



Perinatal Anxiety and Depression

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in [Appendix A](#).

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 2012
Current: March 2015
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Objectives: To provide advice on perinatal anxiety and depression.

Target audience: All health professionals providing maternity and mental health care, and patients.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women's Health Committee in March 2012 and reviewed in March 2015.

Funding: The development and review of this statement was funded by RANZCOG.

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1. Patient summary

Mental health problems are common during pregnancy and after birth. Although there are risk factors, for many women such problems have no past history. Mental health problems can be difficult to identify, and have the potential to cause harm to both mother and baby. Those providing maternity and postnatal care should consider using screening tools to help identify women who would benefit from specialised care.

2. Summary of recommendations

Recommendation 1	Grade
Mental health problems during the perinatal period are common. Routine screening should lead to identification, referral and treatment. There is evidence that early intervention produces the best outcomes for mothers and their families. ¹	Consensus-based recommendation Reference 1
Recommendation 2	Grade
Perinatal mental health care should be culturally responsive and family-centred. Obstetricians are in a unique position to develop a long term trusting relationship with their pregnant patients.	Consensus-based recommendation
Recommendation 3	Grade
In line with the recognition by the College of the importance of reciprocal trust between practitioner and the patients and those who support them (cultural competency), it is imperative that an awareness of systemic inadequacies (such as poor communication, or lack of continuity of care, or non-collaborative models of care) remains a high priority in order to avoid these pitfalls.	Consensus-based recommendation
Recommendation 4	Grade
The mental wellbeing of patients should be seen as important as physical health. Maternal anxiety and depression can have detrimental effects on fetal and infant development and on mother infant attachment.	Consensus-based recommendation
Recommendation 5	Grade
All pregnant women should be screened for psychosocial risk factors. Screening for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the EPDS, should be considered part of routine antenatal and postpartum care.	Consensus-based recommendation
Recommendation 6	Grade
Any treatment offered should involve collaborative decision-making with the woman and her partner including a full discussion of the potential risks and benefits.	Consensus-based recommendation
Recommendation 7	Grade
The safety of mothers and infants needs to be considered at all times; as well as the safety of families.	Consensus-based recommendation

3. Introduction

The perinatal period -in the mental health setting- includes the time from conception to one year postpartum. Perinatal anxiety and depression is the result of biological, sociological and psychological factors occurring at this time and can affect mothers and fathers. It can be new in onset or the recurrence of a pre-existing illness.

The perinatal period is a time of great adjustment for women and their partners. While many couples resolve issues that may arise, for many parents this time can lead to the development of mental health problems. Risk factors can include a history of mental health problems, lack of support, previous trauma including physical, emotional or sexual abuse, isolation (physical, mental, cultural), stressful life events, and a history of drug or alcohol abuse.

Suicide has become one of the leading causes of maternal deaths in Australia.^{2,3} The presence of maternal mental health conditions can also have an adverse impact on the growth and development of the fetus/infant, and the wellbeing of other family members. The psychological wellbeing of pregnant women and new mothers should therefore be considered as important as their physical health and considered as part of routine antenatal and postnatal care.

4. Discussion

4.1 How common is perinatal anxiety and depression?

Up to 80% of mothers experience the 'baby blues' 3-5 days after giving birth. This period of emotional liability is transient and self-limiting usually dissipating within 10 days.

Australian research suggests that up to 10% of women experience antenatal anxiety and/ or depression, increasing to 16% of women experiencing postnatal anxiety and / or depression. 10% of fathers are also affected.⁴ *Puerperal psychosis*, which is considered a psychiatric emergency, affects around 1 in 1000 women. Bipolar disorder is at greater risk of reoccurring and bipolar women are at particularly high risk of suicide in the first postnatal year. Post-traumatic stress disorder is reported to occur in 2-3% of women after childbirth. Those who are particularly at risk are those who have suffered previous trauma (domestic violence, rape or childhood sexual abuse), and those with risk factors for perinatal mood disorder.

Mental health problems affect the wellbeing of the woman, her baby, her partner and family, during a time that is critical to the future health and wellbeing of children. *Early detection and intervention* can improve outcomes for all and are the responsibility of all maternity care providers.

4.2 Why is identification and treatment important?

Of women identified with antenatal or postnatal depression 50-70% of those untreated remain depressed 6 months later. 25% of women will develop a chronic illness and 25% of women will develop recurrent depression. Perinatal anxiety and depression has adverse consequences for mothers, fathers and children especially in respect to the critical parent-infant attachment that potentially influences the mental health of the next generation.⁵

4.3 How is perinatal anxiety and depression diagnosed?

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV TR, 2000) diagnostic criteria suggest that women must exhibit five or more symptoms for at least two weeks with at least one symptom from the first two symptoms listed below:

- Depressed mood

AND/ OR

- Anhedonia (no interest or pleasure or enjoyment)
- Significant change in weight or appetite
- Markedly increased or decreased sleep
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Reduced concentration
- Recurrent thoughts of death or suicide

In addition these symptoms must be accompanied by significant *impairment in capacity to engage and function in usual activities* e.g. parenting, occupational, social and other roles.

As some of these symptoms overlap with common feelings during the perinatal period⁶ a diagnosis can be difficult. Problems sleeping^{7, 8} should be investigated and anxiety disorders should also be considered.⁹ More specific symptoms to perinatal depression are listed below.

Symptoms more specific for perinatal anxiety and depression can include:

- Inability to enjoy activities which were enjoyed prior to pregnancy or birth
- Can't concentrate, make decisions or get things done
- Physical symptoms such as heart palpitations, constant headaches, sweaty hands
- Feeling overwhelmed and constantly exhausted
- Feel numb and remote from family and friends
- Feel out of control, or 'crazy', even hyperactive
- Can't rest even when the baby is sleeping
- Have thoughts of harming themselves or the baby (infanticide)
- Have constant feelings of guilt, shame, or repetitive thoughts
- Feel trapped or in a dark hole or tunnel with no escape
- Experience feelings of anger, grief, loss, tearfulness
- Changes in appetite
- Persistent negative thoughts
- Feeling very irritable or sensitive

4.4 Evidence-based National Guidelines

The first Australian Clinical Practice Guidelines surrounding the detection, management and treatment of perinatal mental health disorders were established in 2011. RANZCOG supports the *beyondblue* Clinical Practice Guidelines which were endorsed by the National Health and Medical Research Council (NHMRC) and recommend universal antenatal and postnatal mental health screening.² Appropriate screening could include administering the Edinburgh Postnatal Depression Scale (EPDS)¹⁰ and / or a psychosocial assessment (see Appendix 1 and 2 in Appendices). Local maternity health care facilities should negotiate ways to implement this.

Screening involves administering the Edinburgh Postnatal Depression Scale (EPDS) and a psychosocial assessment (see Appendix 1 and 2 in Appendices). Screening is currently being rolled out across Australia. Care should be taken to consider physical health issues as well as broader psychosocial issues (as identified by the psychosocial risk questions) such as intimate partner violence, other stressors and co-morbid health problems.

4.5 What are the diagnosis and safety issues?

An EPDS score of 12 or more should be repeated within two weeks, and a very high EPDS score should be investigated further as it may suggest a crisis. Clinicians need to consider the safety of the infant at all times. Appropriate guidelines for the general population and accepted diagnostic criteria (DSM-IV-TR or ICD-10) should be used when diagnosing depression, anxiety, bipolar disorder, psychosis or other mental health

disorders. A diagnosis should not be made before considering physical conditions (e.g. thyroid dysfunction), sleep deprivation or recent events that might be relevant. A diagnosis of adjustment disorder or minor depression should also be considered.

4.6 What are the referral pathways?

Managing a mental health problem should be collaborative. Referral requires consent from the mother, and referral options and/ or treatment plan should take into account the mother’s preferences. In most cases referral will be to the woman’s usual GP or to a health professional with mental health training and expertise. Obstetricians should make themselves aware of referral options to psychologists, psychiatrists, social workers or services in their local area.

4.7 What are the management considerations?

Both psychological and pharmacological treatments have been shown to be effective in treating perinatal anxiety and depression.¹ Women with more severe depression or with bipolar disorder will need medication.

Psychological therapies specifically cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and psychodynamic therapy have been shown to improve depressive symptoms in the postnatal period.

Pharmacological treatment of depression and related disorders during the perinatal period is not likely to differ from approaches at other times. SSRIs are generally considered to be relatively low risk and safe to prescribe during pregnancy and while breastfeeding. Medications should only be prescribed after careful discussion with the mother. When symptoms are severe, involving a psychiatrist is advisable.¹¹

Reference should be made to the most recent TGA *Therapeutic Guidelines and Medications Handbook* for current advice for use of medication in the general population.

5. Recommendations

Recommendation 1	Grade
Mental health problems during the perinatal period are common. Routine screening should lead to identification, referral and treatment. There is evidence that early intervention produces the best outcomes for mothers and their families. ¹	Consensus-based recommendation Reference 1
Recommendation 2	Grade
Perinatal mental health care should be culturally responsive and family-centred. Obstetricians are in a unique position to develop a long term trusting relationship with their pregnant patients.	Consensus-based recommendation
Recommendation 3	Grade
In line with the recognition by the College of the importance of reciprocal trust between practitioner and the patients and those who support them (cultural competency), it is imperative that an awareness of systemic inadequacies (such as poor communication, or lack of continuity of care, or non-collaborative models of care) remains a high priority in order to avoid these pitfalls.	Consensus-based recommendation
Recommendation 4	Grade
The mental wellbeing of patients should be seen as important as physical health. Maternal anxiety and depression can have detrimental effects on fetal and infant development and on mother infant attachment.	Consensus-based recommendation
Recommendation 5	Grade
All pregnant women should be screened for psychosocial risk factors. Screening	Consensus-based

for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the EPDS, should be considered part of routine antenatal and postpartum care.	recommendation
Recommendation 6	Grade
Any treatment offered should involve collaborative decision-making with the woman and her partner including a full discussion of the potential risks and benefits.	Consensus-based recommendation
Recommendation 7	Grade
The safety of mothers and infants needs to be considered at all times; as well as the safety of families.	Consensus-based recommendation

6. References

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2. Slaytor EK, Sullivan EA, King J. Maternal deaths in Australia 1997-1999. Maternal deaths series no. 1. Cat. no. PER 24. Canberra:AIHW, 2004.
3. Austin MP, Kildea S, Sullivan E. Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *Med J Aust.* 2007;186(7):364-7.
4. Bielawska-Batorowicz E, Kossakowska-Petrycka K. Depressive mood in men after the birth of their offspring in relation to a partner's depression, social support, fathers' personality and prenatal expectations. *Journal of Reproductive and Infant Psychology.* 2006;24(1):21-9.
5. Petrillo LF, Nonacs RM, Viguera AC, Cohen LS. Course of psychiatric illness during pregnancy and the postpartum. In: Cohen L, Nonacs R, editors. *Mood and anxiety disorders during pregnancy and postpartum.* 1st ed. ed: Washington, DC : American Psychiatric Publishing; 2005:1-15.
6. Smith M. Perinatal Depression - Assessment, Diagnosis & Management Strategies. Central Sydney GP Network Perinatal Meeting 2010.
7. Born L, Zinga D, Steiner M. Challenges in identifying and diagnosing postpartum disorders. *Prim psychiatry.* 2004;11(3):29-36.
8. Rapkin AL, Mikacich JA, Moatakef-Imani B. Reproductive Mood Disorders. *Prim psychiatry.* 2003;10(11):31-40.
9. Wenzel A, Haugen EN, Jackson LC, Robinson K. Prevalence of generalized anxiety at eight weeks postpartum. *Arch Womens Ment Health.* 2003;6(1):43-9.
10. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry.* 1987;150:782-6.
11. Austin MP. Antenatal screening and early intervention for "perinatal" distress, depression and anxiety: where to from here? *Arch Womens Ment Health.* 2004;7(1):1-6.
12. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Canberra 2009.

7. Other suggested reading

South Australian Perinatal Practice Guidelines Workgroup. Chapter 142: Managing women in distress after a traumatic birth experience. September 2010. Available at:

<http://www.health.sa.gov.au/PPG/Default.aspx?tabid=260>

Austin, M-P Hight, N and the Guidelines Expert Advisory Committee (2011) Clinical Practice Guidelines for Depression and Related Disorders - Anxiety, Bipolar Disorder and Puerperal Psychosis - in the Perinatal Period. A guideline for primary care health professionals. Melbourne; beyondblue: the national depression initiative. Available at: <http://resources.beyondblue.org.au/prism/file?token=BL/0891>

Websites

Beyondblue	http://www.beyondblue.org.au/index.aspx?link_id=94
Gidget Foundation	http://www.gidgetfoundation.com.au
Good Beginnings	http://www.goodbeginnings.org.au
Karitane	http://www.karitane.com.au
MoodGYM	http://www.moodgym.anu.edu.au
Mental Health in Multicultural Australia	http://www.mhima.org.au
Post and Antenatal Depression Association	http://www.panda.org.au/
Parent-Infant Research Institute (PIRI)	http://www.piri.org.au
Tresillian	http://www.tresillian.net
What were we thinking?	http://www.whatwerewethinking.org.au/

Phone Number

National Perinatal Depression Helpline 1300 726 306 (Monday to Friday 9am-7pm AEST)

Clinical Guidance

Depression

Lam RW, Kennedy SH, Grigoriadis S et al. Clinical guidelines for the management of major depressive disorder in adults: III. Pharmacotherapy. Canadian Network for Mood and Anxiety Treatments (CANMAT). J Affective Disorders 2009; 117: S26–S43.

NICE (2009) Depression: the Treatment and Management of Depression in Adults: National Clinical Practice Guideline 90 (Full Guidance). National Institute for Health and Clinical Excellence.

Parikh SV, Segal ZV, Grigoriadis S et al. Clinical guidelines for the management of major depressive disorder in adults: II. Psychotherapy alone or in combination with antidepressant medication. Canadian Network for Mood and Anxiety Treatments (CANMAT). J Affective Disorders 2009; 117: S15–S25.

Patten SB, Kennedy SH, Lam RW et al. Clinical Guidelines for the Management of Major Depressive Disorder in Adults: I. Classification, Burden and Principles of Management. Canadian Network for Mood and Anxiety Treatments (CANMAT). *J Affective Disorders* 2009; 117: S5–S14.

RANZCP. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Aust NZ J Psychiatry* 2004; 38: 389–407.

RANZCP (2009) Position Statement 57 Mothers, Babies and Psychiatric Inpatient Treatment. Royal Australian and New Zealand College of Psychiatrists.

SIGN (2010) Non-pharmaceutical Management of Depression in Adults: A National Clinical Guideline. Edinburgh: Scottish Intercollegiate Guidelines Network.

Anxiety disorders

NICE (2004; amended 2007) Anxiety: Management of Anxiety (Panic Disorder, with or without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. National Institute for Health and Clinical Excellence.

Bipolar disorder

NICE (2006) The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care. National Institute for Health and Clinical Excellence.

RANZCP. Australian and New Zealand clinical practice guidelines for the treatment of bipolar disorder. *Aust NZ J Psychiatry* 2004; 38: 280–305.

Yatham LN, Kennedy SH, Schaffer A et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update. *Bipolar Disord* 2009; 11(3): 225–55.

8. Links to other College statements

[Cultural Competency \(WPI 20\)](#)

[Evidence-based Medicine, Obstetrics and Gynaecology \(C-Gen 15\)](#)

9. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

<https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets>

Appendices

Appendix 1 Example of a psychosocial risk assessment questionnaire

Past or current mental health problems	
1	Have you ever had a period of 2 weeks or more when you felt particularly low or down?
2	Do you sometimes worry so much that it affects your day-to-day life?
3	Have you ever needed treatment for a mental health condition such as depression, anxiety disorder, bipolar disorder or psychosis?
4	Has anyone in your immediate family (eg grandparents, parents, siblings) experienced severe mental health problems?
Previous or current abuse	
5	When you were growing up, did you always feel cared for and protected?
6	If you currently have a partner, do you feel safe in this relationship?
Drugs and alcohol	
7	Do you or others think that you (or your partner) may have a problem with drugs or alcohol?
Recent life stressors	
8	Have you had any major stressors, changes or losses in the last 11 months (eg moving house, financial worries, relationship problems, loss of someone close to you, illness, pregnancy loss, problems conceiving)?
Practical and emotional support	
9	When you were growing up, was your mother emotionally supportive of you?
10	If you found yourself struggling, what practical support would you have available? Who could help provide that?
11	If you found yourself struggling, what emotional support would you have available? Who could help provide that?

(See Page 19 of the Beyondblue Clinical Practice Guidelines 2011 available at:

http://www.beyondblue.org.au/index.aspx?link_id=7.102&tmp=FileDownload&fid=1626)

Appendix 2: Edinburgh Postnatal Depression Scale

1. I have been able to laugh and see the funny side of things:

- 0 As much as I always could
- 1 Not quite as much now
- 2 Definitely not so much now
- 3 Not at all

2. I have looked forward with enjoyment to things:

- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

- 3 Yes, most of the time
- 2 Yes, some of the time
- 1 Not very often
- 0 No, never

4. I have been anxious or worried for no good reason:

- 0 No, not at all
- 1 Hardly ever
- 2 Yes, sometimes
- 3 Yes, very often

5. I have felt scared or panicky for no very good reason:

- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

6. Things have been getting on top of me:

- 3 Yes, most of the time I haven't been able to cope at all
- 2 Yes, sometimes I haven't been coping as well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

- 3 Yes, most of the time
- 2 Yes, sometimes
- 1 Not very often
- 0 No, not at all

8. I have felt sad or miserable:

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Not very often
- 0 No, not at all

9. I have been so unhappy that I have been crying:

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Only occasionally
- 0 No, never

10. The thought of harming myself has occurred to me:

- 3 Yes, quite often
- 2 Sometimes
- 1 Hardly ever
- 0 Never

(Cox JL, Holden JM, Sagovsky R)¹⁰

Appendix A Women's Health Committee Membership

Name	Position on Committee
Associate Professor Stephen Robson	Chair and Board Member
Dr James Harvey	Deputy Chair and Councillor
Associate Professor Anusch Yazdani	Member and Councillor
Associate Professor Ian Pettigrew	Member and Councillor
Dr Ian Page	Member and Councillor
Professor Yee Leung	Member of EAC Committee
Professor Sue Walker	General Member
Dr Lisa Hui	General Member
Dr Joseph Sgroi	General Member
Dr Marilyn Clarke	General Member
Dr Donald Clark	General Member
Associate Professor Janet Vaughan	General Member
Dr Benjamin Bopp	General Member
Associate Professor Kirsten Black	General Member
Dr Jacqui Boyle	Chair of the ATSIWHC
Dr Martin Byrne	GPOAC representative
Ms Catherine Whitby	Community representative
Ms Sherryn Elworthy	Midwifery representative
Dr Nicola Quirk	Trainee representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 2012 and was most recently reviewed in March 2015. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the March 2015 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members

were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.¹² Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.