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Continued overleaf

Postnatal mental disorders

Psychiatric disorders following childbirth are common and many of them can be serious [1]. There are limitations in the current classifications of puerperal mental disorders. The International Classification of Diseases (ICD 10) permits the classification of mental and behavioural disorders associated with the puerperium, not elsewhere classified (F 53), only if the onset is within six weeks postpartum [2]. The American classification system (DSM IV) has an even shorter onset specifier of four weeks and is restricted to four diagnostic categories [3, 4]. The range of postpartum psychiatric disorders is wide and the traditional view of restricting these to maternity blues, puerperal psychosis and postnatal depression seems an oversimplification [5]. Other clinical problems encountered during this period include, disorders of the mother-infant relationship, post-traumatic stress disorder, various morbid preoccupations related to the bodily changes following pregnancy and childbirth, morbid jealousy, anxiety disorders specific to the puerperium and obsessions regarding child abuse.

Patients with maternity blues usually present during the first few days postpartum, particularly in the third to fourth day, and the symptoms include tearfulness, irritability, sleeplessness and impairment of concentration. Half to two thirds of women who deliver a normal child experience such brief episodes [6]. There is evidence that primiparas experiencing more severe maternity blues are at increased risk for postpartum depression [7], and evidence for an association between maternity blues and later more prolonged postpartum depression [8]. Postpartum psychosis may take the form of mania, severe depression (with delusions, confusion or stupor) or acute polymorphic psychosis. Its onset is usually within the first one to two weeks after the delivery but rarely in the first two days. The clinical features are generally the same as those of corresponding non-puerperal disorders. The incidence of admission to hospital for puerperal psychosis is about one per 500 births [6]. The depressive illnesses tend to present later in the puerperium. The overall incidence of postnatal depression is about 10%, and moderate to severe depressive illness 3-5% [9]. Most often, early-onset puerperal psychoses and severe depressive illnesses are very responsive to treatment [1]. Without treatment, 30% of mothers with postnatal depression are still ill at one year postpartum [10]. Maternal suicide rates do not differ significantly from the overall female suicide rates [9]. In fact, the rate is particularly high in women in contact with psychiatric services and among those suffering from puerperal psychosis, challenging the belief that pregnancy and the postpartum year exert a protective effect on maternal suicide [9].

Postnatal depression is associated with disturbances in the mother-infant relationship which can have an adverse effect on the child's cognitive and emotional development [11]. Young children whose mothers have postpartum depression have more behavioural and interpersonal problems

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than children of non-depressed mothers [12]. They may also be predisposed to develop depression as adults [13]. Many mothers who non-accidentally injure or neglect their children have been shown to suffer from less severe forms of depression and anxiety [1]. Prolonged mental health problems in the mother can also have disruptive effects on the older children and the relationship with the husband may become severely strained. Intimate partner violence (domestic violence) may be either a cause or an effect of postpartum depression. A past history of depression, depression and anxiety during pregnancy, experiencing stressful life events during pregnancy or the early puerperium, and low levels of social support seem to be strong predictors of postpartum depression [14]. It is important to note that 50% of postnatal depression may go unnoticed [15]. Females with chronic psychiatric disorders like schizophrenia are more likely to kill their infants because of postpartum stressors or worsening of symptoms due to discontinuation of medicines, whereas non-psychotic, depressed women are unlikely to kill their infants, if they do, they are more likely to commit infanticide for what they perceive to be altruistic purposes [16].

Post-traumatic stress disorder (PTSD) can occur postpartum, particularly following very painful labour. Women may present with distress about bodily changes following pregnancy and childbirth, such as, weight gain, stretch marks or scars. Complaints about obstetric management can follow, particularly after emergency caesarian section. Women may feel disappointed over perceived mismanagement of the delivery and these feelings may even lead to litigation [5]. Worries about the partner's fidelity can present as a reaction to pregnancy changes and the relative quiescence of sexual life [5].

Disorders of the mother-infant relationship is another important category of illness seen in postnatal women. At severe levels of rejection of the baby, the mother may try to persuade others to take over the child permanently or demand that the baby be adopted. She may express the wish that the baby be stolen or succumb to cot death. Rejection is commonly accompanied by pathological anger with shouting, cursing or screaming at the baby and impulses to strike, shake or smother the child [5]. Obsession with child harm may present as impulses to attack or kill the child, where the patient also fantasizes the horror and grief of the family, causing increased distress and reduced contact with the baby [5]. Such mothers avoid being left alone with their children and sometimes take extraordinary precautions to prevent themselves from carrying out the impulse. Obsessions may also have the content of child sexual abuse.

The other important group of mental disorders are those due to organic causes. These seem to be rare in present day obstetric practice. Patients with post-eclamptic psychosis, which is reported to follow 5% of cases of eclampsia, usually present with confusion but may also present with mania [17]. Postpartum women can also develop infective delirium associated with septic metritis or breast abscess [17].

Effective perinatal and postnatal psychiatric services are needed not only because of the substantial morbidity and mortality related to postpartum psychiatric disorders but also because of the availability of effective treatment. In Sri Lanka, pregnant women are seen at regular prescribed times throughout pregnancy by obstetricians, Medical Officers of Health (MOH) and midwives. Most will deliver in hospital and there will then be regular and frequent contact with midwives. Midwives and MOHs as well as obstetricians and paediatricians should be aware of the symptoms of puerperal psychiatric disorders, so that identification and appropriate referral can be done without delay.

In a resource constrained country like ours it is important to identify the location for managing patients with postpartum psychiatric disorders. The need for extra safety and security for the mother and baby when admitted to

acute psychiatry wards has led to establishment of mother and baby units. Joint admissions may also enhance the attachment and bonding process, and women are more likely to agree to informal admission if they can be with their babies. It may also be cost effective to have mother and baby units in general hospital settings because of the easy access to obstetric, medical and paediatric care. In Sri Lanka, the other advantage of managing such women in general hospital units would be the reduced social stigma.

The detection of those at risk, such as mothers with previous episodes, close monitoring, early detection and swift intervention will do much to minimise maternal morbidity and limit adverse effects on the infant and family. In other countries, the Edinburgh Postnatal Depression Scale (EPDS) [18] is used to screen for postpartum depression in the community and to detect changes in the severity of depression over time. The Parental Bonding Questionnaire (PBQ) [19] is used to help to assess the severity of mother-infant bonding disorder and to evaluate improvement. In patients with postpartum depression, the PBQ is best used together with the EPDS, so that the effects of treatment on depression as well as the difficulties of the mother to relate to the child can be assessed [19]. The Sinhala translation of the EPDS has been validated recently in Sri Lanka [20], and healthcare workers could be trained to use it. Mothers who have puerperal mental disorders may either neglect, abuse or unduly seek medical advice with regard to the well being of the infant. Paediatricians and general practitioners should be made aware of this and the urgent need for psychiatric referral of such mothers.

Perinatal psychiatry has been given special consideration in the developed world. The time has come to address this important issue in our country as well. It is mandatory to educate policy makers and relevant professionals regarding the importance of early identification and proper management of puerperal mental disorders, and develop innovative care plans which are feasible and sustainable.

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Notice of retraction of abstracts

The following papers, based on abstracts that were accepted and published in the *Ceylon Medical Journal* 2009; **54** (Supplement 1), were not presented at the 122nd Annual Scientific Sessions of the Sri Lanka Medical Association held in March 2009.

1. Abstract OP 1. Acute ischaemic strokes following bites by Sri Lankan Russell's viper: an authenticated case series. **Gawarammana IB, Jeganathan K.** South Asian Clinical Toxicology Research Collaboration and Department of Medicine, Faculty of Medicine, University of Peradeniya, and Medical Unit, Teaching Hospital, Anuradhapura.
2. Abstract OP 7. Derivation of BMI and waist circumference cut-off values for Sri Lankan adults. **Katulanda P, Jayawardena MANAAD, Lamabadusuriya D, Sheriff R, Mathews DR.** Diabetic Research Unit, Faculty of Medicine, Colombo, and Oxford Centre for Diabetes Endocrinology and Metabolism, University of Oxford.
3. Abstract OP 17. Peripheral burning pain predicts mortality in paraquat poisoning. **Gawarammana IB, Dawson AH.** South Asian Clinical Toxicology Research Collaboration and Department of Medicine, Faculty of Medicine, University of Peradeniya, and School of Population Health, University of Newcastle, Australia.
4. Abstract PP 32. Corticosteroid therapy: short course or prolonged course in the management of the initial attack of nephritic syndrome. **Jayantha UK, Wijayasiri WAA.** Faculty of Medicine, Galle.

The four abstracts are hereby retracted.

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