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PUERPERAL DEPRESSION

DEAR SIR,

I was very pleased to read Dr. Katherina Dalton's prospective study in your June issue (vol. 118, pp. 689–92). Dr Dalton quotes my work (*Lancet*, 1964, *ii*, 1264) as suggesting that I assume a psychological explanation for the illness; this is in fact not entirely correct. What I said was:

'Dramatic deterioration in the depressive state a few days or weeks after parturition was very noticeable. Possibly pregnancy, with its hormonal and electrolytic changes, has a beneficial effect, and it is the disappearance of this effect after parturition that precipitates the final breakdown. Perhaps, therefore, the oestrogen production of normal pregnancy forms a built-in protection mechanism accounting for the well-being commonly enjoyed; and the depressive reaction results from the sudden fall in oestrogen levels at parturition.'

There appears little doubt that changes in hormone production during monthly cycle are associated with psychological disturbances when women take oral contraceptives. These disturbances are not entirely explained by psychological mechanisms.

At the International Conference of Psychosomatic Medicine in Obstetrics and Gynaecology held earlier this year, puerperal depression was one of the subjects discussed, and I suggested in a paper that there had been a fall in the incidence of puerperal depression since folic acid administration during pregnancy became routine. This suggests that alterations in the metabolic pathways are involved in aeteology of puerperal depression.

Dr. Dalton confirms my findings that anxiety in early pregnancy indicates the possibility of puerperal depression. She also confirms that some women were in the best of physical and mental health and if anything elated. I would agree with her suggestion that the women who are elated may well experience some difficulties in adjusting to their hormonal levels in the puerperium and thus become even more depressed.

The value of Dr. Dalton's study is that the triad of mood change—anxiety, elation and depression—during the pregnancy and the puerperium are established. It is now much easier for us to understand why in the past various workers in the field differed from one another in their publications and conclusions.

I hope that now all obstetricians, psychiatrists and general practitioners will take note that anxiety and/or elation symptoms during pregnancy cannot be ignored, and that as a result fewer women will be allowed to become depressed in the puerperium.

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CHLORIMIPRAMINE IN THE TREATMENT OF SEVERE DEPRESSION

DEAR SIR,

In your August issue (vol. 119, p. 230) there is a letter from Dr. Abenson commenting on the severe extra-pyramidal reaction experienced by a female patient after a course of intravenous infusions of chlorimipramine.

Since my original paper, Vol. 117, pp. 211–2, we have now given intravenous chlorimipramine by drip infusion to over 60 patients. No severe reaction of the type described has been encountered, but a number of patients have complained of tremor, which has usually responded to a reduction in dosage, or if necessary by the use of anti-parkinsonian drugs. In no case has it proved necessary to discontinue treatment on account of these side effects.

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AMALGAMATION OF PSYCHIATRIC AND GENERAL HOSPITAL GROUPS

DEAR SIR,

We, the undersigned, have been asked to send you the views of 21 consultants employed in twelve hospital groups in the South West Metropolitan Region in the hope that publication of this information in your Correspondence columns will stimulate interest in what is now a national problem. The criticisms are as follows:

1. *Delay:* There is evidence of increased delay in communicating with the R.H.B. Similarly, there is an increased delay in the transmission of official information from the R.H.B. to consultants.

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