

GUIDELINES

Antenatal and postnatal mental health: summary of updated NICE guidance

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This is one of a series of *BMJ* summaries of new guidelines based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

Further information about the guidance, a list of members of the guideline development group, and the supporting evidence statements are in the full version on bmj.com.

This guideline is an update of the 2007 National Institute for Health and Care Excellence (NICE) guideline on antenatal and postnatal mental health.¹ It covers a broad range of mental disorders, including depression, anxiety disorders, eating disorders, drug and alcohol use disorders, and severe mental illness (such as psychosis, bipolar disorder, schizophrenia, and severe depression), which can all occur in the antenatal and postnatal periods. The guidance focuses on aspects of the identification and management of these disorders that are specific to this context. For example, women with bipolar disorder are at increased risk of a relapse in the early postpartum period, and postpartum psychoses (whether in women with bipolar disorder or not) are particularly rapid in onset and severe.² These problems are managed differently during the antenatal and postnatal periods than at other times because of the impact that the mental disorder and its treatment (for example, the use of psychotropic drugs) can have on the fetus or baby.^{3,4}

This article summarises the most recent recommendations from NICE on the clinical management of antenatal and postnatal mental health (Clinical Guideline CG192).⁵

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group's experience and opinion of what constitutes good practice. Evidence levels for the recommendations are in the full version of this article on bmj.com.

Considerations for women of childbearing potential

- Discuss with all women of childbearing potential who have a new, existing, or past mental health problem:
 - The use of contraception and any plans for a pregnancy

- How pregnancy and childbirth might affect a mental health problem, including the risk of relapse (for example, at least a fifth of women with bipolar disorder have a severe recurrence after childbirth)
- How a mental health problem and its treatment might affect the woman, the fetus, or baby and have an impact on parenting. (New recommendation.)
- Do not offer valproate for acute or long term treatment of a mental health problem in women of childbearing potential because of the increased risk of major congenital malformations (event rate 7-10% relative to a baseline risk of about 3% in the general population) and adverse neurodevelopmental outcomes (average decrease in IQ of 9 points). (New recommendation.)

Recognising mental health problems in pregnancy and the postnatal period and referral

- At a woman's first contact with primary care or her booking visit, and during the early postnatal period, all health professionals should consider asking the following depression identification questions as part of a general discussion about mental health and wellbeing:
 - During the past month have you often been bothered by feeling down, depressed, or hopeless?
 - During the past month have you often been bothered by having little interest or pleasure in doing things? (New recommendation.)⁶
- Also consider asking about anxiety using the two item generalised anxiety disorder scale (GAD-2):
 - During the past month have you been feeling nervous, anxious, or on edge?
 - During the past month have you not been able to stop or control worrying? (New recommendation.)⁶
- If the woman answers yes to any of the above questions, or where there is clinical concern, further assessment is needed. Consider using formal measures such as the patient health questionnaire (PHQ-9),⁷ the Edinburgh postnatal depression scale (EPDS),⁸ or GAD-7⁹ and referral to a general practitioner or mental health professional, depending on the severity of the presenting problem. (New recommendation.)⁶
- Assess all women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period for treatment within two weeks of referral and provide psychological interventions within one month of initial assessment. (New recommendation.)

THE BOTTOM LINE

- Do not offer valproate for acute or long term treatment of mental health problems in women of childbearing potential
- Assess women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period for treatment within two weeks of referral; provide psychological interventions within one month of initial assessment
- At a pregnant woman's first contact with services, ask about any past or present severe mental illness, previous or current treatment, and any severe postpartum mental illness in a first degree relative
- Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment

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- ▶ Diagnosis and management of community and hospital acquired pneumonia in adults (*BMJ* 2014;349:g6722)
- ▶ Intrapartum care of healthy women and their babies: summary of updated NICE guidance (*BMJ* 2014;349:g6886)
- ▶ Identification, assessment, and management of overweight and obesity (*BMJ* 2014;349:g6608)
- ▶ Diagnosis and management of gallstone disease (*BMJ* 2014;349:g6241)
- ▶ Diagnosing and managing acute heart failure in adults (*BMJ* 2014;349:g5695)

- At all subsequent contacts during pregnancy and the first year after birth, the health visitor and other healthcare professionals who have regular contact with the woman should consider asking the two depression questions and using GAD-2 as well as the EPDS or the PHQ-9 as part of monitoring. (New recommendation.)
- If alcohol misuse is suspected, use the alcohol use disorders identification test (AUDIT) as an identification tool in line with the guideline on alcohol use disorders. (New recommendation.)¹⁰
- If drug misuse is suspected, follow the recommendations on identification and assessment in the guideline on drug misuse—psychosocial interventions. (New recommendation.)¹¹
- At a woman's first contact with services, ask about any past or present severe mental illness, previous or current treatment, and any severe postpartum mental illness in a first degree relative. Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, and ensure that the woman's GP knows about the referral. (New recommendation.)
- If a woman has any past or present severe mental illness or there is a family history of severe antenatal or postnatal mental illness in a first degree relative, be alert for possible symptoms of postpartum psychosis in the first two weeks after childbirth. (New recommendation.)
- If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within four hours). (New recommendation.)

- Any current or past treatment for a mental health problem and response to any treatment
- Social networks, living conditions, and social isolation
- Domestic violence and abuse, sexual abuse, trauma, or childhood maltreatment
- Housing, employment, economic and immigration status
- Responsibilities as a carer for other children and young people or other adults. (New recommendation.)

Advice on treatment for women with mental health problems in pregnancy and the postnatal period or who are planning a pregnancy

- Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment should discuss the following, depending on individual circumstances:
 - The uncertainty about the benefits, risks, and harms of treatments for mental health problems during pregnancy and the postnatal period
 - The likely benefits of each treatment, and the woman's response to any previous treatment
 - The background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk associated with no treatment
 - The risks or harms to the woman and the fetus or baby associated with each treatment option
 - The possibility of the sudden onset of mental health symptoms, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
 - The need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
 - The risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. (New recommendation.)

Principles of care

Coordinated care

- Develop an integrated care plan for a woman with a mental health problem that sets out:
 - The care and treatment for the mental health problem
 - The roles of all healthcare professionals, including who is responsible for:
 - Coordinating the integrated care plan
 - The schedule of monitoring
 - Providing the interventions and agreeing the outcomes. (New recommendation.)

Assessment

- Assessment and diagnosis of a suspected mental health problem should include:
 - A history or family history of any mental health problem
 - Physical wellbeing and history of any physical health problem
 - Alcohol and drug misuse
 - The woman's attitude to and experience of the pregnancy
 - The mother-baby relationship

Starting, using, and stopping treatment

- Before starting any treatment in pregnancy and the postnatal period discuss with the woman the higher threshold for starting psychotropic drugs because of the risk-benefit ratio at this time (the impact on the fetus or baby and the mother) and the likely benefits of a psychological intervention. (New recommendation.)
- If a pregnant woman has taken psychotropic drug(s) with known teratogenic risk at any time in the first trimester:
 - Confirm the pregnancy as soon as possible
 - Explain that stopping or switching the drug after pregnancy is confirmed may not remove the risk of fetal malformations
 - Offer screening for fetal abnormalities and counselling about continuing the pregnancy
 - Explain the need for additional monitoring and the risks to the fetus if she continues to take the drug. (New recommendation.)
- Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. (New recommendation.)

Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service

Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby, or holding the baby

Tricyclic antidepressants, selective serotonin reuptake inhibitors, (serotonin)-noradrenaline reuptake inhibitors

- Take the following into account when choosing antidepressant drugs:
 - The woman's previous response to treatment with these drugs
 - The stage of pregnancy
 - What is known about the reproductive safety profile (for example, any risk of cardiac fetal abnormalities and persistent pulmonary hypertension in the newborn baby)
 - The uncertainty about whether any increased risk of fetal abnormalities and other problems for the woman or baby can be attributed to these drugs or may be caused by other factors
 - The risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby (usually mild and self limiting adverse neurobehavioral effects such as irritability, sleep disturbance, or hypoglycaemia) with most antidepressants, in particular paroxetine and venlafaxine. (New recommendation.)

Considerations for women who experience traumatic birth, stillbirth, or miscarriage

- Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby, or holding the baby. This should be facilitated by an experienced healthcare professional and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If the baby is known to be dead in utero, this discussion should take place before the delivery. (New recommendation.)

Overcoming barriers

The guideline emphasises recognition of mental health problems by all healthcare professionals during both the antenatal and postnatal periods.¹² It also emphasises the need to include anxiety disorders as well as depression,¹³ and to promptly identify severe mental disorders, as well as understand their nature and rapid onset. Improved recognition will come from staff training and revision of routine care pathways to provide prompt access to further assessment, including that by specialist perinatal mental health services. In addition, easily available public health information is needed to:

- Promote recognition
- Rectify women's misplaced but understandable concerns that disclosure of a mental disorder may lead to their baby being taken into care¹⁴
- Prevent the risks associated with women deciding to stop psychotropic drugs (without consulting a healthcare professional) when they discover they are pregnant.¹⁵

Barriers to providing effective care include a lack of knowledge and skills. For example, many services fail to follow previous NICE advice against prescribing sodium

valproate to women of childbearing potential,¹⁶ and coordination between primary care, maternity services, social care, and specialist mental health services can be poor. The guideline recommends a raised threshold for using psychotropic drugs for some disorders (such as mild or moderate depression or anxiety) and more emphasis on providing psychological therapies. This requires greater and faster availability of psychological interventions that meet the needs of pregnant women and those with newborn babies.

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- ▶ Necrotising fasciitis (*BMJ* 2012;345:e4274)

Ask about any changes in bite or vision, which could indicate a facial fracture

PRACTICE POINTER

Acute nasal injury

A Razavi,¹ A Farboud,¹ R Skinner,² K Saw¹

Nasal injuries are a common presentation to emergency departments and primary care settings. Acute nasal injury often occurs as a result of trauma and can lead to epistaxis, nasal fracture, or even nasal septal haematoma. Epistaxis accounts for 33% of all admissions to emergency ear, nose, and throat (ENT) departments and head and neck surgery facilities, and it can require cautery or packing.¹ Occasionally surgical intervention might be required. Nasal fractures are the third most common type of fracture and the most common type of facial fracture.²⁻³ The nasal spine lengthens and begins to ossify at around 3 years of age, completing its growth and ossification during puberty.⁴ Nasal fractures are therefore predominantly seen in the adult population. The incidence of nasal fractures is rising in the United Kingdom, especially among girls and women, and is most commonly caused by assault.⁵ Other forms of trauma, such as sporting injury, account for most other cases. Nasal septal haematomas are rarer, but require urgent evaluation to prevent nasal deformity.

A recent study showed that after clinical teaching to junior emergency doctors, appropriate nasal examination and documentation rates increased from 30% to 97%,⁶ and the rate of unnecessary facial and nasal radiographs performed also decreased from 42% to 0%.⁷

Sources and selection criteria

We performed a literature review up to April 2014 using the Medline and EMBASE databases. We identified relevant publications using the search terms “nose” or “nasal” and “trauma” or “injury” or “fracture.” These, combined with our current clinical practice, have formed the basis of our review. Because of the paucity of randomised controlled trials and prospective cohort studies, most of the data come from inter-departmental audits. There are no widely used guidelines. The available evidence is lacking in quality and quantity and there is plenty of scope for more definitive studies.

THE BOTTOM LINE

- After ensuring there is no airway and cardiorespiratory compromise, a careful clinical assessment should include preceding events, accompanying symptoms (such as extent of epistaxis, deformity), and damage to adjacent structures
- Refer immediately to the emergency department if the patient has persistent epistaxis, nasal septal haematoma, persistent rhinorrhoea, visual disturbance, suspected facial fracture, severe headache or neck pain, or neurological signs
- Radiographs are not indicated in most cases
- Refer people with nasal fractures and obvious nasal deformity but no other injuries to the ear, nose, and throat (ENT) department within 7-14 days

Clinical features that warrant immediate referral from general practice to the emergency department

- Persistent epistaxis
- Nasal septal haematomas
- Persistent rhinorrhoea (might indicate cerebrospinal fluid leakage)
- Visual disturbances (might indicate a facial fracture)
- Compound fractures or suspected facial fracture
- Severe headache, neck stiffness, or neurological signs

What should you ask?

Patients with nasal injury might present in the emergency department immediately after injury or in primary care a few days later.

Ensure that the airway is patent and there is no cardio-respiratory compromise—Once this has been established, take a more detailed clinical history.

Relevant preceding events—Ask about these especially in the case of assault, as they might be needed for medicolegal reasons. Explore the possibility that an underlying medical problem might have caused the injury. For instance, in the event of a fall, ask whether the patient had any dizziness or weakness before the fall. Try to obtain a collateral history to determine whether seizures or syncope might have led to the injury. Determine the mechanism of the injury by establishing whether the trauma was blunt or penetrating and what force resulted in the injury—for example, face hitting the ground or a fist making contact with the nose. This could give an indication to the degree of trauma incurred and whether other facial fractures or other injuries were sustained.

Common symptoms after nasal trauma—Ask about nasal pain, epistaxis, and nasal deformity.⁸ Less commonly, the nose can be inflamed and blocked; this could affect a patient’s ability to breathe through his or her nose. Inquire about the duration of epistaxis and the approximate quantity of blood lost. Ask about the type and severity of pain so that adequate analgesia can be prescribed. Also, ask patients whether they have noticed a substantial change in the appearance of their nose, although the nose is likely to be more swollen immediately after trauma.

Exclude damage to adjacent tissues—Ask about any changes in bite or vision, which could indicate a facial fracture, and whether there has been any persistent fluid leakage from the nose, which could indicate cerebrospinal fluid leakage. The olfactory nerve passes through the cribriform plate, and if it is damaged or compressed anosmia may result. Therefore ask about changes in the patient’s sense of smell. Rarely, a patient may develop ascending meningitis after a breach in the skull base. Photophobia and neck stiffness are therefore important symptoms to ask about.⁹ Document a history of surgery or trauma to the nose, including when and where the surgery was performed, because it might influence future management.

Paraesthesia or anaesthesia over the face suggests a more serious facial injury



A nasal septal haematoma¹²

Ask if there is any change in nasal deviation because the nose might have been deviated by previous, healed injuries.

How should you examine the patient?

External nasal examination—Start distally and move proximally. Fractures of the nasal bone most commonly occur distally where the nasal bone is at its broadest and thinnest.¹⁰ The presence of bruising, haemorrhage, or haematoma suggests structural injury. Palpate for tenderness, mobility, and irregularity. A step deformity is common in fractured nasal bones because it indicates displacement of the bony nasal pyramid. Occasionally, the nasal pyramid collapses and a fragment might become depressed. This requires elevation under general anaesthetic.

Internal nasal examination—Ideally, this should be performed using a Thudichum’s speculum to improve the view. A local anaesthetic nasal spray may be needed if this is painful for the patient. However, if a Thudichum’s speculum or an alternative is not available, use a pen torch to inspect the anterior part of the nose. Check for septum deviation and for a fluctuant swelling consistent with septal haematoma.¹¹ Septal haematomas are usually bilateral and can have the appearance of cherries up the nose (see figure). It is unusual for haematomas to be unilateral. If nasal septal haematoma is suspected, refer urgently to the ENT department for incision and drainage.

Examination of other areas—If the trauma is substantial, perform a full neurological examination to rule out any intracranial bleeding. Paraesthesia or anaesthesia over the face suggests a more serious facial injury.¹³ Evaluate visual acuity because visual disturbances might indicate fractures of other facial bones—for example, orbital fractures. An orbital fracture may require review by the ophthalmology department and intervention from a maxillofacial surgeon.

What should you do next?

Carefully document all findings. In simple nasal trauma diagnosis should be through clinical findings.¹⁴ Radiographs are not indicated in most cases of nasal injury unless there is suspicion of fractures of the other facial bones. The diagnosis of simple nasal trauma should be through clinical findings. For all acute nasal injuries, ensure the patient has adequate analgesia.

In general practice—Refer patients with the features in the box to the emergency department immediately. Analgesia can be used to alleviate pain associated with the injury. For those with simple nasal fractures alone, see the management advice below.

In the emergency department—If blood loss was considered extensive, check the patient’s haemoglobin levels and consider transfusion based on local guidelines. Management of epistaxis depends on whether or not bleeding has resolved spontaneously before the consultation. Should there be ongoing bleeding, pack the nose using a nasal tampon, intranasal balloon device, or alternative. This might result in reduction of a nasal fracture—if present—and help the epistaxis to resolve. After 24 hours, nasal packing can be removed and nasal examination performed. If bleeding has stopped spontaneously, nasal examination can be done immediately. If a bleeding point is identified, attempt cautery and dress the nose with chlorhexidine hydrochloride-neomycin sulfate (marketed as Naseptin) cream. Prescribe chlorhexidine hydrochloride-neomycin sulfate cream for two weeks to be placed in both nostrils as long as the patient does not have a peanut allergy (chlorhexidine hydrochloride-neomycin sulfate contains peanut products).

Nasal septal haematoma requires urgent referral to the ENT department so that the haematoma can be incised and drained, which reduces the incidence of nasal deformity (saddle nose deformity).¹⁵

Should the fracture break the skin, or if bone is protruding, check the patient’s tetanus status and consider a booster if indicated.

Consider facial radiographs such as anteroposterior skull films and an orthopantomogram to determine the extent of trauma if a more complex facial injury is suspected—for instance because of paraesthesia, degree of facial trauma, suspected fracture of other bones, visual disturbance, neck stiffness, and photophobia. Refer compound fractures to an ENT specialist and facial fractures to a maxillofacial surgeon for an immediate review.

In the case of persistent rhinorrhoea an urgent neurosurgical opinion is necessary.¹⁶

Simple nasal fractures

Patients with simple nasal fractures and no deformity do not necessarily need to be seen by a specialist. Patients with suspected nasal fractures and obvious nasal deformity but no other injuries should be referred to an ENT casualty clinic or an equivalent service with a view to assessment by a specialist within 7-10 days from the time of injury. They will then undergo nasal manipulation under anaesthesia (closed reduction), an endonasal septorhinoplasty, or an external septorhinoplasty (open reduction), depending on the extent of their nasal fractures and the time elapsed since injury. Most noses are amenable to closed reduction as long as the procedure is not delayed. Arrange referral for seven or more days after the injury to allow the swelling from the initial injury to subside and enable successful inspection of the dorsum. Do not delay referral for more than 14 days because this increases the risk of an unsuccessful closed reduction due to bony fusion as part of the healing process.

If patients do not require immediate referral to the ENT department, advise them to go to an emergency department if they develop persistent epistaxis; persistent nasal discharge; or headache, photophobia, and neck stiffness. They should also avoid contact sports and strenuous exercise until they are seen by a specialist.

Most nasal fractures are amenable to closed reduction and produce a satisfactory outcome, especially if referred early.¹⁷ It is essential to make patients aware that revision surgery is a possibility if they are not pleased with the aesthetic outcome. A recent survey found that 42% of 151 respondents who underwent closed reduction would consider this.¹⁸

After nasal surgery patients are often advised to avoid strenuous exercise for two weeks and avoid contact sports for up to six weeks, although advice varies between departments because of a lack of widely accepted evidence based guidelines.¹⁹

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STATISTICAL QUESTION

Bias in observational study designs: prospective cohort studies

Answers *b, c, d, e,* and *f* are true, whereas *a* is false.

ANATOMY QUIZ

Axial T2 weighted magnetic resonance image of the left thigh

- A: Rectus femoris muscle (quadriceps muscle; anterior compartment)
- B: Vastus intermedius muscle (quadriceps muscle; anterior compartment)
- C: Vastus lateralis muscle (quadriceps muscle; anterior compartment)
- D: Biceps femoris muscle (hamstrings; posterior compartment)
- E: Sciatic nerve
- F: Adductor magnus muscle (adductor compartment)
- G: Superficial femoral vessels

PICTURE QUIZ

A man with generalised lymphadenopathy

- 1 Generalised lymphadenopathy can be caused by infections (viruses, bacteria, fungi, or protozoans), cancer (including lymphoproliferative disorders), autoimmune disorders (including chronic inflammatory rheumatic diseases such as systemic lupus erythematosus and vasculitis), hypersensitivity states (including drug reactions), and storage disorders (such as Gaucher's disease).
- 2 The section shows apple green birefringence as a result of amyloid deposition; a diagnosis of amyloidosis was made.
- 3 Further investigations are needed to determine the amyloidosis subtype (including serum immunoglobulin free light chains, serum amyloid A assay, serum β 2-microglobulin concentration, and genetic testing), its cause (including serum protein electrophoresis, imaging, endoscopy, and autoantibodies), and organ damage. Organ damage is assessed by means of 24 hour urine collection for proteinuria, echocardiography, electrocardiography, and nerve conduction studies.
- 4 Treatment of underlying cause while supporting the function of the affected organs.