

# CME Bulletin 香港醫學會持續醫學進修專訊

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[Header – Introduction of HKMA CME Programme]

## MONTHLY SELF-STUDY SERIES 每月自修資料

*Please read the following article and complete the self-assessment questions. Participants in the HKMA CME Programme will be awarded 1 credit point under the Programme for returning completed answer sheet on P.[ ] via fax (2865 0943) or by mail to the HKMA Secretariat on or before **10 March 2001**. Answers to questions will be provided in the next issue of the HKMA CME Bulletin.*

請細閱以下文章並完成自我評估測驗。香港醫學會持續醫學進修計劃參加者如於二零零一年三月十日前，將已填妥之答題紙傳真或寄回本會秘書處，將可獲持續醫學教育一個積分點；至於是期自我評估測驗之答案，將刊於下一期的《持續醫學進修專訊》之中。(本會秘書處傳真號碼:2865 0943)

## ***Post-partum (puerperal) Mood Disorders***

We are all indebted to colleagues who read our bulletin and comment on the material. We believe that improvement of our profession can only be achieved through communication. The letter from Dr. Stewart Chan is reprinted in this issue with thanks and we hope for further two-way communication between the panel and readers. The current issue will discuss post-partum mood disorders. This is a condition not uncommonly seen by the family doctor. We hope we can help out in its management. Happy Chinese New Year.

《持續醫學進修專訊》編輯小組誠意感謝所有讀過《專訊》，並就文章內容為我們提供寶貴意見的讀者，我們相信，同業間彼此加強溝通與交流，當能令醫學界一同與時並進；上月我們收到了威爾斯親王醫院陳兆華醫生的來函，盼望在未來的日子，編輯小組能繼續與讀者保持緊密的交流。

今期我們討論產後抑鬱症的診斷及處理，今時今日，產後抑鬱已成為家庭醫生不時遇見的病症，透過是期的討論，讓我們同來溫故知新。

謹祝新春快樂！

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### ***What is Puerperal Mood Disorder?***

Elation after childbirth is quite common and understandable, but depression after delivery is not uncommon either. Because unhappiness during such a joyful event as the birth of a child is rather socially unacceptable but regarded as attention seeking or weakness in

character, post-partum mood disorder is thus quite hidden and go undetected especially in the early stages. Studies in China showed that up to 17% of postnatal Chinese women could be suffering from post-partum depression (Guo, 1993; Pen et al, 1994) while Lee et al (1998) found a 5.5% of the general postnatal population suffered from a major depression at six weeks post-partum. The etiology is probably a combination of biological (hormonal) changes and psychosocial factors consequent to the childbirth, such as sleep deprivation, new parenthood, etc. The mid-wife/ obstetrician, the paediatrician and the general practitioner are thus the frontline medical professionals to detect post-partum mood disorder among the postnatal women. The lack of awareness of such disorders can have grave consequences including marital discord, suicide and even infanticide.

### **Case 1**

Mrs. Wong is a 32 year old lawyer who returned from Canada in 1990 and has chosen you as her family doctor for the past 7 years. Her husband is a busy businessman. Mrs. Wong enjoys good health except mild allergic rhinitis and bronchial asthma which has not been active for years.

Recently, Mrs. Wong delivered a healthy baby girl uneventfully. 3 weeks after delivery, she attends your surgery complaining of headache and insomnia. She feels guilty because she failed breast-feeding. Her appetite is poor and general activity low. She breaks down and cries in your office and declares that she is a poor mother.

- (1) *What is your provisional diagnosis*
  - (a) *Panic disorder*
  - (b) *Post-partum depression*
  - (c) *Post-partum blue*
  - (d) *Post-partum psychosis*

### ***When is depression after childbirth pathological?***

There are various degrees of severity, each with a special diagnostic label:

1. Post-partum 'blues' - it is a time-limited condition that occurs in about half to even three-quarters of post-partum women. It is characterized by lability of mood (irritability, sadness, tearfulness, and anxiety without obvious reasons) within two to three days after delivery, and usually disappears within 2 weeks.
2. Post-partum 'depression' - it occurs in about 5 to 10% of the post-partum women and develops within 4 weeks of delivery. The duration is at least 2 weeks and it has the same characteristics of a 'major depressive disorder' (see Table 1 below) and this has led to the hypothesis that post-partum depression is basically a 'major depressive disorder' triggered off by childbirth.
3. Post-partum 'psychosis' - it occurs in about half to 1% of the post-partum women and develops within the first 3 days of delivery. It is characterized by the development of hallucinations, delusions, disorganized thoughts and speech, together with eccentric or bizarre behaviour. The delusion usually concerns the baby such as the child is malformed, possessed or a curse to the family etc. The depressed mood in such a condition is quite severe and the suicidal risk is high. Infanticide may also result from hallucinations commanding the patient to kill from the delusion. A hypomanic spell sometimes occurs, and occasionally the psychotic features are more alike that of schizophrenia. Most of the patients subsequently develop either bipolar affective disorder or a major depressive disorder.

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**Table 1: Diagnosis of a Major Depressive Disorder**

At least 5 of the following features:

1. There must be depressed mood for at least 2 weeks, and such a low mood must occur most of the day.
2. Significant decrease in interest of nearly all activities, including the cuddling and playing with the baby.
3. Significant changes in appetite and body weight, usually a decrease (not due to feeding the baby).
4. Significant sleep disturbance, either too much or too little, unrelated to baby crying or midnight feeding schedule. For insomnia, it is more likely difficulty in falling asleep than the typical early morning wakefulness.
5. Significant loss of energy even after recuperation from the stress of delivery. The fatigue experienced is not relieved despite adequate sleep and rest.
6. Abnormal feelings of worthlessness or hopelessness including the ability to feed the child or be a normal rearing mother. There may also be undue guilt towards the child, or of bringing a child into a troubled world.
7. Presence of psychomotor (speech and action) retardation or agitation.
8. Decreased concentration and attention, resulting in difficulties in making decisions and the need for repeated reassurance from others.
9. Uncontrollable and recurrent thoughts of suicide and even infanticide, including nasty thoughts of harming the child.

The above symptoms should last more than two weeks and should cause significant impairment in daily function.

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(2) *What further history would you like to explore?*

- ( a ) *Suicidal ideation*
- ( b ) *Infanticide tendency*
- ( c ) *Psychotic features*
- ( d ) *Family history of depression*
- ( e ) *Family dynamic*

On further exploration, Mrs. Wong's elder sister and mother, both in Canada, had post-partum depression managed by supportive therapy with complete recovery. The financial background of the family is good with 2 domestic helpers to help care of the newborn and the family. However, most of Mrs. Wong's family are in Canada and she has few friends in Hong Kong. She also confesses to compulsive features of organizing all her old photos again and again recently because it can occupy much of her time when she does not feel crazy.

(3) *Your management plans are:*

- (a) *immediate psychiatric referral*
- (b) *simple reassurance: things will get better with time*
- (c) *counseling with supportive therapy*
- (d) *prescription of antidepressants*
- (e) *family visit and interview with husband*

Besides supportive counseling, tricyclic antidepressant (Prothiaden 75 mg nocte) is prescribed. Since the medication takes about 2 weeks to exert its action, you assess Mrs. Wong's condition every 3 days in your surgery. Her situation slowly improves over a month's time.

(4) *What are the common side effects with TCA?*

- (a) *Insomnia*
- (b) *Weight loss*
- (c) *Urinary retention*
- (d) *Constipation*
- (e) *Postural hypotension*

Two months later, Mrs. Wong's husband call you early in the morning because his wife is admitted to hospital for repeated 'fainting' without reason.

(5) *What runs through your mind while you rush to the hospital?*

- (a) *Suicide*
- (b) *Side effect of TCA*
- (c) *Epilepsy*
- (d) *Psychosis*
- (e) *Hysteria*

A detailed medical history, physical examination and investigation including EEG, and cardiac evaluation reveal nothing remarkable except a severe postural hypotension especially after straining during micturition.

As Mrs. Wong cannot stand the side effect of TCA, you stop the Prothiaden gradually and switch to a newer antidepressant - SSRI (i.e. Prozac 20 mg OM). After 9 months with continuous supportive counseling, she eventually gets out of her depression and returns to her energetic life and enjoy her happy family.

#### ***How to manage post-partum mood disorder?***

1. Screening for high-risk cases

- a. Pregnant women with a history of post-partum mood disorder; a major depressive disorder, or a bipolar affective disorder have a 30 to 50% risk for developing post-partum depression. Those with a past history of post-partum psychosis have even a higher (70-80%) risk for recurrent psychosis.
- b. Those with a family history of mood disorders (including post-partum mood disorder) are also at risk.
- c. The lack of psychological and social support, especially in the absence of an understanding husband, is a risk factor.
- d. Those with a stormy/complicated pregnancy and delivery history including lack of nutrition and sleep are also at risk
- e. Those who are sensitive to hormonal changes, either related to menstruation or to the intake of hormones, including oral contraceptives, may be at a higher risk than non-sensitive women. Some have postulated that post-partum mood disorders result from a rapid drop in progesterone level during the early puerperal period.
- f. Excessive stressors during pregnancy or dramatic changes in life-style, severe anxiety and undue expectations towards the pregnancy (especially for the elderly primiparous) are possible contributing factors.

For those with very high risks, some would recommend a course of anti-depressant at least 2 weeks prior to delivery. The suggestion of using lithium or oral oestrogen appears alarming and should not be employed easily.

2. Prompt diagnosis after childbirth

- a. Routine screening of all women for features of depression after childbirth, preferably on day 3 or 4.
- b. Regular screening of those women with high risks as mentioned above.

- c. Close monitor of those women with post-partum blues as regard the development of a more severe disorder.

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The **Edinburgh Postnatal Depression Scale** (Cox and Holden 1994) is a convenient instrument to use for screening. It is a 10 item self-report questionnaire each with a grading from 0 to 3; and a score of 12 is the cut-off point for pathology. A validation study using a local translated Chinese version in Hong Kong suggested that the cut-off score of 9/10 was needed for a general post-natal population (Lee et al, 1998).

Besides the screening instrument, clinical examination with a detailed history (past/present) and physical/mental examination are mandatory. Medical illness (e.g. hypertension, Sheehan's syndrome or delirium due to medical complications of childbirth) and other psychiatric disorders (e.g. ongoing schizophrenia or obsessive-compulsive disorder) may have to be ruled out. Laboratory testing for hormonal level is usually not necessary except for academic purposes.

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### 3. Active treatment

- a. Prevention is difficult but should be attempted prior to, during and after delivery. Psychological and social support should be given, whenever possible from the relatives and the obstetrician. Antenatal classes with education on childcare and parenthood are useful preparatory measures. The husband is particularly important, and should be encouraged to attend, including the time in the labour room. There should be adequate rest and nutrition after childbirth, with release of baby care duties. The traditional Chinese practices of 'doing the month' (confining and resting at home, taking nutritious food and avoiding undue exertion) and 'attending the month' (with a female aide to help around and even to breastfeed the child) are found to be useful (Pillsbury, 1978).
- b. Prompt counseling should be given by the attending doctor for post-partum blues, and referral to a psychiatrist when more serious mood symptoms develop. Supportive psychotherapy can render immediate though temporary relief, as interpersonal psychotherapy and the cognitive-behavioural therapy take time to be effective. Concerning medications, discrete use of benzodiazepines in the early days can be useful if there is significant anxiety symptoms or insomnia. The anti-depressant of choice is the SSRIs, especially if the patient has some suicidal thoughts, and sometimes the psychiatrist may add on a mood stabilizer. Anti-psychotics are indicated in the presence of psychotic features. Electro-convulsive therapy is a rapid and effective treatment for severe conditions, especially for psychotic and suicidal patients; but the practice is limited to the specialist care. Usually, the patient is advised against breast-feeding, but if the patient insists, then a course of amitriptyline, valproic acid or carbamazepine may be tried. Hormonal therapy has been suggested before but have not been found to be better than placebo. It should be noted that medications should be given in adequate dosage and duration.

### 4. Active rehabilitation

- a. In order to hasten recovery, the psychosocial conditions of the patients should be looked into, with prompt assistance from medical social workers and/or hospital chaplains/priests. Advice and training on child care and breast feeding/weaning should be given by the relevant professionals.
- b. Marital therapy and perhaps multi-generation family therapy may be needed. For some patients, support groups can be quite beneficial.
- c. There should be a lookout for the subsequent development of a major psychiatric disorder, and sometimes prophylactic medications using mood

- stabilizer or continued anti-depressants are justified for those with unremitting symptoms.
- d. Last but not the least, counseling as regard future post-partum disorders can be given to the patient and her spouse.

## **Case 2**

Madam Ng presented to your office on 24 August 1993. She delivered 1 month ago. This was her second child. She complained of anorexia and weakness for the past 3 weeks after the delivery. She complained of anxiousness, sweating and difficulty in caring for the baby. When questioned further, she broke down into tears and admitted to suicidal ideation in the form of jumping from her flat (situated on the 10<sup>th</sup> floor) with the new born baby.

- (6) *You should enquire about:*
  - (a) *the first childbirth*
  - (b) *the exact postnatal date of the onset of the symptoms*
  - (c) *her thoughts about the baby*
  - (d) *details of the suicidal and infanticide thoughts*
- (7) *You should also ask about*
  - (a) *past psychiatric history*
  - (b) *family history of psychiatric disorder*
  - (c) *family and social support*
  - (d) *marital harmony and support*
  - (e) *experience as a child in her family of origin*

She has been seen by you since 1987 on and off. She was on birth control pills since 1988. She had complained of ulcer syndrome but upper endoscopy in January 1988 was negative. She has on and off precordial pain for one year since 1991 and lower abdominal pain for 1 week in August 1992.

Her parents lived in Shek Yam while she lived in Tuen Mun. Her mother, also your patient since 1984, was seen for precordial pain, ulcer syndrome with normal upper endoscopy in 1984, chronic psychiatric illness treated at Kwai Chung psychiatric OPD since 1984 and NIDDM since 1991. Her mother was on treatment for rosacea since 1993. Madam Ng's husband was a lorry driver who could not help with the chores at home. Sometimes he was on the road for days before returning home. Madam Ng had few friends and contacts in Tuen Mun. She could not afford a maid or a baby sitter. She lived in a housing estate flat.

- (8) *The differential diagnosis include:*
  - (a) *acute adjustment reaction*
  - (b) *post-partum depression*
  - (c) *post-partum blues*
  - (d) *post-partum psychosis*
  - (e) *normal post-partum reaction*
- (9) *The treatment of choice would be*
  - (a) *Tricyclic antidepressant*
  - (b) *Lithium carbonate*
  - (c) *MAOI (Monoamine Oxidase Inhibitor)*
  - (d) *SSRI*
  - (e) *Supportive psychotherapy*
- (10) *The risk factors for post-partum depression are*

- (a) *history of depression*
- (b) *history of bipolar disorder*
- (c) *recent stressful life event*
- (d) *experience as a child in her family of origin*
- (e) *post-partum drop, greater than average, of serum progesterone*

She was put on an antidepressant and a mild tranquillizer. A social worker from Baptist Hospital arranged for volunteer workers to visit her at home and introduced her to friends and various facilities in the Tuen Mun area. A psychiatric consultation was arranged and she was followed up by the psychiatrist for 6 months. A telephone interview in January 2001 revealed the patient was well and not on any medication. She had one therapeutic abortion after this second baby. Both children were fine.

(11) *To alter the course of post-partum mood disturbance, the doctor should*

- (a) *encourage the attendance of the husband at prenatal visits*
- (b) *provide education materials on specific mood disturbance*
- (c) *question the couple about prenatal education received concerning mood change in pregnancy*
- (d) *emphasize the importance of husband in all aspects of the pregnancy*
- (e) *describe all tests, examination procedures and reasons for all routine questions and any deviation from normal protocol that may occur during pregnancy*
- (f) *make at least one visit to the patient during early labour*
- (g) *explain every possible intervention during labour and the reasons for same*
- (h) *encourage the patient at every opportunity during labour and delivery*
- (i) *assess immediately post-partum and monitor. Attention to those with risk factors of post-partum mood disorders.*

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