

Postnatal depression

Most psychiatrists would accept that a psychiatric illness is puerperal if it occurs within 12 months of childbirth.

Elation in the first 24 hours after pregnancy can precede one of the following three types of psychiatric disturbance:

- post-partum blues occurs at 3-6 days 30% women.
- depressive illness peaks at 3-6months 13% pregnancies.
- puerperal psychosis occurs 2-4 days

Postpartum blues is a mild and transient disturbance in mood. Estimates of incidence vary between 50-70%, and it is more common in primips

Usual features include crying, fatigue, sensitivity to criticism, anxiety, irritability, helplessness and lability of mood. Symptoms last from few hours to a few days.

There are many causes, including:

- physical discomfort
- the emotional drain of the delivery
- lack of sleep
- anxiety about the ability to cope in the future
- the fear of diminished attractiveness to the partner
- poor relationship with the father
- an unwanted baby

It is a short-lived syndrome which requires support rather than pharmacological treatment.

Moderately severe depressive illness can occur during the puerperium. The peak incidence appears to be at 3 months but with significant numbers of cases still appearing by 6 months and after.

It occurs after 10-15% of pregnancies.

The usual features are similar to non-psychotic depression appearing in women at any other time of life.

Possible causal factors include:

- previous psychiatric history
- poor marital relationship
- lack of social support
- stressful life events
- severe postnatal blues

Puerperal psychosis is a rare complication of childbirth, with an incidence of about 1 to 2 per 1000 births.

- The onset is usually 2 to 4 days after delivery and it is often characterised by clouding of consciousness, perplexity, delusions and hallucinations. The majority of these conditions are affective in nature, either depressive or hypomanic; some are schizophrenic and a mixed picture is not uncommon.
- Paranoid delusions often centre around the child, for example a belief that the child is the devil, or that the world is too evil for the child to live in. Consequently there may be a risk of infanticide or injury to the child. Apart from this specific risk the child may suffer neglect or inappropriate treatment at the hands of a psychotic mother.
- Treatment of puerperal psychosis usually entails admission to hospital, preferably with the baby. In this setting the relationship between mother and baby can be preserved without putting the baby at risk.
- ECT may be necessary together with major tranquilizers, practical help with the child, and support for the rest of the family.

Detection

- the Edinburgh Postnatal Depression Scale (EPDS) is a screening instrument used in the identification of women with postnatal depression. When validated, a score of 11-12 on the EPDS (out of a maximum of 30) has a specificity of postnatal depression of 92.5% and has a sensitivity of 76.7%

PRACTICE POINT

- At the 6 week check, ask about depression symptoms AND make an assessment of the mother's feelings for and attachment to the baby

Management

First line management is psychological intervention often performed by the health visitor or at the surgery.

Antidepressant therapy is indicated for women who have severe depression or who fail to respond to appropriate counselling

state (4):

- when choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account:

safety of the drug in pregnancy, effectiveness, tolerability and adverse effects

tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants · most tricyclic antidepressants have a higher fatal toxicity index than SSRIs

- tricyclic antidepressants (TCA) are relatively safe in breast feeding but most manufacturers advise avoid.

Risks of SSRIs in pregnancy

- **SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate**
- available evidence indicates that in utero exposure to SSRIs during the last trimester through delivery may result in a self-limited neonatal behavioral syndrome that can be managed with supportive care
- **paroxetine taken in the first trimester may be associated with fetal heart defects NICE advise stop paroxetine if woman becomes pregnant.**
- venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal
- all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting
- **fluoxetine is the SSRI with the lowest known risk during pregnancy and it is the only SSRI licensed for use in pregnancy**
- the majority of SSRIs are not licensed for use in breast feeding and manufacturers recommend that they are not used during lactation.
- imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels
- **citalopram and fluoxetine are present in breast milk at relatively high levels**
- **fluoxetine - licensed for use in pregnancy - excessive sleepiness in the baby may occur if continued during breast feeding**
- sertraline - published studies on more than 30 infants have demonstrated no untoward effects and levels in plasma at the limits of detection; has a shorter half-life than fluoxetine and an inactive metabolite
- **Sertraline and paroxetine have the lowest levels in milk.**

the **current evidence does not seem to warrant a recommendation that the mother stops breast feeding whilst taking a serotonin selective re-uptake inhibitor (SSRI)** (though there is less available data than for TCAs) or a TCA (3)

the mother should be alerted to watch for signs of poor handling, drowsiness and poor feeding in the child

if a woman is receiving a high dose or a combination of antidepressant drugs then there is a stronger argument, in light of the lack of data, for stopping breast feeding

- The respective summary of product characteristics must be consulted before prescribing an antidepressant during pregnancy.

CONSIDER ?Tricyclics if tolerated for pregnancy or fluoxetine.

CONSIDER ?sertraline for breast feeding (or paroxetine but not in pregnancy)

Prescribing pregnancy/lactation. <http://www.ukmicentral.nhs.uk/drugpreg/guide.htm>

The use of any drug during pregnancy should be carefully considered.

The drug thalidomide was used during the early 1960's as a sedative during pregnancy. It was withdrawn in 1962 when it was shown that taking the drug during days 30 to 70 of gestation resulted in gross limb deformity (phocomelia). This experience has demonstrated that animal models and tests on adults are insufficient to guarantee the absence of teratogenic effects.

However, one should be circumspect about attributing single cases of deformity to a drug taken during pregnancy.

Of 1000 births there will be: 5 deaths from major malformations, 10 babies with clinically significant abnormalities. Only very rarely may these deformities be attributed to drugs taken during the pregnancy.

The following three points must be borne in mind when prescribing during pregnancy:

- can therapeutic benefit be achieved by means other than pharmacology? Give drugs that have been in wide use for many years. Give drugs that are used in pregnancy as an established medical practice.

ANTIBIOTICS

- penicillins and cephaloridines are safe to use throughout pregnancy
- erythromycin - not known to be harmful
- trimethoprim - this is safe after the first trimester. However, the sulphonamide warning applies for trimethoprim - sulphonamide preparations
- nitrofurantoin, -not known to be harmful, avoid at term
- sulphonamides should be avoided if delivery is imminent
- tetracyclines should not be used in pregnancy. This group of drugs stain developing bone and teeth in the foetus.
- metronidazole - manufacturer advises avoidance of high-dose regimens

ANTI-HISTAMINES

Chlorpheniramine maleate, although referenced to the BNF guidance regarding breast feeding and pregnancy below, is not explicitly mentioned in any of the BNF guidance and **can be used with caution** in these circumstances.

During pregnancy: no evidence of teratogenicity. Embryotoxicity in animal studies with high doses of hydroxyzine and loratadine. Manufacturers of cetirizine, cinnarizine, desloratadine, dimenhydrinate, hydroxyzine, ketotifen, loratadine, and mizolastine advise avoid

Breast feeding: significant amount of some antihistamines present in milk. Although not known to be harmful, manufacturers of cetirizine, cinnarizine, desloratadine, fexofenadine, hydroxyzine, loratadine advise avoid.

Benzodiazepines-Increased risk of cleft palate + other fetal malformations.