HOW TO TREAT

Detailed treatment updates for common conditions

postnatal depression

Postnatal depression is extremely rewarding to diagnose and treat. There is an opportunity for the general practice team to screen systematically and intervene early in an illness that has the capacity to profoundly influence the next generation. It requires an awareness of prevalence, good communication skills and the ability to shed light on the true nature of this condition. The diagnosis should be seen as good news, as it is a treatable condition and its recognition can lift a considerable burden from the mother. This article was written by William Ferguson, a Kumeu GP who has a longstanding interest in maternal mental health.*

Societal ideals can mask condition

Postnatal depression (PND) is the most common and serious disorder of the first postnatal year. Affecting about 15 per cent of all women who bear children, the condition exhibits almost no regard for age, ethnicity, cultural or socioeconomic factors. It is a uniquely stressful time for a family, and unfortunately coincides, for the mother, with a period of unparalleled biological vulnerability to mood disorder. Furthermore, the infant is also passing through his or her most vulnerable and sensitive phase of brain development.

This unique juxtaposition of risk and vulnerability is often poorly managed. Although women have more exposure to various healthcare providers during pregnancy and the postnatal period than at any other time in their lives, enigmatically this illness goes largely undetected and untreated. The art and science of supporting motherhood over this period is a key role for every family doctor.

It is no exaggeration to state motherhood is the central foundation of human life, and the key relationship from which all others derive. Modern social constructs have downgraded the importance of motherhood, but a simple biological observation underscores its significance – across all mammals it can be shown intelligence and brain complexity are directly proportional to the duration of the mother–infant bond.

Western art and literature are replete with works that elevate to sacredness ideal images of mother and child. Such cultural ideals perhaps conspire to make PND difficult to recognise, not only for clinicians but also friends, family and the mother herself. When finally recognised, these unconscious archetypes serve to further stigmatise PND, and stand in stark contrast to its subjective reality. Tragically, many women – and society at large – misunderstand the nature of PND, interpreting it as some deep, personal failure. A long-time researcher in the field, Cheryl Beck, describes PND as "the thief that steals motherhood".

How much does it matter? Two-thirds of cases resolve spontaneously within a year, and in its mildest form the illness simply causes abnormal postnatal fatigue of some three months' duration, usually unnoticed by the mother among the expected chaos and disturbed nights. However, it can be severe and debilitating and commonly contributes to relationship breakdown. Furthermore, research over the last 15 years on untreated PND and infant brain and cognitive development reveals a very worrying picture (see following page).

With appropriate and timely intervention more than 85 per cent of mothers respond well to treatment. Remission after three months of treatment is significantly associated with a reduction in infant symptoms and diagnoses (Weissman et al. 2006). Concerns about the need for treatment of an ultimately self-limiting condition, or the risks of treatment (eg, drugs and breastfeeding), should be set against the known effects of untreated PND on infant development and the profound loss of maternal wellbeing and enjoyment at this critical time.

* *The author acknowledges the review and feedback kindly provided by Dr Cathy Hapgood, Marinoto North Child Adolescent & Family Service, Waitemata District Health Board.*

Do you need to read this article? Try this quiz

1. Most women at risk of PND can be identified antenatally by their risk profile. **True/False**
2. Tiredness alone is insufficient to suggest a diagnosis of PND. **True/False**
3. The benefits of antidepressants in breastfeeding outweigh the risks in most instances, even though PND is self-limiting. **True/False**
4. Most women who develop PND have deep conflicts with their role as mothers or their relationship with their babies. **True/False**
5. A majority of women diagnosed with PND are lost to follow-up before remission is confirmed. **True/False**

Answers on page 25

No one obvious cause for PND

Pregnancy has accurately been described as a neuroendocrine and psychosocial stress test for the propensity to mood disorder. Yet, the fundamental cause of PND remains contentious.

Any simplistic aetiology is hampered by the fact many women have no identifiable risk factor at diagnosis. Despite the momentous hormonal changes before, during and after birth, no conclusive link with gonadal or other hormones has been shown. Risk factors are generally the same as for depression at other times (Panel 1), and those with apparent validity, eg, obstetric difficulties, are not linked.

Psychosocial factors such as marital stress and inadequate social supports are associated, and a deteriorating partner relationship is most significant. A New Zealand study (McGill et al. 1995) identified a sevenfold increase in risk of partner relationship problems for women scoring high on the Edinburgh Postnatal Depression Rating Scale (EPDS) compared with low-scoring women. An Australian study identified a 12-fold increased risk of partner conflict with the diagnosis.

Partner discord and loss of social supports can easily be viewed as a cause, but arguably they are just as likely to be an effect. This author overwhelmingly finds that diagnosing and treating the illness almost always fixes the discord! If a woman cannot articulate or even recognise she is depressed, then, not getting on well with her partner may be a very strong clue she is not functioning well.

Many studies find the biggest risk factor is antenatal depression. McGill found high scoring women (EPDS) six times more likely to have had antenatal depression than low scorers. A large Danish study found psychological distress in late pregnancy to have an odds ratio (OR) for PND of 6.3, well above the risk associated with a history of prior psychological illness (OR 2.1). Clearly, whatever the prime determinant of PND, it must be as operative in late pregnancy as postnatally, but during pregnancy the illness is even harder to perceive.

Some evidence hints at two aetiologies within the PND population, with different levels of vulnerability to the condition. In the first group, events in pregnancy, childbirth, puerperium and motherhood may represent a non-specific stress capable of triggering depression. In the second, a specific neuroendocrine vulnerability may be evident. Case-control studies indicate, while a past history of non-puerperal depressive illness increases PND risk and subsequent PND to 18 per cent, women with a de novo episode of PND are at subsequent risk of a recurrence of PND of 41 per cent (Cooper and Murray 1995).

In concert with these observations, new research associates abnormal copper/zinc ratios, particularly in women with a history of PND, compared to those with non-puerperal depression or no history of depression (Crayton and Walsh 2007). Copper is thought to promote angiogenesis and is elevated in normal pregnancy, but has a propensity to deplete zinc. Copper and zinc are important cofactors in neurotransmitter biosynthesis, so persisting abnormalities of this ratio have the potential to disrupt brain chemistry over a long period of time. Further research is required; however, the association certainly explains the unique chronology of the illness, the striking absence of known risk factors for most sufferers, and it potentially could add to the understanding of the neurodevelopmental implications of PND.

Untreated PND and child development

The primary mother–infant bond influences neurological development. Evidence in mammals demonstrates early influences on brain structure, function and genetic expression (Francis et al. 1999). Research comparing the influence of high and low nurturing rats on the brains of their new pups shows early and profound differences. By six days, the reactivity of the limbic-hypothalamic-pituitary axis (LHPA) is significantly modified and there are differences in the expression of 324 genes influencing neurotransmitter function, neuronal development and synaptic transmission.

Research in various mammals shows even subtle disruption of early mother–infant bonds is associated with prolonged cortisol elevation. This influences LHPA development and affects hippocampal function, damaging memory and interfering with attention and control of behaviour.

Studies of infants of mothers with untreated PND have mirrored these theoretical concerns. Left frontal lobe EEG abnormalities have been demonstrated in 14-month-olds, with changes directly proportional to depression severity. A long term case-control study (Hay et al. 2001) of the children of mothers with untreated PND shows, by age 11 years, boys were 15 IQ points lower than controls and exhibited increased behavioural problems, violence, attention deficits and had increased special education needs. The girls, not previously thought to be significantly impacted, were now also starting to show significant variance from the norm, although less so than for boys. This study identifies the unique imprint of PND at three months postpartum, and yet shows very little discernable effect of maternal depression later in childhood or depression current while the study was conducted. It appears, as if we did not already know, the first postnatal year is critical to infant brain development.

An interesting picture has emerged (Lyons-Ruth et al. 2006) that maternal unavailability and associated "disorganised attachment strategies" constitute a "hidden trauma". All but imperceptible to an untrained observer, the infant's sense of safety and protection is dependent on an emotionally responsive maternal presence. The infant uses intense and engaged communication with its mother to modulate fearful arousal. Infants who are unable to adequately engage in this dialogue have large and prolonged elevations of salivary cortisol in response to separation and reunion. The implication is that exhausted, unresponsive mothers can subtly impair infant brain development by removing a buffer to the impact of stress upon the LHPA axis, which normally would enable an infant to experience stress without producing elevations of cortisol. A consequence of this is that it is only when the infant's attention is freed from issues of threat and security that it can be directed towards developmental aspects such as exploration, learning and play.

Summary of risk factors

Panel 1

Major

- antenatal depression
- past history of PND
- past history of depression
- family history of mood disorder
- stress in relationship with partner

Minor

- poor social support
- history of severe PMT
- severe baby blues (see later)
- adverse life events
- infant stress

If only...

Case study 1

Presentation (six-week checkup): Michele, aged 25 years, suffered PND after the delivery of her first child. It was not diagnosed, but in retrospect she says she felt "blanked out" for almost a year postpartum. With her second, she had a normal term delivery and presented to her GP at six weeks.

Diagnosis: The GP listened, asked her to complete the EDPS questionnaire and found her to be quite severely depressed (EPDS 24).

Management: The GP commenced Michele on nortriptyline, increasing the dose as tolerated. A month later she had side effects at 50mg, and serum levels were subtherapeutic.

Three-month visit: Michele had become increasingly anxious, agitated and irritable. She agreed to trial paroxetine 20mg and a week later told the GP she felt a lot calmer, and three weeks later "heaps better". Michele's partner left her shortly after this and she moved to another area.

Five-month visit: Michele returned, tearful, not sleeping, agitated and admittedly "off and on the Aropax". The GP emphasised the need for its consistent use.

Nine months: Michele returned, again severely depressed and reported often using P and cannabis as self-medication. The GP increased paroxetine to 30mg then 40mg. On review two weeks later, she described feeling dramatically better. It seemed clear, in retrospect, she had never been fully well, and had only partially responded on 20mg.

Sixteen months: Michele had remained very well, she discontinued paroxetine two months earlier and, with EPDS 8, she was hardly recognisable as the same woman who had suffered from this severe illness. Sadly, at 17 months, child custody proceedings were initiated by her "ex" in view of her P use. The family court judge rejected evidence she had suffered PND and had recovered. She lost custody to the paternal grandparents.

Important messages are closer follow-up, perhaps initiated by the practice nurse, may have speeded up initiation of truly effective treatment and prevented the downward spiral and its consequences. When a patient has a partial treatment response she may well be "heaps better" but is still not fully well. Finally, untreated PND destroys relationships and families.

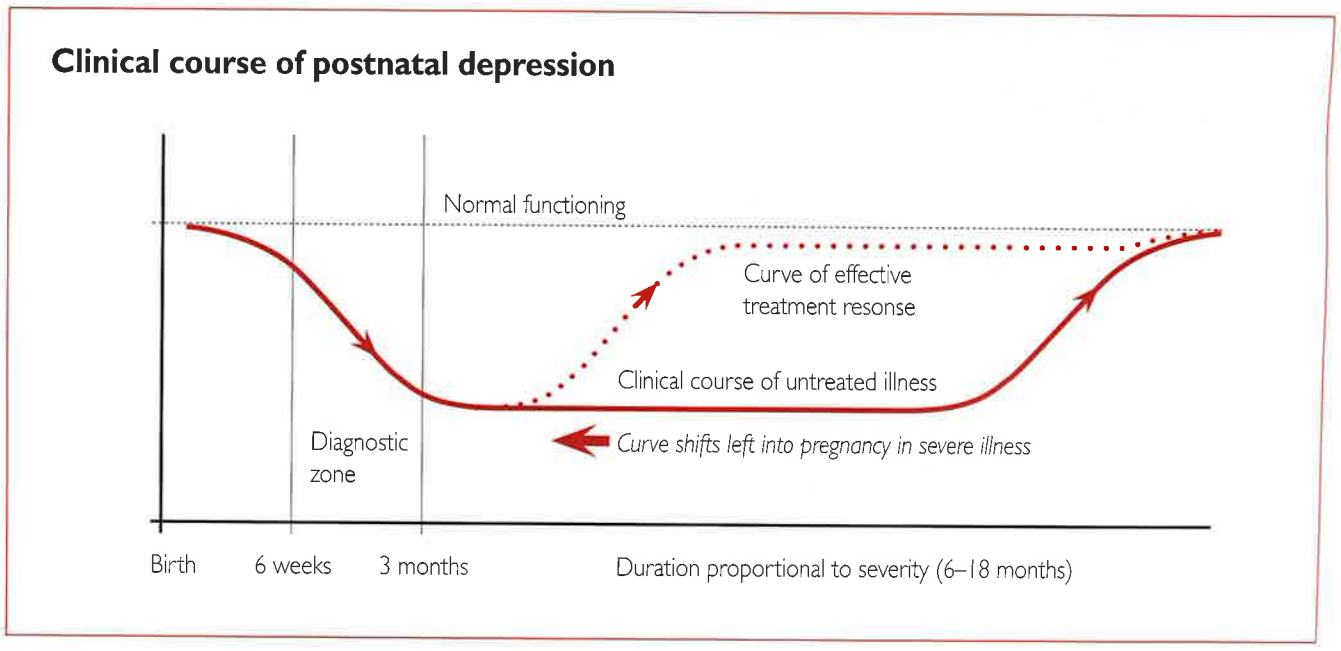

Figure 1. The clinical course of PND

Tiredness the only symptom all admit

Essentially, there is no clear difference in the clinical presentations of PND and non-puerperal major depression, although many traditional endogenous markers for major depression (eg, sleep disturbance, loss of libido, weight change) are partially or completely obscured (Panel 2).

"I feel grotty, I don't manage, I blame myself and nobody understands." – Mother when asked 'How are you really?' at the six-week check.

Almost invariably, severe PND has its onset in pregnancy, usually the latter half. Typically, it remains unrecognised as all of the symptoms are brilliantly concealed by the travails of pregnancy. A useful clinical marker, and the most significant pregnancy-related risk factor, is a high number of antenatal visits, for whatever reason, towards the end of the pregnancy.

To meet DSM-IV diagnostic criteria, PND is required to have its onset in the first month postpartum and, as with other forms of depression, at least two weeks of unremitting symptoms. PND is usually not recognised in its early stages, so onset and recognition can differ greatly. It may require progressive and entirely unconscious draining of the woman's coping reserves, and those of her social network, before anyone detects an "illness".

The diagnostic hallmark of mild-to-moderate PND is symptom progression from before the six-week check, unfolding through the three and five-month marks. Tiredness is the only symptom every woman with PND admits to. It is often the first symptom to arise and the very last to resolve on remission. To distinguish normal tiredness, normal anxiety, etc from that of PND, it helps to look at the unfolding clinical course. This commonly has a trademark profile: manifestation, progression and resolution (Figure 1).

Every woman is tired at the six-week check. However, those with "normal tiredness" find at six weeks they are just starting to become progressively more functional. Women with PND or other clinical conditions causing postpartum tiredness (Panel 3) experience an ongoing lowering of function. PND is not a diagnosis that can be made from a single observation unless it is already quite severe.

PND or baby blues, puerperal psychosis?

The baby blues is a transient state of uncharacteristic mood swings, tearfulness and increased sensitivity that peaks three to five days postpartum. It affects 70 per cent of women giving birth and is described in all cultures. It is presumed to have a hormonal or biochemical basis. It should completely resolve by 10 to 14 days at the latest. When severe or prolonged it is a significant risk factor for PND.

First-time mothers can be completely demoralised by it, and partners and family left bewildered. Strong reassurance and support is critical as the mother is negotiating major hurdles (eg, breast feeding, an unsettled baby and any childbirth trauma).

Puerperal psychosis occurs in about 2/1000 births and is characterised by sudden-onset (one to two weeks postpartum) psychotic and affective symptoms of a pattern much like type I bipolar disorder. This is potentially life threatening for mother and baby and is always a medical emergency, requiring urgent psychiatric referral and usually admission.

Symptoms of PND

Panel 2

- low mood for at least two weeks
- significant unremitting tiredness
- increased anxiety (beyond a usual response)
- not getting on well with partner
- irritability
- feelings of worthlessness
- sleep disturbance
- "difficult baby" (but some babies are difficult)
- low libido, anhedonia
- reduced concentration, memory and cognitive function
- indecisiveness
- agitation/retardation
- guilt

Significant postpartum fatigue

Panel 3

Causes of clinically significant postpartum fatigue

- postnatal depression
- iron deficiency anaemia
- infection, eg, low-grade endometritis
- postpartum thyroiditis
- cardiomyopathy
- exacerbation of pre-existing illness in the fibromyalgia or chronic fatigue syndrome spectrum
- *postnatal depression (think of it again!)*

Quiz answers

1. False **2.** False **3.** True
4. False **5.** True

Overcoming barriers part of diagnosis

A series of observations, an established relationship with the patient and mindfulness of the clinical course of PND are needed to accurately identify the illness and intervene early in its downward trajectory.

It is a curious but well described feature of maternal postnatal care in general, but PND in particular, even women with severe PND are not forthcoming in declaring their symptoms or seeking help. Screening questionnaires have revealed unprecedented morbidity in the first postnatal year, yet this is commonly not presented to us in primary care. For example, women suffer more significant health problems (average 2.5) in the first eight weeks postpartum than during the post-delivery hospital stay. It is almost as if new mothers are biologically programmed to be less perceptive of their own health needs and more attentive to their baby's wellbeing.

McGill's study found less than a third of high scorers on the EPDS recognised they suffered from PND. This highlights a conceptual barrier to a label like "depression" when, from the mother's perspective, she just feels exhausted all of the time and is worried about her baby.

"If one more person says, 'Hi, how's the baby?' I am going to kill them" – distressed mother, six months postpartum

Often, the early subtle deviation into clinically significant symptoms only becomes apparent with a baseline knowledge of a woman's prior mental health and coping style. Women with high coping styles and positive dispositions are most at risk of progressing to serious illness without their caregivers, partners, friends or family being aware.

The diagnosis is made most accurately and earliest within the context of ongoing healthcare provision by a trusted professional. This relationship exists within the framework of ongoing family healthcare, and was greatly augmented while the GP–practice nurse team was, even to a small extent, involved in antenatal care. The 2003 MaGPIe study by the Wellington School of Medicine demonstrated how much more likely it is for psychopathology to be detected by the GP if there have been previous visits and an established patient relationship exists. This is particularly so for PND because of the heightened barriers obscuring its diagnosis. Differential diagnoses are summarised in Panel 4.

Assessment is best done with a family member present (most often the partner), especially when psychotropic medication is involved. If not present, at least one prompt follow-up appointment with the woman's partner is advised, to provide education and discuss treatments.

Specific attention must be directed to how the symptoms affect the mother's relationship with her baby, and her ability to care for the baby and any other children. Her relationships with her partner and other family members are important and how, if at all, they have changed recently. A key piece of information regarding recent change of functioning is irritability, which can be profound in PND.

The woman's experience of childbirth is relevant, as symptoms of post-traumatic stress disorder can be concurrent and, if so, may need to be separately addressed. Symptoms include nightmares, flashbacks (usually of birth), hypervigilance and, sometimes, avoidance of the baby.

It is important to ask about suicidal ideas. These are an item on the EPDS and must be elaborated on if marked positive. Suicide attempts are rare in the postnatal period, but completed suicide is the most common cause of maternal death in the first postpartum year (Oates 2003). Any suicidal ideas at this time point to serious illness. Thoughts such as "the baby would be better off without me" indicate serious illness and hopelessness. Together with a relative lack of infant bonding, they are a reason for urgent psychiatric referral. Ideas of infanticide or infant harm warrant immediate psychiatric referral (Panel 5). This requires careful assessment, as even in the absence of depressive illness one study revealed 70 per cent of mothers of babies with colic admitted at some point to having thoughts of harming the baby.

NATIONAL GALLERY, LONDON

Detail from The Virgin and Child with St Anne and St John the Baptist *– Leonardo da Vinci – Western art and literature are replete with works that elevate to sacredness ideal images of motherhood and child*

Screening for postnatal depression

To assist screening, the GP has three invaluable allies:

- the EPDS
- the practice nurse
- the immunisation schedule – the six-week, three-month and five-month visits fortuitously map out key points in the progression of PND.

The EPDS is a useful screening tool of 10 simple questions (scored 0 to 3) that is well validated in many populations (Cox et al. 1987). A score of 13 or more is shown to detect major depressive illness (sensitivity 86 to 95 per cent, specificity 78 to 84 per cent; Holt 1995). Holt accurately surmised, "The EPDS is not intended to take the place of genuine concern and tactful, sensitive enquiry on how a mother is finding postnatal life." It does provide a particularly good benchmark for assessing functional decline between scheduled immunisation visits, and it has a 97 to 100 per cent reported acceptability with patients.

An acknowledged weakness of the EPDS is it is not good at identifying the extent of psychomotor retardation and fatigue, which can be profound. A relative strength is in unveiling abnormal levels of anxiety. It can be very instructive to compare one's clinical impressions of the severity of the illness with the EPDS descriptors the woman identifies. This commonly amplifies one's sense of the seriousness of the illness. Occasionally, this comparison can identify women who seriously underrate or underreport their own illness.

Six-week check and the practice nurse

The traditional six-week check was a unique opportunity to appraise the health and wellbeing of mother and baby while linking the family with the GP–practice nurse team. Unfortunately it was an early victim of the dislocation of maternity care from primary healthcare when funding to GPs for the maternal health check was removed. In 2003, ProCare in Auckland self-funded a practice nurse-delivered screening programme using the EPDS at two out of three of the scheduled visits. The mother used the 20 minutes in the waiting room after the immunisation to complete the survey. The project was taken up vigorously by practices, and often continued after funding ended. Over the three years since implementation over 14,000 women have been screened with a detection rate (EPDS ≥13) of 17 per cent.

Effective treatment and follow-up just as important

A survey of patterns of care after diagnosing major depression and outcomes showed alarmingly high rates of disengagement from treatment and loss of follow-up. In 2005, Solberg and colleagues showed 67 per cent of patients discontinued treatment by three months, and only 1 per cent had three or more GP visits within six months of diagnosis. The clear message is GPs can find their limitations when dealing with such long term conditions. Research into effective interventions in primary care for depressed patients shows repeatedly some form of follow-up or case management is the one intervention that consistently improves outcomes.

In essence, this involves the practice nurse making weekly, or as required, phone contact to ensure adherence and response to treatment, and relaying side effect and other vital information to the GP. Case study 1 illustrates the devastating consequences of a patient with PND not receiving sufficiently active follow-up.

Increasing tiredness

Case study 2

Presentation at three months postpartum: On her visit, Sue reported increasing tiredness since the six-week check and three episodes of mastitis. She admitted some "low spots", some difficulty sleeping but denied depression (EPDS was well within normal range). Blood tests, including thyroid function, were normal. No diagnosis was possible at this time, so she was kept under observation.

Follow-up at four months: A month later Sue was profoundly tired, complained of body aches, myalgia and looked "rundown". Test repeats showed her TSH was stratospheric (175mIU/L) and thyroid microsomal antibodies were 1:6400. Hypothyroidism secondary to postpartum thyroiditis was diagnosed. Over three months of treatment, her thyroid function normalised but she remained tired.

At eight months: Sue was still tired, and was withdrawing socially. She complained of poor concentration and short term memory and difficulty sleeping. She still denied depression (EPDS now 12). However, in view of her level of dysfunction it was agreed to trial paroxetine; however, within three days Sue complained of nausea, headache and dizziness and medication was stopped. Sue then commenced nortriptyline, titrating up to 100mg. She then reported of episodes of tachycardia. Her ECG showed a prolonged QT interval and widening of the QRS complex. The drug was discontinued and the ECG normalised. Finally, Sue commenced fluoxetine 20mg with startling results. She claimed her "foggy head cleared on day one of taking the Prozac" and she felt "100 times better now. I can do everything!" Fluoxetine was continued until her PND finally remitted at 16 months postpartum.

Differential diagnoses

Panel 4

- major depressive episode, postpartum onset, plus/minus psychosis
- adjustment disorder with depressed mood
- bipolar depression (usually type II bipolar)
- panic disorder, postpartum onset
- adjustment disorder with anxious mood
- obsessive compulsive disorder, postpartum onset
- post-traumatic stress disorder
- puerperal psychosis
- bonding disorder

Reasons for referral

Panel 5

For psychiatric evaluation

- suicidal ideas or self-harm attempt
- infanticidal thoughts
- intense irritability resulting in risk to infant/children
- evidence of bipolarity
- evidence of psychosis
- evidence of bonding disorder
- post-traumatic stress disorder

To Child, Youth and Family

- if baby at risk of abuse
- in setting of domestic violence, baby at risk from either parent

Treatment requires diligent follow-up

The GP can be a "light in the fog" by identifying PND, and educating the woman and a family member about its frequent occurrence and responsiveness to treatment (Kennedy et al. 2002). This may have considerable therapeutic effect; it allows an understanding that it is an illness, not some personal failure. Family understanding and support hopefully then enable a reduced burden of domestic chores and more "time out" for the mother.

It is therapeutic to allow a woman to talk about her experience of childbirth, her baby and her new role. Adaptation to the role of motherhood can be difficult for some women and discussion of this can be helpful.

Plunket Karitane Family Centres, Home Help and other home healthcare agencies, PND support groups, local women's centres and other services all have useful roles. Parents as First Teachers will visit a mother regularly and give guidance on infant development, which can assist confidence. Barnados and Parents Centres provide supportive parenting courses. The website www.beyondblue.org.au provides a valuable resource on all aspects of depression and PND.

It is important to understand, in other than mild illness, support in all its manifestations is not a substitute for effective treatment.

Counselling, psychotherapy are important in treatment

Many different forms of therapy have been shown to have some benefit in the treatment of PND. Women are often opposed to taking antidepressant medication at this time if they are breastfeeding and usually find non-pharmacological treatments more acceptable. There is little clear evidence in the literature, however, which form of therapy is most effective (Dennis 2004). In mild depression, non-pharmacological treatments are first-line. In moderate to severe depression, these therapies complement antidepressant treatment.

Women with PND benefit from a variety of therapies; cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and supportive counselling. Group therapy is often useful and has the added benefit of decreasing social isolation. The treatment offered will often depend upon what is actually available in the community and this poses a challenge in both primary and secondary care. There are significant differences throughout New Zealand in what women can access. Even if therapy is not available, women should be encouraged by their doctors to talk about worries, and acknowledge the difficulties of feeling depressed at such a crucial time. It does remain a problem in primary care to provide timely psychological support in addition to antidepressants as a treatment for PND.

The role of antidepressants

The risks and benefits of pharmacotherapy often need elaborating, particularly if the woman is breastfeeding. Many women worry about possible effects on the infant, and time taken in this regard is mandatory to ensure ongoing compliance. Antidepressants would be indicated under the following circumstances.

- Moderate or severe depression – symptoms must have been present for at least two weeks.
- Significant anxiety or panic attacks.
- Psychomotor change or significant biological symptoms.
- When a woman has previously responded to an antidepressant medication and is requesting an antidepressant again (Boyce and Condon 2004).

Before prescribing, the use of alcohol and other substances must be elicited as misuse can help perpetuate depression. It is also useful to do a full blood count, iron studies and thyroid and liver function tests.

Usually, SSRIs are the first choice antidepressant for PND on account of their safety and efficacy. The literature generally supports safety in breastfeeding. Citalopram and paroxetine pass into breast milk in small amounts, not usually detectable in the infant. Fluoxetine has a higher level of passage into breast milk, and it would tend to be the antidepressant of choice only if the woman has responded to that particular medication in the past.

Breastfeeding infants whose mothers are taking SSRIs very rarely show any signs of toxicity or behavioural change, but mothers should be advised to observe and report any changes. Babies who may be particularly vulnerable are those who are premature, newborn or physically unwell. Some babies of depressed mothers tend to have more colic and reflux anyway, and these unsettled infants must be distinguished from those who may be unsettled by antidepressants. It is, therefore, useful to clarify baseline infant behaviour with the mother. In the case of a premature or an unwell baby, discussion with a paediatrician may be advisable. There remains no long term study of babies who were breastfed while their mothers received antidepressants.

Women initiating an SSRI should start at 10mg/day and increase to 20mg only after four to six days. They should be warned about the possibility of increasing anxiety in the first few days and reassured about this. Extra phone support can be particularly useful in week one. If the anxiety is profound, sparing use of lorazepam (0.5–1mg as needed) may help.

The usual dose of paroxetine or citalopram needed to treat depression is 20–40mg mane and higher doses than these are rarely used. If there is no improvement after six weeks it is usual practice to change the class of drug to a tricyclic antidepressant (TCA), or venlafaxine (if this is the second treatment failure).

"When you try to gauge how we're doing, stick to finite questions. How many hours do you sleep? Can you read a book? A magazine article? OK then, the back of the cornflakes packet? Have you laughed?"

With the single exception of doxepin, TCAs are relatively safe when used during breastfeeding. The use of doxepin has been associated with isolated reports of unexplained apnoea and it remains a contraindication in breastfeeding women. The sedating properties of TCAs make them useful, particularly at night and they often provide a relatively good anxiolytic effect. They are, however, more problematic in higher doses with side effects of dry mouth, postural hypotension and constipation. They are also lethal in overdose.

In practice, TCAs are rarely prescribed in primary care nowadays in full antidepressant doses, but they remain a treatment option. Venlafaxine needs a Special Authority and is fully funded only after the failure of two other antidepressants. The limited data suggest it is compatible with breastfeeding (Hendrik et al. 2001, Islett et al. 2002). Breastfeeding should not deter the GP from adequately treating an episode of depression postnatally.

Contraception should not be forgotten

Contraception must be addressed. Low libido and breastfeeding often lead women to think this unnecessary. However, unplanned pregnancy requires a sudden decision regarding continuation of antidepressants, especially in view of first trimester teratogenicity with paroxetine.

Antidepressant treatment is normally continued for 12 months after remission of symptoms; however, in practice this is determined by the timing of remission of the underlying illness, illustrated in Figure 1. Treatment following recurrent depression may last considerably longer. In appropriate cases, prophylactic treatment can be considered, and at least one study using an SSRI showed efficacy in this regard. A useful website (www.psychiatry.net.nz) provides up to date resources on all aspects of the pharmacotherapy of ante- and postnatal depression.

Long term considerations and follow-up

The central theme of treatment is support of the mother whether through pharmacological, psychological, social or other interventions. Careful follow-up is then required, as non-response to treatment requires early detection and appropriate further intervention or referral. Proceeding from one inadequately or untreated episode of PND directly into a subsequent pregnancy carries very high risks in every respect.

Contraception should be constantly monitored and enquired about. Often, women have a time-frame in which they imagine having another baby and may welcome the option of a gap to ensure full remission before becoming pregnant again. Women should be counselled about pregnancy planning and frequently want advice on its advisability while on antidepressants. The benefits of early diagnosis, treatment and, in appropriate cases, prophylactic treatment can be discussed. D

Online resources

www.beyondblue.org.au
www.psychiatry.net.nz

Further reading

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