Professor Tony Dowell

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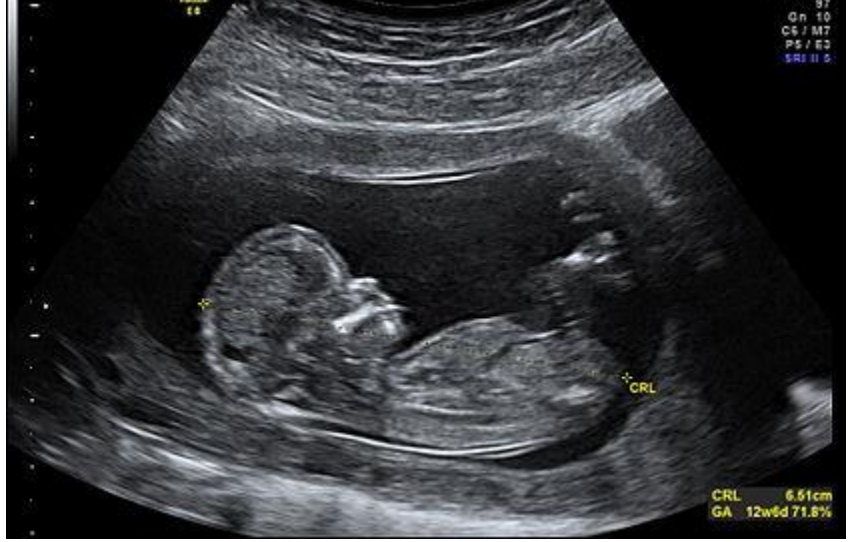
Wellington

Saturday, June 10, 2017 (Room 11)

14:00 - 14:55 WS #139: Hot Topics in Obstetrics and Gynaecology

15:05 - 16:00 WS #151: Hot Topics in Obstetrics and Gynaecology (Repeated)



Hot topics in Obstetrics , Gynaecology and women's health

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UNIVERSITY OF OTAGO
Te Whare Wānanga o Otāgo

Context and Disclaimer

- Once upon a time
- Lots of Obstetrics and Gynaecology
- Now
- Part time GP
- Interim Head of Department of O and G !!!
  - Things I know very little about
  - What is the GP role

Today

- The GP role in the management of Gestational Diabetes.
- Hypertension in pregnancy: Red flags and when to act.
- Severe and Acute Maternal Morbidity: lessons for General Practice.
- Chronic pelvic pain revisited

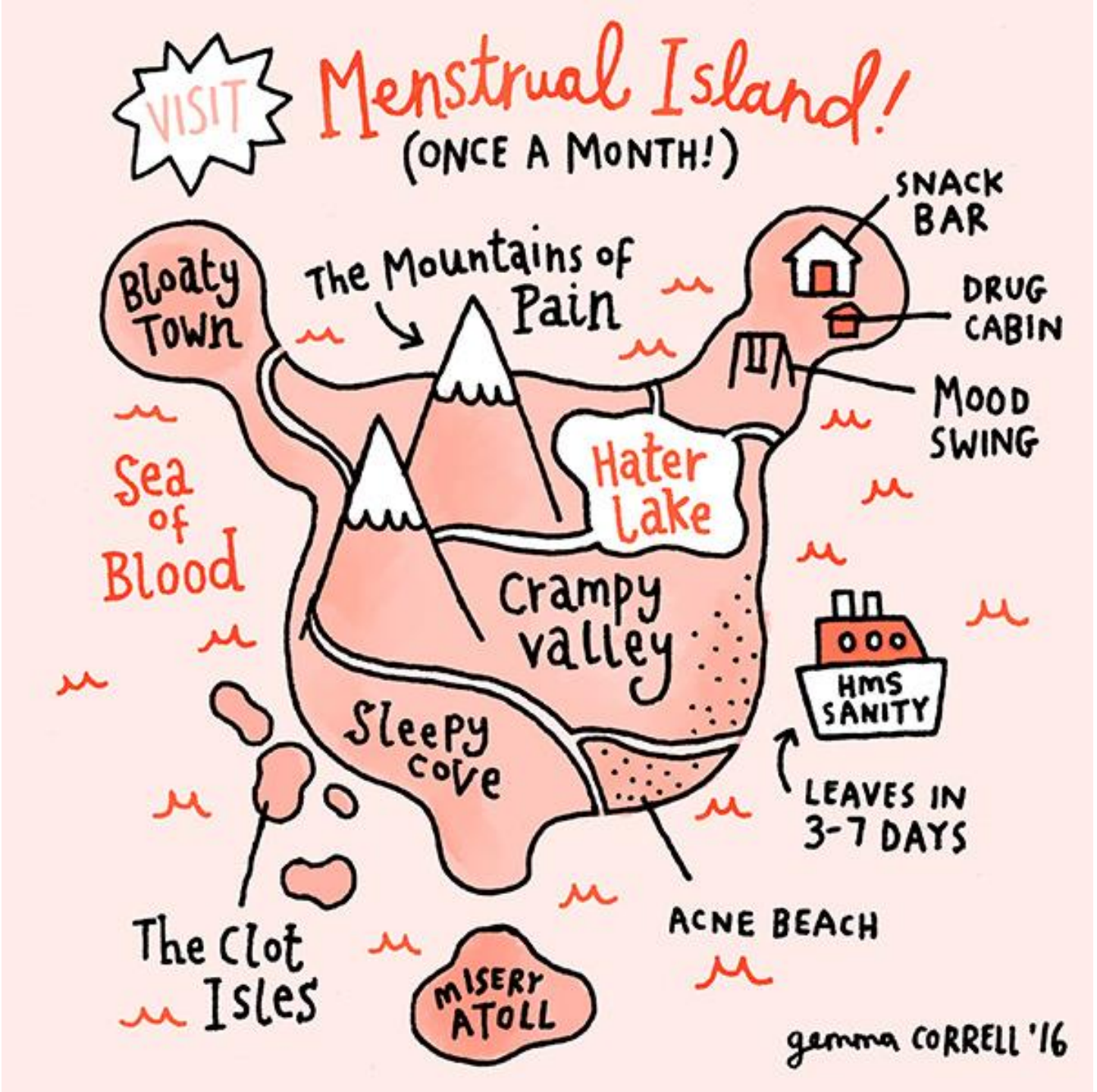
Epidemonology

- 60,000 births / year. 52% male , 48% female.
- 40% of the children were not planned
- > 10 % smoking in pregnancy
- Miscarriage 50% all pregnancies
- 69% births spontaneous vaginal birth (primip)
- 15% Caesarean , 16% instrumental
- 10% Pre-eclampsia
- GDM - Auckland (8.2%), Wairarapa (1.4%)
- 50% overweight or obese

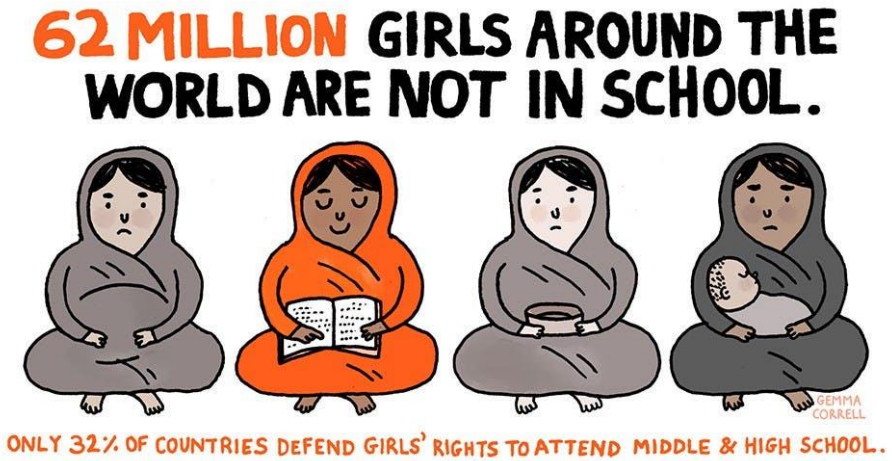
Epidemonology

- Cervical Screening
  - uptake = 73.9% (High need 66%)
  - 25,000 abnormal smears
  - 160 cases cervical cancer, 50 deaths.
- Gynae cancer 10% all cancer cases and deaths
  - 1000 women diagnosed , 400 die each year

Women's Health



Women's Health

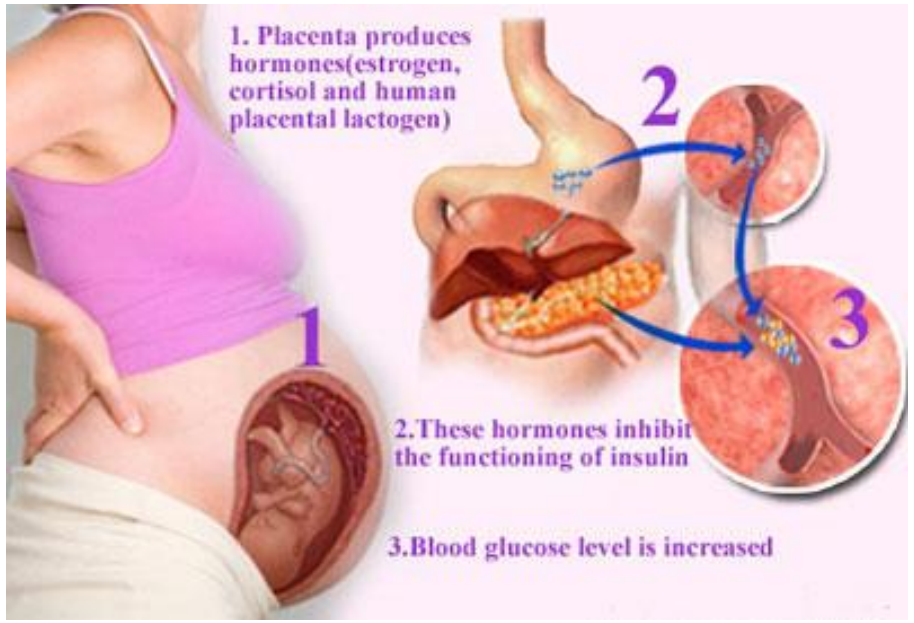


Gestational Diabetes

- Why is it an NZ problem?
- What is the GP role in 2017?

GDM

- GDM: pancreatic function is insufficient to overcome ‘natural’ pregnancy insulin resistance.
- Gestational: 90%
- Pregestational: 10% -increasing



GDM

- 3 to 5% of all pregnancies (Marked variation)
- Risk factors:
  -**Maternal obesity**
  -Family history of diabetes
  -Previous or current macrosomia
  -Previous stillbirth
  -Polycystic ovarian syndrome
- Higher prevalence in Maori, Pacific, Indian

Risks of diabetes in pregnancy

- Foetal macrosomia
- Birth trauma (to mother and baby)
- Induction of labour or caesarean section
- Miscarriage
- Congenital malformation
- Stillbirth
- Transient neonatal morbidity
- Neonatal death
- Obesity and/or diabetes developing later in the baby’s life.

Management

- 30% of non pregnant NZ women are overweight or obese.
- All overweight women in reproductive age group – have the talk !! ??

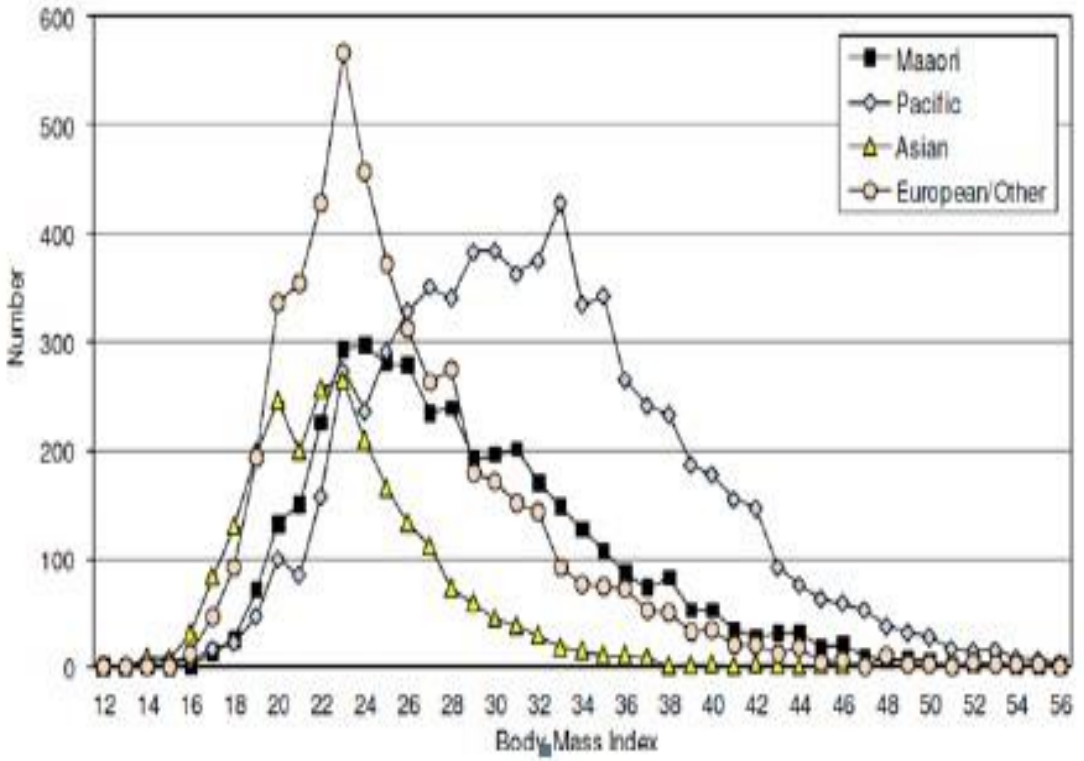
NZ BMI in pregnancy data 2012

- National data for BMI at booking
- 28% overweight (BMI >=25)
- 22% obese (BMI >=30)
- 50% overweight or obese

BMI in pregnancy

- Obese (BMI ≥ 30) who birthed at CMH facility
  - 65% of Pacific mothers
  - 45% of Maori
  - 26% of European

Counties Maternity Quality and Safety report 2014/2015



Overweight and Obese in pregnancy

In pairs - Talk to the person next to you.

- Doctor and overweight patient
- Either
  - Wanting to become pregnant
  - Positive pregnancy test
- Patient has BMI of 37
- What do you say ?

Not yet pregnant

- Existing stigma and ‘fear’
- A time of opportunity
- Practitioners should initiate discussions by asking women how they feel about discussing weight.
- Weight gain matters during pregnancy
- Women want to be healthy for their baby
- Nikolopoulos H, Mayan M, MacIsaac J, Miller T, Bell RC. Women’s perceptions of discussions about gestational weight gain with health care providers during pregnancy and postpartum: a qualitative study. BMC pregnancy and childbirth. 2017 Mar 24;17(1):97.

Overweight and pregnant

- Base your meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible
- Watch the portion size of your meals and snacks and how often you eat. Do not ‘eat for two’
- Usual advice Fats and Sugars

In general you do not need extra calories for the first two-thirds of pregnancy and it is only in the last 12 weeks that women need an extra 200 kilocalories a day.

Trying to lose weight by dieting during pregnancy is not recommended even if you are obese, as it may harm the health of your unborn baby. However, by making healthy changes to your diet you may not gain any weight during pregnancy and you may even lose a small amount. This is not harmful.

Why your weight matters during pregnancy and after birth RCOG 2015
https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-why-your-weight-matters-during-pregnancy-and-after-birth.pdf

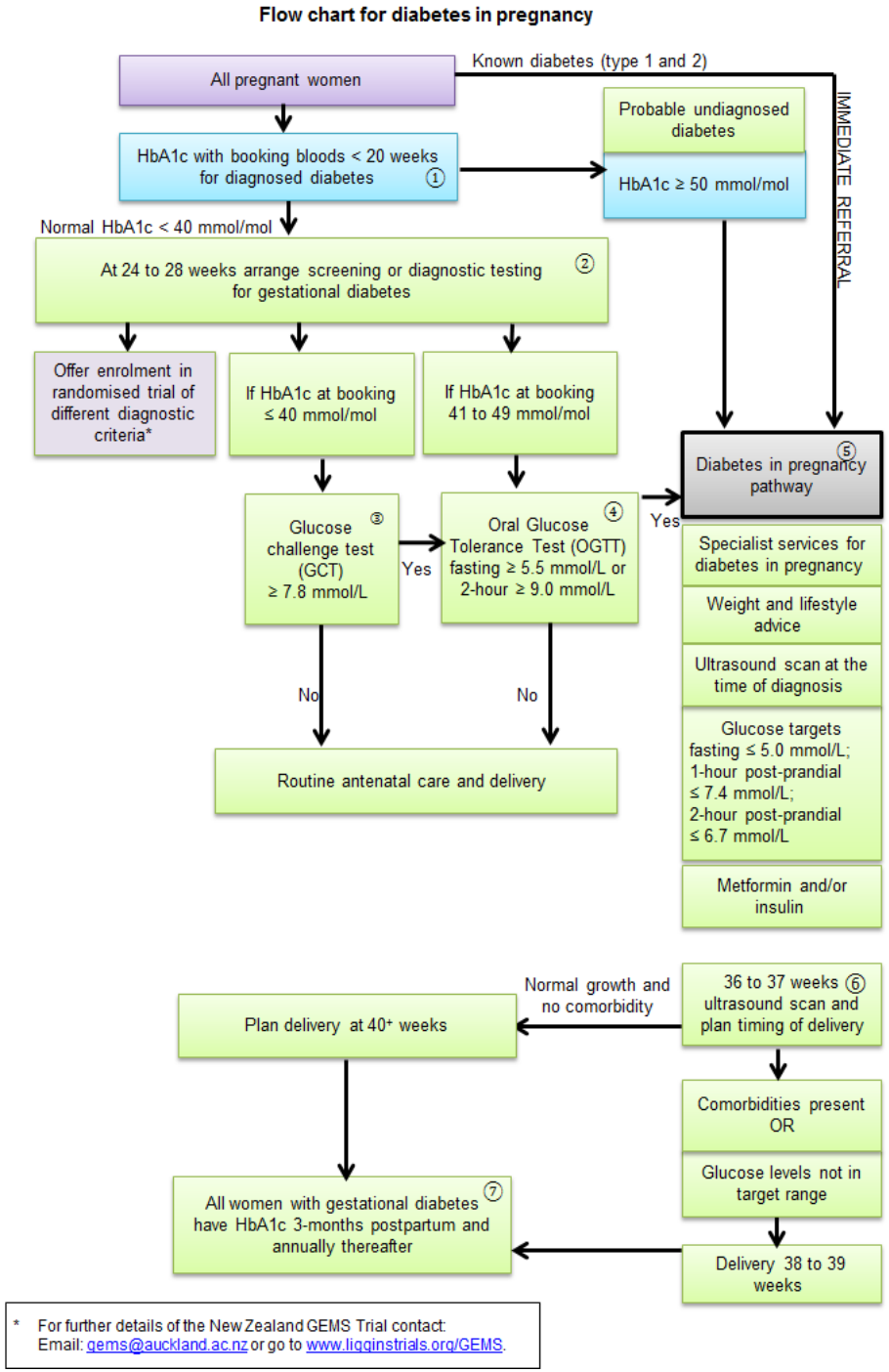
GDM – GP role

- Check all women have HbA1c pre- and early pregnancy to check for undiagnosed pre-diabetes and diabetes.
- Usual cut offs (>50 = DM , 41-49 = Pre DM)
- 24-28 weeks
- Booking 41-49 HbA1C = 75G 2 hour OGTT
- Other wise 50G , 1 Hour OGCT
- Diabetes in pregnancy pathway
- Postpartum
- 20-30% women result in permanent type 2 diabetes
- 3/12 postpartum , and annually = HbA1c

Interventions

- Diet
- Probiotics 20% reduction in GDM Luoto et al
- Text messaging for weight Mgx
- Exercise – not great
- HUMBA trial – Auckland
  - culturally appropriate, affordable, sustainable dietary education
  - probiotic capsules
  - McCowan et al

British Journal of Nutrition (2010), **103**, 1792–1799



- **Screening, Diagnosis and Management of Gestational Diabetes in New Zealand**
- A clinical practice guideline
- http://www.health.govt.nz/publication/screening-diagnosis-and-management-gestational-diabetes-new-zealand-clinical-practice-guideline

How Mother and Baby "Picked Up"

A case of Blatz Beer in your home means much to the young mother, and obviously baby participates in its benefits.

The malt in the beer supplies nourishing qualities that are essential at this time and the hops act as an appetizing, stimulating tonic.

Main 2400

BLATZ

MILWAUKEE

Always the same good old Blatz

Tayla W.
A case of Respiratory infection

- 18 - year-old pregnant (gravida 1, para 0)
- Presents at 32 weeks' gestation
- Initial ‘cold ‘ 3/7. – now some aches
- Smoker
- Mild asthma
- Temp 37.8
- Signs of URTI
- Chest clear
- RR 18
- Pulse 68
- Baby well
- Management ?

Tayla W.
A case of Respiratory infection

- 24 hours later
- Feeling unwell
- Nausea , chills , difficulty breathing
- Lost ventolin inhaler.
- Temp 38.2
- RR 24
- Pulse 88
- Wheeze
- Persistent creps R base
- Management ?

Tayla W.
A case of Respiratory infection

- Option B
- 24 hours later – Had been started on Amoxycillin
- More unwell
- Temp 38.5
- Persistent creps R base
- BP 100/ 70

Tayla W.
A case of Respiratory infection

- 6 hours later
- Collapse => ED
- Acute respiratory distress - respiratory rate 44 breaths/min; oxygen saturation 54%
- Immediate intubation and transfer to ICU
- 48 hours – Emergency LSCS – 1300G live infant

Influenza in Pregnancy

- **Physiological changes during pregnancy**
- Immune system: Humoral (antibody mediated) immunity enhanced, the cellular arm of the immune system is temporarily suppressed.
- Physical changes: Changes in the pelvic region, abdominal and thoracic cavities place pressure on surrounding organs.

Influenza in pregnancy

Risk to the woman

- 5 x more likely hospitalisation
- Healthy in pregnancy = comorbidity in non-pregnant.

Risk to the Foetus

- Unlikely any vertical transmission.
- High risk to young babies

GP Role – encourage immunisation

Severe and Acute Maternal Morbidity

Severe and Acute Maternal Morbidity: lessons for General Practice.

- SAMM : severe acute maternal morbidity
- “a very ill pregnant or recently delivered woman who would have died had it not been that luck or good care was on her side.”
- 3.8-13.8 per 1000 deliveries
- Multidisciplinary Team audits (4 DHBs)
- 98 SAMM cases were assessed;
  - 38 (38.8%) cases were deemed potentially preventable,
  - 36 (36.7%) not preventable but improvement in care was needed,
  - 24 (24.5%) not preventable

Severe and Acute Maternal Morbidity

Results

- Most frequent preventable factors were clinician related:
- Delay or failure in diagnosis or recognition of high-risk status (51%)
- Delay or inappropriate treatment (70%).
- Blood loss > 1999ml
- Septicaemia
- Uncontrolled hypertension
- Cerebrovascular
- HELLP syndrome
- DIC

- Lawton B, MacDonald EJ, Brown SA, Wilson L, Stanley J, Tait JD, Dinsdale RA, Coles CL, Geller SE. Preventability of severe acute maternal morbidity. American journal of obstetrics and gynecology. 2014 Jun 30;210(6):557-e1.

Implications for General Practice

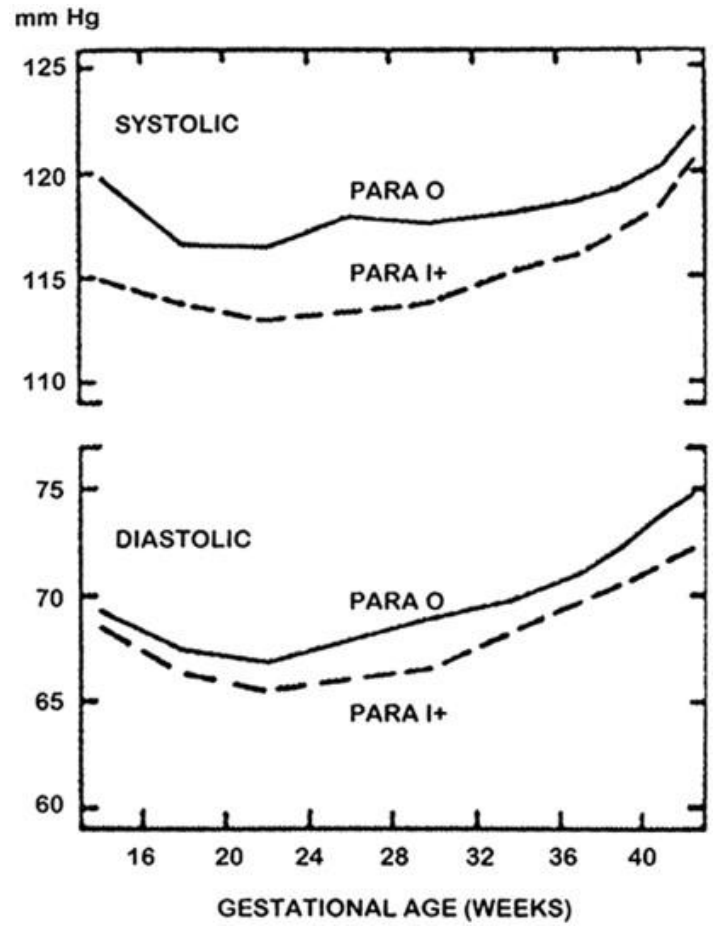
- Although rare – severe and rapid deterioration can occur in pregnancy and post partum.
- Risk to mother and baby
- Caution in interpreting symptoms and signs
  - Respiratory infection
  - Urinary infection
  - Post partum sepsis of any kind.
- Contraception

MacDonald EJ, Lawton B, Geller SE. Contraception post severe maternal morbidity: a retrospective audit. Contraception. 2015 Oct 31;92(4):308-12.

Hypertension in pregnancy

Blood Pressure Changes in Normal Pregnancy

- Blood pressure drops 12-26 weeks
- Increases to pre pregnancy levels by 36/40
- Bp drop caused by fall in systemic vascular resistance
  - Smooth muscle relaxation & vasodilatation



Definitions

- Gestational hypertension (PIH)
  - Bp ≥ 140/90 after 20/40
  - No proteinuria
- Preeclampsia (PET)
  - BP ≥ 140/90 AND
  - Proteinuria ≥ 0.3g /24 hours, PCR ≥ 30
  - Oedema NOT required for diagnosis of PET
- Eclampsia
  - Grand mal seizure in a woman with PET
- Pre-existing hypertension
  - Bp ≥ 140/90 predating pregnancy or < 20/40
  - 40% increase risk PET
- Chronic hypertension with superimposed PET
  - New onset of proteinuria in a woman with chronic hypertension

Burden of Disease

- 10-15% maternal deaths worldwide associated with PET & eclampsia
- Hypertension complicates 5-7% of all pregnancies
- Foetal morbidity
  - Growth restriction
  - Prematurity
  - Worldwide: responsible for 20% of 13million preterm births
  - 500 000 neonatal deaths worldwide per year
  - 2nd most common cause direct maternal death NZ

Risk Factors for PET

- Nulliparity
- First pregnancy to new partner
- Extremes maternal age
- Multiple pregnancy
- PET in a previous pregnancy
- Family hx of PET
- Long inter-pregnancy interval
- Underlying medical conditions
  - Hypertension
  - Renal disease
  - Diabetes
  - APL syndrome
- High BMI
- Partner has fathered a previous pregnancy with PET
- Foetal hydrops

Clinical Presentation of PET

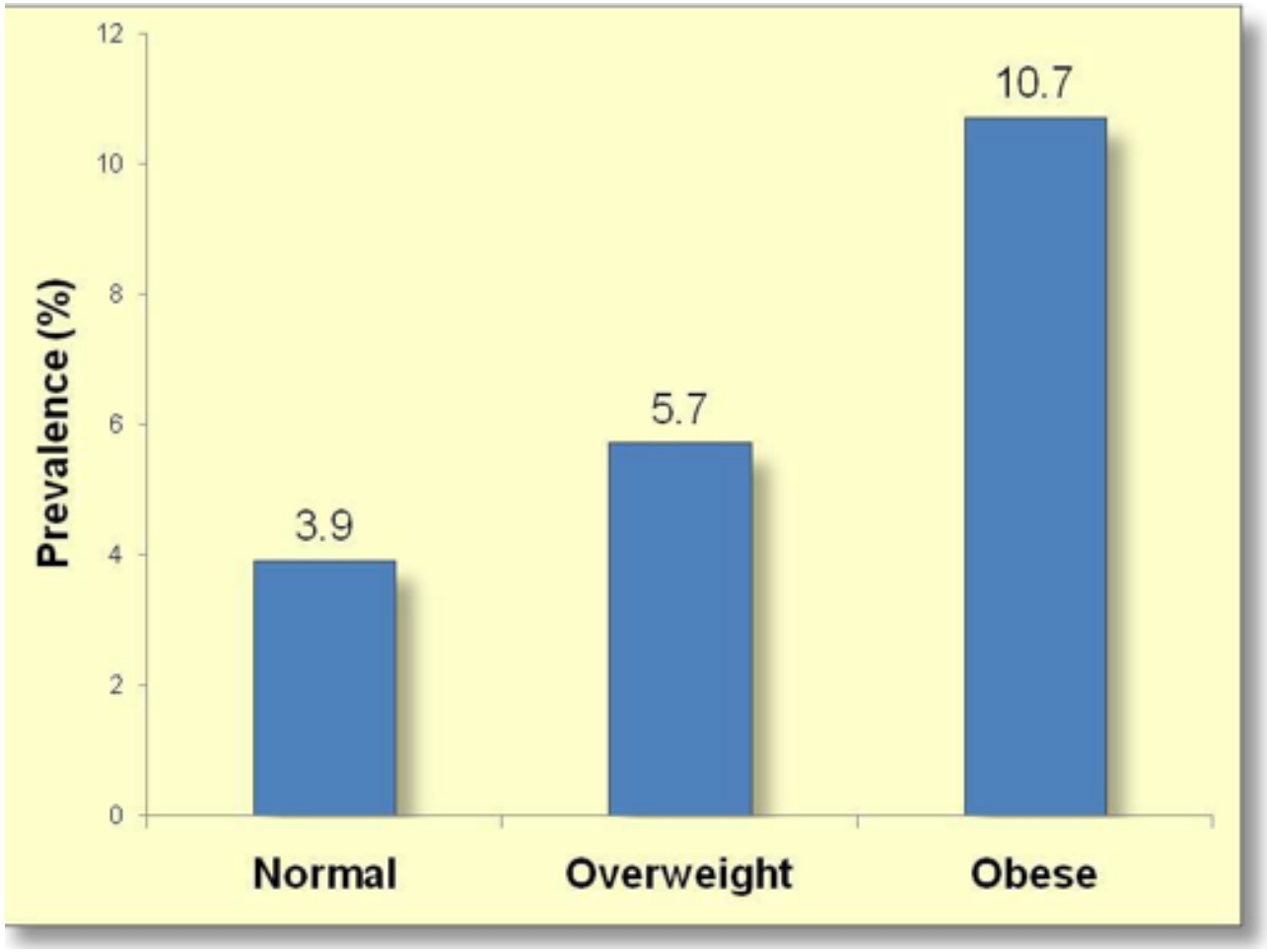
- Signs & Symptoms
  - Hypertension
  - Headache
  - Visual disturbances
  - Epigastric / RUQ pain
  - Nausea / vomiting
  - Oliguria
  - Dyspnoea
  - Foetal growth restriction
  - Oligohydramnios
  - Altered mental status
- Lab abnormalities
  - Haemoconcentration
  - Haemolytic anaemia
  - Thrombocytopaenia
  - Elevated creatinine **
  - Elevated liver enzymes
  - Proteinuria
  - Raised uric acid

GP role

Pre-conception

- **Assess risk factors in all pre-pregnant women**
- **BMI**
- **BP**
- Existing hypertension ;check current antihypertensive treatment safe in pregnancy, or switch to one that is.
- If the patient is on an ACE inhibitor or an ARA (angiotension-II receptor antagonist), consider changing to an agent that is safe for pregnancy.
  - Methyldopa
  - Labetolol
  - OR - discontinue medication as soon as there is a positive pregnancy test.
- Counsel regarding risk of preeclampsia; for women who have pre-existing hypertension the risk of preeclampsia is around 40%.

Preeclampsia by BMI (SCOPE study)



Adapted from Anderson et al BJOG DOI: 10.1111/j.1471-0528.2012.03278.

GP Role – Pregnancy

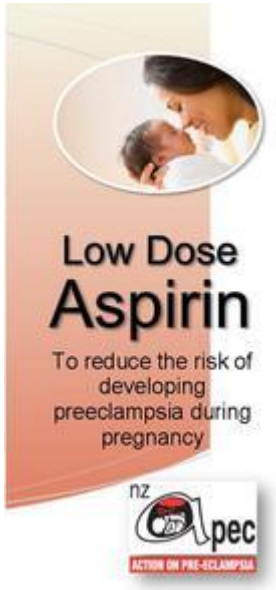
Hypertension

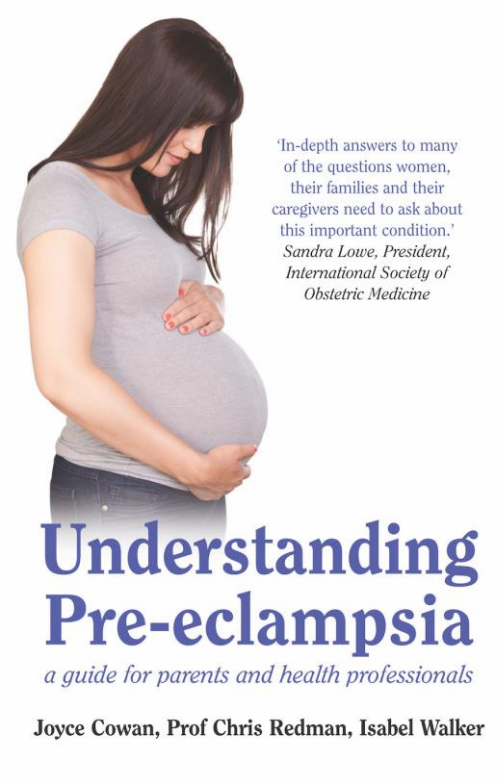
- Diastolic pressure 90 mmHg and/or systolic pressure 140 mmHg, at least 2measurements.
- Urine, bloods and consider diagnosis
- PET, Pre-existing, Gestational hypertension

Red Flags

- Any new onset hypertension after 20 weeks
  - Check for proteinuria
  - Ask about headache, visual disturbance, swelling, epigastric pain
- If severe hypertension (i.e. systolic BP ≥ 160, seek urgent advice

GP role – awareness





Emily T

- 25 year old G1P0
- Smoker
- Mild asthma
- BMI 27
- Booked early EDD based on 9/40 scan
- BP 100/60
- Normal AN bloods

Emily T

- Seen at 30/40
- BP 140/80, no oedema, urine NAD
- Seen at 32/40 with intermittent mild abdominal pain
- VE cx closed
- All well, FMF and FH 138-151

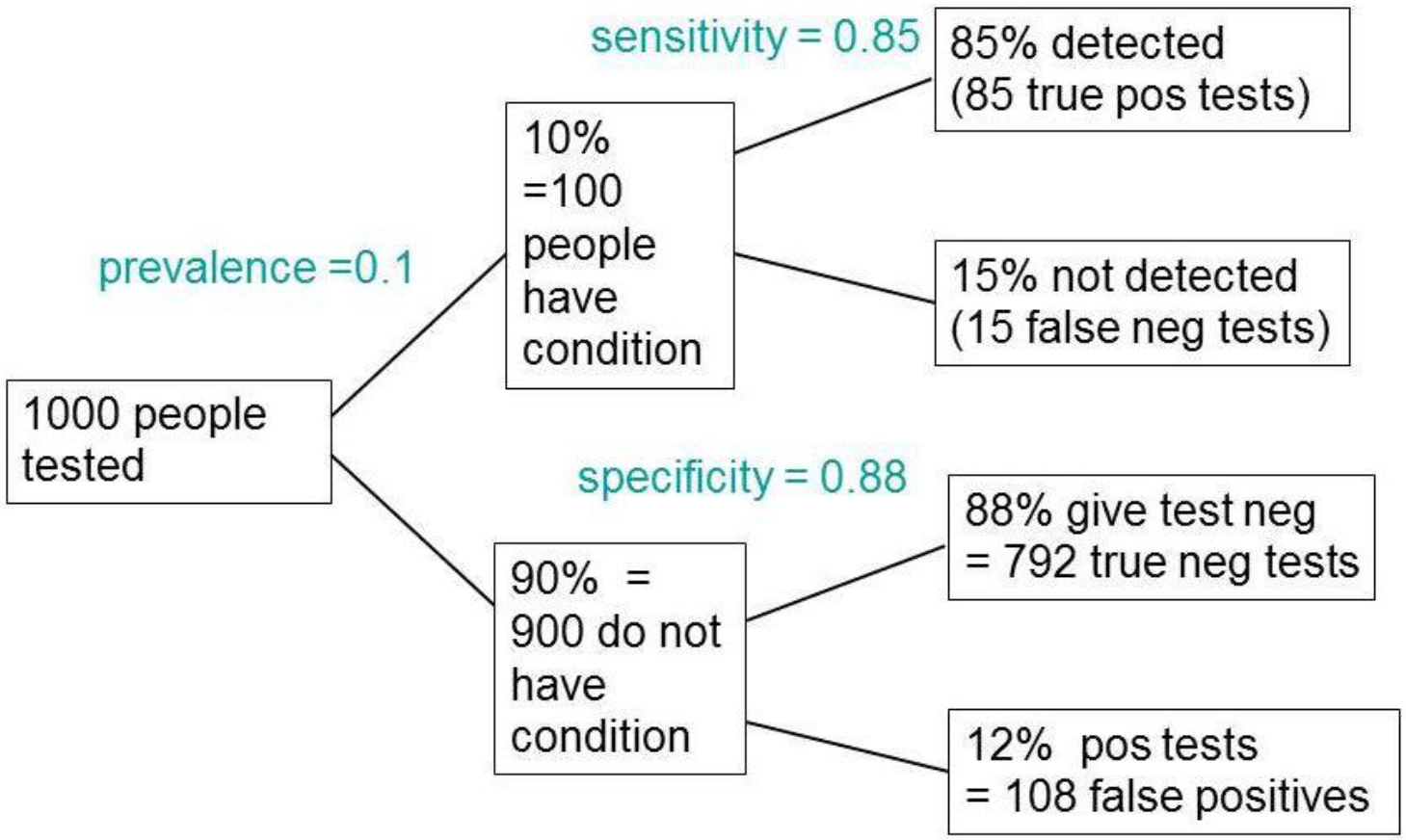
Emily T

- 33+/40
- Phone call not feeling well
- @ 1200 Looks unwell
- BP 180/120
- Proteinuria +++
- Generalised oedema

Emily T

- @1840 s/b SMO for emerg CS
- Paeds aware
- @1900 s/b anaethestist
- @1940 spinal/epidural
- LSCS
- Baby delivered 2000
- Eclamptic seizure in PACU lasting 1 min
- Post op mum to ICU babe to NICU

Screening tests



- There are very few good screening tests

Women's health Screening

- Cervical Screening
  - Pap – Sensitivity 50 % (19% - 77%) , Specificity 86 -100%
  - HPV testing – Sensitivity 90% - but 30% of HPV +ve don't +> cancer.
- Ante- natal genetic testing
  - Sensitivity 80% - Specificity 95%
  - NIPT – Sensitivity 99% Specificity 99.8%
    - But – main tests so far in high risk (older) women

Non-invasive prenatal testing (NIPT)

- Antenatal screening of fetal chromosomal abnormalities.
- Maternal blood sample and isolating freely circulating fragments of feto-placental DNA.
- Abnormalities of specific chromosomes (e.g. 13, 18, 21, X, Y).
- Much higher screening capability for chromosomal abnormalities than current combined first trimester screening – (99% sensitivity for trisomy 21.
- Low false positive rate (1%–3%)
- NIPT can be performed from around 10 weeks in pregnancy.
- NIPT is not currently publicly funded.

Screening - caution

Language matters - Cervical cytology talk

- " The cervical smear test is a test for cervical cancer "
- " the plan of attack from here on in "
- " We use a speculum – its like a ducks beak"
- " Your cervix is like a donut – we sweep it with a little brush with bristles on it"
- " We put a metal device in the vagina "
- " Its like a blade "

Chronic Pelvic Pain revisited

Susan B

- Susan is 38, and has presented multiple times with pelvic pain. The pain began in her early 20's and she has one child now aged 8.
- The pain is worse at times with her periods which are regular.
- She has tried a 'Depo' injection which made her gain weight and feel bloated.
- Gynaecologist => laparoscopy – no definite endometriosis.

The GP role

- To listen to the patient's story
- To have a logical framework for assessment
- To maintain a balance between passivity and over referral and investigation

Definition

- Pelvic pain of more than 6 months duration that has a significant effect on daily function and quality of life
- Does not occur exclusively with menstruation or intercourse
- “risk being labelled as difficult or needy and may struggle to be believed when accessing healthcare services” - BPAC

New Zealand

- 2% to 27% of adult females worldwide
- NZ – 25% between 18 and 50 experienced in the last 3 months
- ? Maori (18%) and other ethnicity less likely to report pain

Aetiology ?

- No apparent cause (33%)
- Gynae
  - Hormonally driven: Endometriosis (?33%)
  - Adhesions
  - Adenomyosis and masses
- IBS and Interstitial Cystitis
- Musculoskeletal
- Pelvic floor damage
- Nerve entrapment
- Psychological and Social issues

Red Flags

- New pelvic pain in postmenopausal patient
- Pelvic mass
- Significant family history of breast, ovarian, bowel, or uterine cancer
- Unexplained or excessive weight loss
- Regional lymphadenopathy
- Irregular postmenopausal or post-coital bleeding in patient aged > 40 years
- Rectal bleeding or change in bowel habit in patient aged > 50 years

Assessment and Investigation

- A gynae history and examination

But also

  - Sexual history
  - GI Tract
  - Musculoskeltal
  - Psychological
  - The challenge of PTSD
- Family History
- Investigations
  - CBC, CRP, urinalysis, STI swabs,
  - Pelvic ultrasound (? Only after the endometriosis journey)

Endometriosis

Pelvic pain which varies markedly over the menstrual cycle is likely to be attributable to a hormonally driven condition such as endometriosis.

- Continues to be challenging and mysterious
- 5% aysmptomatic women
- 20% of chronic menstrual pain
  - Abdominal bloating
  - Dysparaeunia
  - Dyschezia
  - Dysuria (menstrual)
  - Abnormal bleeding
  - Unilateral , bilateral
- Trial by hormones –
  - MPA, COC, GnRH, Mirena
- Pelvic congestion ??

Lifestyle and Drugs

- Exercise
  - Reduces pain
  - Increases level of physical function
  - Improves sleep
  - Lessens fatigue
  - Improves mood, depression and anxiety
  - Reduces weight
  - Mitigates inflammation
- Sleep
- Smoking
- Dietary modification

- Analgesics
- Tricyclic antidepressants (TCAs)
- Gabapentine
- Clonidine

Laparoscopy

"Diagnostic laparoscopy has been regarded in the past as the 'gold standard' in the diagnosis of chronic pelvic pain. It may be better seen as a second-line investigation if other therapeutic interventions fail."

- Risk of death of approximately 1 in 10 000, and a risk of injury to bowel, bladder or blood vessel of approx-imately 2.4 in 1000, of whom two-thirds will require laparotomy
- 33-50% of laparoscopies negative
- Much of identified pathology not the cause of the pain

Bodily Stress Syndrome

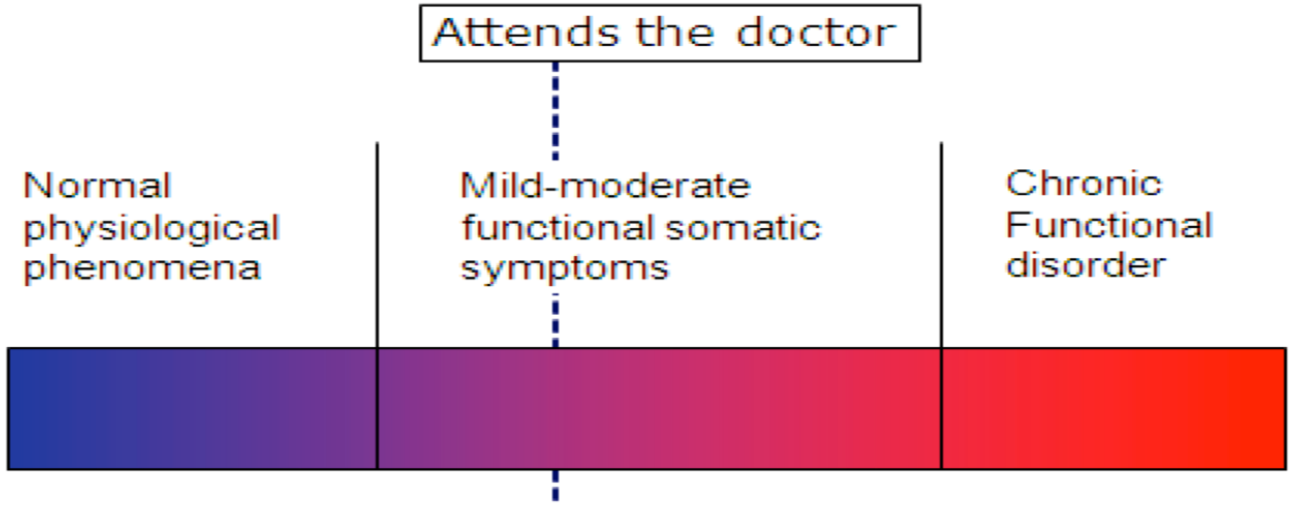
- Psychological symptoms with a focus on the physical
- Artist previously known as somatiform disorder heartsink etc
- Patients suffer from various physical symptoms of bodily distress.
- Positive criteria - not a diagnosis of exclusion as the current somatoform disorders.

Bodily Stress Syndromes

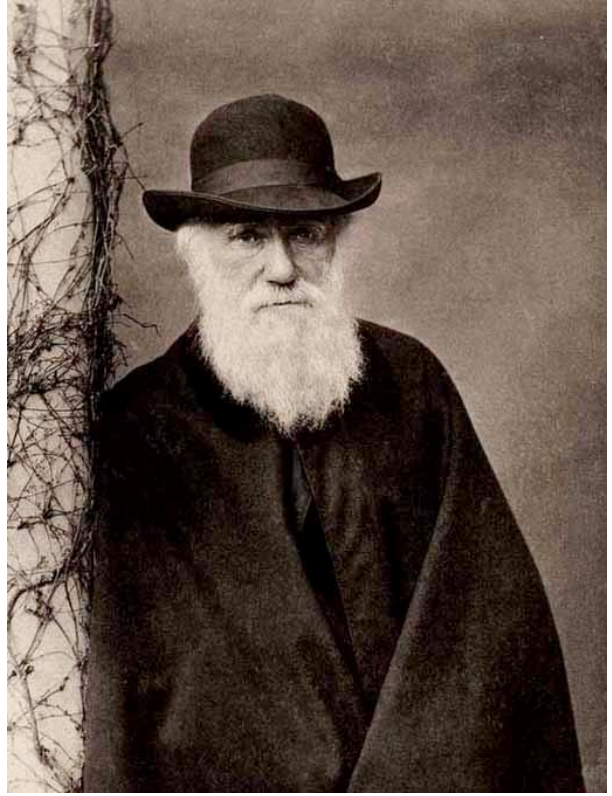
- Gastroenterology – IBS, Non ulcer dyspepsia
- Rheumatology – Fibromyalgia
- Cardiology – Non cardiac chest pain
- Respiratory – hyperventilation
- Dental - TMJ syndrome
- Neurology – ‘ headache’
- Gynaecology – chronic pelvic pain
- Psychiatry – somatiform disorders
- Chronic fatigue Syndrome

What is going on ?

- Autonomic hyper-arousal +
- Seyle's final stage of stress exhaustion.



A typical patient



- Malaise , vertigo, dizziness, muscle spasms, vomiting, cramps, bloating and nocturnal intestinal gas, headaches, alterations of vision, severe tiredness, nervous exhaustion, breathless, eczema, tachycardia, tinnitus.
- “ Severely debilitated for long periods of time, incapable of normal life and intellectual production Constant attacks…. stops all work.”

Bodily Stress Syndrome

Family Practice 2013; 30:76–87
doi:10.1093/fampra/cms037
Advance Access publication 28 July 2012

Proposed new diagnoses of anxious depression and bodily stress syndrome in ICD-11-PHC: an international focus group study

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Received 22 February 2012; Revised 2 May 2012; Accepted 17 May 201

Background. The World Health Organization is revising the
behavioural disorders for the International Classification of Di

Journal of Psychosomatic Research 91 (2016) xxx–xxx

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

Multiple somatic symptoms in primary care: A field study for ICD-11 PHC, WHO's revised classification of mental disorders in primary care settings

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Management

Appropriate investigation / reassurance

Iatrogenic over-investigation

Rx Anxiety and Depression

Helps you take the misery out of menopause

as hormones alone often don't do

Fast-acting Milprem directly relieves both emotional dread and estrogen deficiency

Many physicians find that estrogen therapy is not enough for the woman who is also filled with anxiety by her menopause. Her emotional dread may make her so miserable that it becomes a real clinical problem.

This is where Milprem helps you so much. It calms the woman's anxiety and tension; prevents moody ups and downs; relieves her insomnia and headache. At the same time, it checks hot flushes by replacing lost estrogens. The patient feels better than she did on estrogen therapy alone. And your counsel and your assurances can now help her make her adjustment much faster.

Composition: Miltown (meprobamate) + conjugated estrogens (equine).
Supplied: Milprem-400, each coated pink tablet contains 400 mg. Miltown and 0.4 mg. conjugated estrogens (equine). **Milprem-200**, each coated old-rose tablet contains 200 mg. Miltown and 0.4 mg. conjugated estrogens (equine). Both potencies in bottles of 60.
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Dosage: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

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WALLACE LABORATORIES / *Cranbury, N. J.*

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A "SENSE OF WELL-BEING" MEANS A FULLER LIFE

every woman who suffers in the menopause deserves "Premarin," natural oral estrogen prescribed by thousands of physicians

Mental Health issues in Women's Health

- Maternal mental health
  - Ante and post natal
- The menopause
- The Psychology of sexual health

Maternal Mental health disorders

- **Most mental disorders are similar in pregnancy and the postnatal period to those experienced at other times.**

- No evidence that prevalence is higher in this population
- BUT missed disorder could result in:
    - poor antenatal self-care
    - obstetric and perinatal problems
    - poor mother-child interaction
    - relationship difficulties
    - developmental problems in offspring
    - child/fetal neglect/abuse
    - maternal self-harm
- Psychotic disorders may develop more rapidly and be more severe
- Childbirth can trigger a severe bipolar episode
- **Suicide rare,- leading cause of maternal death**

Antenatal Mood Disorders

Myth that pregnancy is ‘protective’ against psychiatric disorders.

Severe psychiatric episodes are less frequent during pregnancy.

Research has shown women experience anxiety and depression *during* pregnancy at the same rate as postpartum 10-15% (Heron et al.,2004) .

Post partum

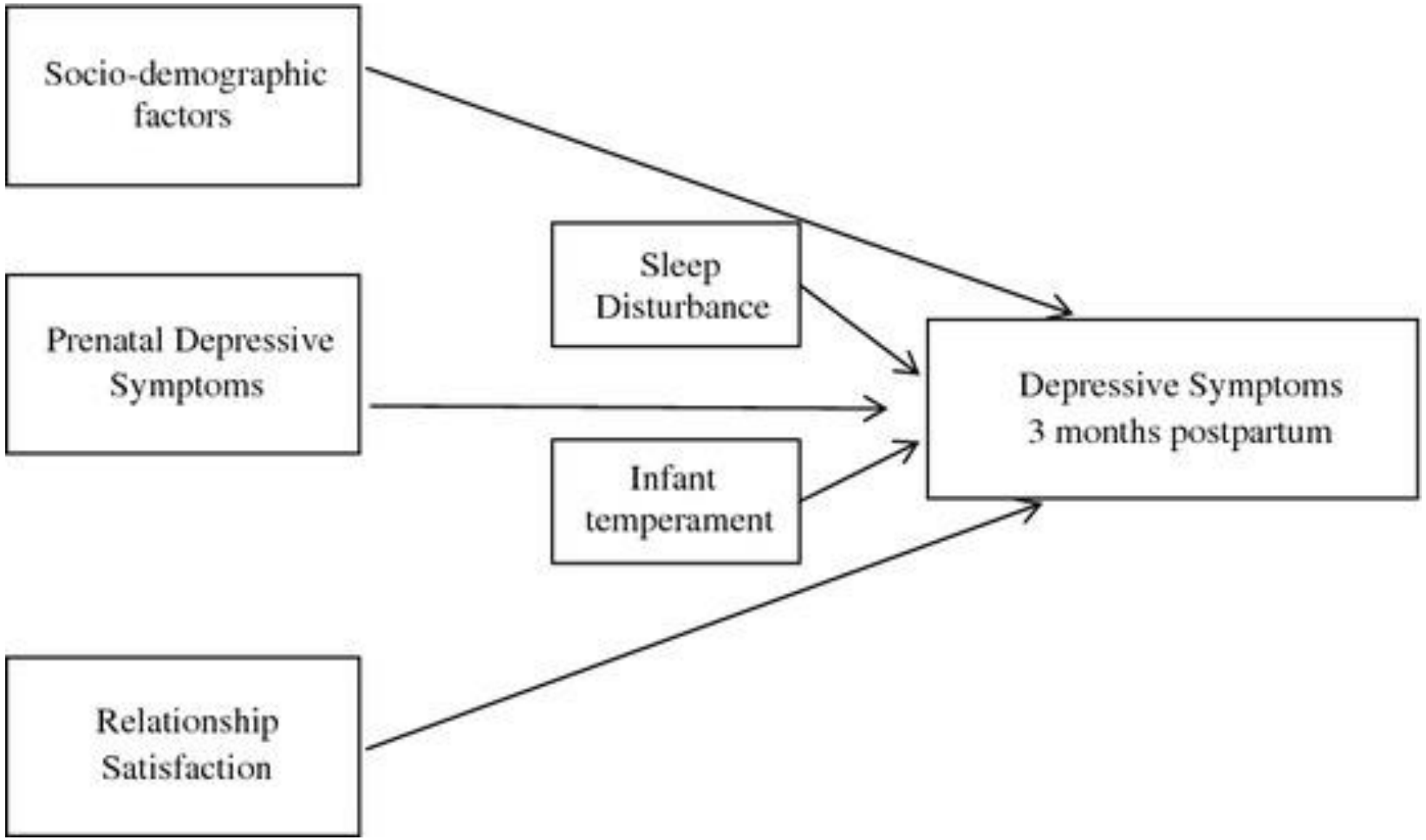
‘Blues’

- Most common perinatal mood disturbance
- Prevalence: 30-75%
- Onset day 3 or 4
- Mild, transient lasting hours to days
- Resolve within 2 weeks
- No treatment necessary (?????)

Post Natal Depression

- Postnatal depression is inadequately recognised and treated in New Zealand
- Screening of high risk groups recommended
- EPDS / PHQ-9 / HADS
- 22% of women PND onset > 6 weeks after childbirth.

Post Natal Depression



Management

- Collaboration
- Midwife , GP, Others involved
- Active support and self-management
- Education and support
- Stepped Care
- Mild to moderate depression. Brief psychological intervention
- Moderate to severe
- Psychological + SSRI
- Awareness of other conditions Biploar + Psychosis

SSRI use

High use (8% US)

- Pregnancy loss,
- Congenital heart disease
- Pulmonary hypertension in the newborn
- Childhood autism
- Higher risk of neonatal maladaptation (lower APGAR score and admission to neonatal ICU)

But

- Lower risks of preterm birth and caesarean section
- Known risks are low
- Untreated disorder carries significant risk

Psychological changes in the menopause

- Depression
- Anxiety
- Fatigue
- Irritability
- Memory loss
- Mood disturbance
- Sleep disturbance
- Tension and ‘aggression’