop clindamycin and test for C. diff. · Piperacillin-tazobactam can cause allergic reactions in women allergic to penicillin—ask about penicillin allergy before starting; it can also lower platelets (thrombocytopenia) and cause bleeding if used for many days. · All these antibiotics can trigger anaphylaxis (a severe allergic reaction with throat swelling, trouble breathing, and dropping blood pressure) in rare cases—watch for rash, itching, or breathing trouble in the first hour after the first dose. · If the mother is breastfeeding, small amounts of clindamycin and piperacillin-tazobactam pass into milk, which is usually safe but can rarely cause diarrhea or rash in the baby; gentamicin does not pass into milk well, so it is safe for nursing.

Red flags

- Confusion, extreme sleepiness, or trouble staying awake (sign that the brain is not getting enough oxygen)
- Blood pressure under 90/60 or very fast breathing (over 24 breaths per minute)—signs of septic shock
- Skin that looks mottled, cold, or bluish, or urine output that stops or drops way down (kidneys and circulation failing)
- Severe belly pain that spreads, or belly becomes hard and rigid (infection may be spreading beyond the uterus into the abdomen)

Nursing priorities

1. Obtain two sets of blood cultures from different sites before starting antibiotics, then give first IV antibiotic dose within 1 hour — Blood cultures identify which bacteria are causing infection so doctors can narrow antibiotics later; drawing before antibiotics prevents false-negative results; early antibiotic administration reduces progression to septic shock which drops blood pressure dangerously
2. Start continuous monitoring of heart rate, blood pressure every 15 to 30 minutes, oxygen saturation, and temperature until patient is stable for 2 hours — Sepsis causes a fast heart rate (tachycardia) (fast heart rate over 100), low blood pressure (hypotension) (systolic blood pressure below 90), and sometimes low oxygen (hypoxia) (low oxygen); frequent monitoring detects septic shock early when vasopressors (medications that raise blood pressure) and ICU transfer are needed
3. Give IV fluid bolus of 30 milliliters per kilogram lactated Ringer solution or normal saline over 2 to 3 hours while monitoring lung sounds and urine output — Sepsis causes vasodilation (blood vessels widen) and capillary leak (fluid escapes blood vessels), dropping circulating blood volume; rapid fluid replacement restores tissue blood flow (perfusion) (blood flow to organs) and prevents acute kidney injury; lung listening with a stethoscope (auscultation) detects pulmonary edema (fluid flooding the lungs) (fluid in lungs) from overload
4. Measure urine output every hour using a Foley catheter and report if less than 30 milliliters per hour or 0.5 milliliters per kilogram per hour — Kidneys need adequate blood pressure to filter blood; low urine output (oliguria) means sepsis is reducing renal blood flow (perfusion) or causing acute tubular tissue death (necrosis) (kidney cell damage); catching this early guides more aggressive fluid resuscitation or vasopressor therapy

5. Perform fundal assessment checking uterine firmness and position every 4 hours and note any severe tenderness beyond normal postpartum discomfort — A boggy uterus (soft, not contracted) may indicate retained placental fragments providing food for bacteria or uterine atony (failure to contract) causing bleeding (hemorrhage); exquisite tenderness confirms endometritis; these findings guide need for ultrasound or uterine curettage (scraping procedure)
6. Assess lochia amount, color, and smell every 4 hours and report foul odor or clots larger than a golf ball immediately — Pus-filled (Purulent) (pus-filled) or foul-smelling lochia confirms anaerobic bacterial infection; large clots or heavy bleeding suggest retained products of conception (leftover placenta tissue) that need removal; this changes treatment from antibiotics alone to possible surgical evacuation
7. Keep patient NPO except ice chips until fever resolves and pain improves in case imaging shows abscess needing percutaneous drainage or surgery — TOA (tubo-ovarian abscess, a pus pocket near ovaries) or pelvic abscess develops in 5 to 10 percent of endometritis cases; these require drainage procedures or possible hysterectomy (uterus removal) under anesthesia which is safer on an empty stomach to prevent aspiration (breathing in stomach contents)
8. Do not stop breastfeeding unless mother is critically ill or on contraindicated antibiotics; assist with pumping if separation needed — Clindamycin and gentamicin are compatible with breastfeeding; continued nursing or pumping prevents mastitis (breast infection) and maintains milk supply; separation only needed if hemodynamic instability (unstable vital signs) requires intensive care focus

Sources

- CDC – Maternal Morbidity and Mortality
- ACOG Practice Bulletin No. 195: Prevention and Management of Obstetric Lacerations at Vaginal Delivery (2018)
- WHO recommendations on maternal and newborn care for a positive postnatal experience (2022)
- Surviving Sepsis Campaign International Guidelines (2021)

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