Optima Health

Perinatal and Postpartum Depression: "Tips for Treatment"

History

Date Approved	09/04
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Key Points

General:

- ✓ Discuss risks, benefits and alternatives. Document this discussion and the patient's consent to the treatment plan.

Depression:

- ✓ Depression is very common in women, especially in women of reproductive age. It is estimated that 14%-23% of pregnant women experience depression during pregnancy, and 5%-25% experience depression postpartum.

- ✓ Perinatal depression affects as many as one in seven women. The American College of Obstetricians and Gynecologists all pregnant women be screened at least once during the perinatal period.

- ✓ Significant risk factors for perinatal depression include personal or family history of depression; discontinuation of antidepressant prior to or during pregnancy; poor social support; marital or relationship problems; ambivalence about the pregnancy.

- ✓ The Edinburgh Postnatal Depression Scale (EPDS) has been 100% sensitive and 95.5% specific in detecting major postpartum depression at a threshold score higher than 13. Use of a formal screening tool significantly increases the detection rate of antenatal depression.

- ✓ Risks of untreated depression during pregnancy may include lack of follow through with prenatal care, inadequate weight gain, preeclampsia, preterm birth, and difficulty bonding with the unborn baby.

- ✓ For mild or moderate depression, psychotherapy alone may be effective. In moderate to severe cases, treatment may include the use of antidepressant medications as well as counseling.

- ✓ Paroxetine use in pregnant women should be avoided, if possible.

- ✓ Postpartum psychosis usually occurs within hours to days of delivery. Incidence is 1 in 1,000 women overall, but 25-35% in women with a known history of bipolar disorder.

Information for Providers on Antidepressants During Pregnancy & Breast Feeding - September 2011

This chart is produced by the University of Illinois at Chicago (UIC) Perinatal Mental Health Project as a summary of research on antidepressants in human pregnancy and breastfeeding.

Sources of data:

- **Pregnancy data**: Data summarized here are from controlled studies in human pregnancy. The Food and Drug Administration (FDA) Pregnancy Risk Categories, as found in the Physicians' Desk Reference[1], are based on both animal and human studies. No antidepressants are yet specifically FDA-approved for use during pregnancy. All antidepressants cross the placenta, so there are none that are 'Category A' ("no risk"). Medications that are non-teratogenic in animal studies but have never been studied in humans are classified as 'Category B'. Since teratogenicity does not generalize across species, a 'Category B' classification does not imply greater safety in human pregnancy than a 'Category C' or 'D' classification. Several medications have been shifted from 'Category B' to 'Category C' or 'Category D' as their risks became better known.
- **Breastfeeding data**: Data about antidepressant effects on breastfeeding babies are predominantly from case reports and case series. For medications with no reported side effects, that does not necessarily mean the medication is "safe"; often it means there are few case reports available. Reported percents of maternal dose to breastfeeding babies are weight-adjusted estimates that include the agent and its active metabolite(s).
  *Specific references are available on request.

General guideline:

- Optimal treatment is based on individual patient characteristics and clinical judgment, especially weighing medication risks against risks of untreated illness. Risks of untreated perinatal depression may include preterm birth and other obstetric complications, increased risk of infection and difficult temperament in the infant, impaired parenting, and psychological effects such as impaired cognitive development, emotional and behavioral problems and increased reactivity to stress in children.

Antidepressants as a group may be associated with following risks:

- Increased risk of preterm birth and lower gestational age at birth, but without adverse effects on birth weight or Apgar scores
- Increased risk of miscarriage, but rates within norms of the general population.

SSRI antidepressants as a group (citalopram, escitalopram, fluoxetine, paroxetine, sertraline) may be associated with the following risks:

- Neonatal side effects, including respiratory distress, excessive crying, changes in sleep and behavioral state, difficulty sleeping, increased or decreased muscle tone, hyperreflexia, seizures, and/or cardiac arrhythmias.
- Most studies have found no increased risk of gestational hypertension. One retrospective study[2] found a possible increased risk of gestational hypertension.
- Possible increased risk of persistent pulmonary hypertension in the newborn with exposure later in pregnancy.
- Most studies have found no increased risk of birth defects. One retrospective study[3] found a possible increased risk of anencephaly, craniosynostosis, and omphalocele; another[4] found an increased risk of anomalies in general, although absolute risks were small.
- Delay in lactation, however the delay was only for 14 hours on average.
- Kaiser Study showed 2-fold increased risk for Autism spectrum disorder with use of SSRI within one year of delivery and 3-fold increased risk with SSRI use in first trimester.

For questions, references, or permission to reprint, call the UIC Perinatal Mental Health Project at 1-800-573-6121

Information for Providers on Antidepressants during Pregnancy & Breast Feeding - September 2011

Antidepressant	Advantages During Pregnancy	Teratogenicity	Other Disadvantages During Pregnancy	Estimated % of Maternal Dose to Breastfeeding Baby	Reported Side Effects to Breastfeeding Babies
Bupropion	• Fewer sexual side effects • Less risk of weight gain • Helps with smoking cessation	**Morphologic**- limited evidence of cardiac malformations; increased risk for pulmonary hypertension **Behavioral**- limited evidence of increased risk of ADHD	• Limited data available • Lowers seizure threshold • Can cause insomnia • May increase risk of miscarriage	2.0%	Seizures
Citalopram	• Few interactions with other medications	**Morphologic**- risk of neural tube defect **Behavioral**- none found	• Limited data available	0.7% - 9.0%	Uneasy sleep, drowsiness, irritability, weight loss
Desipramine	• More studies in human pregnancy, including neurodevelopmental follow-up	**Morphologic**- none found **Behavioral**- none found	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	1.0%	Agitation of newborn, potential triggering of seizure activity if there is a history of seizures
Duloxetine	• Also treats diabetic peripheral neuropathic pain	**Morphologic**- unknown **Behavioral**- unknown	• No systematic studies in human pregnancy	0.1%	Unknown
Escitalopram	• Few interactions with other medications	**Morphologic**- unknown **Behavioral**- unknown	• No systematic studies in human pregnancy	3.9% - 7.9%	Enterocolitis
Fluoxetine	• More studies in human pregnancy, including meta-analysis and neurodevelopmental follow-up	**Morphologic**- increased risk of cardiovascular malformations* **Behavioral**- none found	• More reports of neonatal side effects than most other antidepressants	1.2% - 12.0%	Excessive crying, irritability, vomiting, watery stools, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain, hyperglycemia
Mirtazapine	• Fewer sexual side effects • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting	**Morphologic**- none found **Behavioral**- unknown	• Limited data available • Can cause excessive weight gain • Tends to be sedating • May increase risk of preterm birth	0.6% - 2.8%	None

Antidepressant	Advantages During Pregnancy	Teratogenicity	Other Disadvantages During Pregnancy	Estimated % of Maternal Dose to Breastfeeding	Reported Side Effects to Breastfeeding Babies
Nortriptyline	• More studies in human pregnancy, including neurodevelopmental	**Morphologic**- none found **Behavioral**- none found	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental	1.3%	None
Paroxetine	• Minimal association with cardiovascular malformations but may be	**Morphologic**- possible increased risk of cardiovascular	• More reports of neonatal side effects than most other antidepressants ACOG recommends fetal echo for all exposed fetuses	0.1% - 4.3%	Irritability, sleepiness, constipation,
Sertraline	• Relatively well-studied in human pregnancy • Fewer reports of	**Morphologic**- unlikely increased risk of omphalocele and septal	• Minimal association with omphalocele and septal defects	0.4% - 2.3%	Drug of choice by OBs & Pediatricians
Venlafaxine	• None specific, but may be optimal for some individual	**Morphologic**- none found **Behavioral**- unknown	• Limited data available	5.2% - 7.6%	Decreased weight gain
Desvenlafaxine	• None specific, but may be optimal for some individual	**Morphologic**- unknown **Behavioral**- unknown	• No systematic studies in human pregnancy	Unknown	Unknown

* Findings from one study at variance with other data, perhaps due to methodological flaws

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1. Physician's Desk Reference. Thomson Reuters. Montvale, NJ. **2**. Toh et al. Selective serotonin reuptake inhibitor use and risk of gestational hypertension. Am J Psychiatry. 2009 Mar; 166(3):320-8. **3**. Alwan, S. et al. Use of selective serotonin-reuptake inhibitors in pregnancy and the risk of birth defects. N Engl J Med. 2007 Jun 28; 356(26):2684-92. **4**. Wogelius et al. Maternal use of selective serotonin reuptake inhibitors and risk of congenital malformations. Epidemiology. 2006 Nov; 17(6):701-4. **5.** Suri et al. Effects of Antenatal Depression and Antidepressant treatment on gestational age at birth and risk of preterm birth. Am J Psychiatry. 2007 Aug; 164:1206- 1213. **6**. Figueroa. Use of antidepressants during pregnancy and risk of Attention-Deficit/Hyperactivity Disorder in the offspring. JDBP. 2010 Oct. Vol 31, No.8. **7**. Alwan et al. Maternal use of Bupropion and risk of congenital heart defects. Am J Obstet Gynecol 2010.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

this would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.

Instructions for Using the Edinburgh Postnatal Depression Scale[1] (EPDS)

The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for perinatal depression.

It is a proven screening tool.

It is easy to administer.

It can be completed at home and brought to a physician's office (OB, Pediatric, Family Practice) or the office of a mental health practitioner.

It can also be downloaded in the medical setting.

The scale indicates how the woman has felt ***during the previous week***.

It may be useful to repeat the screen in 2 weeks in questionable cases.

The EPDS score should inform but not override clinical judgment as a complete and thoughtful clinical assessment should be carried out to confirm the diagnosis.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. Ask the woman to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All items must be completed.
3. The mother should complete the scale herself, unless she has limited English or has difficulty with reading. She should not discuss her answers with others.

SCORING

A score of greater than 13 as a threshold value is:

100% sensitive, 95.5% specific for PPD[2]

Possible Depression: 10 or greater

Always look at item #10 for suicidal thoughts.

Responses are scored 0, 1, 2, or 3 according to increased severity of symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items.

Good clinical care also involves asking if the mother has fears about hurting the baby or fears of the baby coming to harm.

[1]Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Boyce, P. Stubbs, J., and Todd, A. 1987. The EPDS: validation for an Australian sample. Aust N Z J Psychiatry 27:472-6.

References

American College of Obstetricians and Gynecologists, District II/NY. *Perinatal Depression Screening: Tools for Obstetricians-Gynecologists.* *http://mail.ny.acog.org/website/DepressionToolkit.pdf*

The University of Illinois at Chicago Perinatal Mental Health Project. *Information for Clinicians on Antidepressants during Pregnancy & Breastfeeding- September 2011.*

Yonkers, Kimberly A., MD, et al. *The Management of Depression during Pregnancy: A Report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists.* General Hospital Psychiatry 31 (2009) 403-413.

Resources

American Psychological Association. Brochure: *Postpartum Depression* May be downloaded from https://www.apa.org/pi/women/resources/reports/postpartum-depression-brochure-2007.pdf

The American College of Obstetricians and Gynecologists http://www.acog.org

The American College of Obstetricians and Gynecologists. *Postpartum Depression.* Patient educational Pamphlet AP091. Washington, DC: American College of Obstetricians and Gynecologists; 2013.
Print copies can be ordered online at http://sales.acog.org or by calling 1-800-762-2264.

Massachusetts General Hospital Center for Women's Health: Reproductive Psychiatry Resource and Information Center. Psychiatric Disorders During Pregnancy
http://www.womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy

Massachusetts Child Psychiatry Access Project (MCPAP) for Moms Toolkit available at
https://www.mcpapformoms.org/Toolkits/Toolkit.aspx

Postpartum Support International. 6706 SW 54th Avenue, Portland, OR 97219. (503) 894-9453. Available at http://www.postpartum.net. Support Helpline: 1-800-944-4PPD (4773)

The 2020 Mom Project website: http://www.2020mom.org/

US Department of Health and Human Services; Health Resources & Services Administration, 2010. *Depression during and After Pregnancy: A Resource for Women, Their Families, and Friends.* Patient educational brochure.
Available online at www.mchb.hrsa.gov/pregnancyandbeyond/depression
Print copies can be obtained from the HRSA Information Center 1-888-Ask-HRSA.