POSTPARTUM DEPRESSION

Week 39

Prepared by: Annie Fu, MD MS

Reading Assignment:
Familiarize yourself with ACOG’s Depression and Postpartum Depression: Resource Overview
https://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
LEARNING OBJECTIVES

• Learn the definition, epidemiology, background, evaluation, and management of postpartum depression

• Understand the importance of screening patients for depression
CASE VIGNETTE

• 18 yo G1P0101 presents for a postpartum visit. She reports difficulty sleeping since delivery. She also reports frequent crying episodes daily.

• Upon further questioning, she reports a 3 week history of symptoms. She reports poor appetite and difficulty concentrating on some housework/tasks occasionally. She has missed feeding her child several times over the past few weeks. She reports feeling guilt but also concerned that doesn’t feel as close to her newborn as anticipated. She is alone most days as her partner is working but he has been involved and takes over childcare whenever he is home. She denies any SI/HI.
FOCUSED HISTORY

What elements of the patient’s history are most important?

• **POBHx:** G1-Preterm delivery at 32 weeks for HELLP syndrome
• **GynHx:** LMP unknown, breastfeeding; no STI/abnormal paps/fibroids/cysts
• **PMH:** denies
• **PSH:** C/S x 1
• **FH:** denies
• **SH:** no toxic habits; lives with husband and child; denies IPV; friends and family are back in DR
• **All:** NKDA
• **Meds:** PNV
PERTINENT PHYSICAL EXAM FINDINGS

• **Vital Signs:**  T 36.9, HR 90, RR 15, BP 101/66
• **General:**  NAD, disheveled; avoids eye contact; ignores infant’s crying/distress
• **HEENT:**  No thyromegaly, oropharynx clear
• **Chest:**  CTAB
• **CVS:**  RRR
• **Abdomen:**  NT/ND, no rebound, guarding, masses, HSM
• **GU:**  NEFG; cervix WNL, no CMT; uterus 6 week size, nontender; no adnexal masses or tenderness
• **Psych:**  A&O x 3; slow speech, depressed affect
Depression is the most common mood disorder in women
- Affects women twice as frequently as men
- Initial onset peaking during reproductive years

What is postpartum depression?
- Major episode of depression that occurs within the first 4-6 weeks postpartum but can occur up to 1 year after delivery

What is perinatal depression?
- Major and minor depressive episodes during pregnancy or first 12 months after delivery
- VS baby blues: unexplained crying, trouble sleeping, eating, making choices, questioning ability to parent, frustration/anxiety with family/newborn; starts 2-3 days after childbirth and last 1-2 weeks

Prevalence
- 5-25% of PP women (14-23% of pregnant women)

Maternal suicide is a much more common cause of maternal mortality than providers are aware
- Symptoms are unrecognized as they are attributed to normal pregnancy and postpartum changes
ACOG (2018) & American Psychiatric Association: OB/GYNs and other OB care providers screen patients during the perinatal period at least once for depression/anxiety symptoms with a standardized, validated tool

- All should perform a complete assessment of mood and emotional well-being at the postpartum visit with additional screening as indicated with symptomatic patients
- Screening alone has known clinical benefits

USPSTF (2016): Grade B recommendation – Routine screening for depression in all populations
Sequelae of Untreated Maternal Depression

Maternal effects
- Unhealthy coping behaviors, noncompliance, poor prenatal care, inadequate nutrition, drug and alcohol abuse, poor cognition, poor mother-infant bonding, disruption in family environment, self-injury, suicidality, psychosis
- Relapse of depression

Pregnancy effects
- Possible association with adverse reproductive outcomes
  - SAB, PTD, LBW/SGA

Neonatal effects
- Increased risk for irritability, less activity, less attentiveness, fewer facial expressions
- No increased risk of congenital anomalies

Long-term effects on offspring
- Weak evidence for risk of developmental problems (conduct disorder, suicidal behavior, emotional instability, increased requirement for psychiatric care)
RISK FACTORS FOR DEPRESSION

Depression during pregnancy
- Maternal anxiety
- Life stress
- History of depression
- Lack of social support
- Unintended pregnancy
- Medicaid insurance
- Domestic violence
- Lower income
- Lower education
- Smoking
- Single status
- Poor relationship quality

Postpartum depression
- Depression during pregnancy
- Anxiety during pregnancy
- Experiencing stressful life events during pregnancy and the early postpartum period
- Traumatic birth experience
- Preterm birth/infant admission to NICU
- Low levels of social support
- Previous history of depression
- Breastfeeding problems
SCREENING TOOLS

Several validated screening instruments are utilized

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Number of Items</th>
<th>Time to Complete (Minutes)</th>
<th>Sensitivity and Specificity</th>
<th>Spanish Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh Postnatal Depression Scale</td>
<td>10</td>
<td>Less than 5</td>
<td>Sensitivity 50–100% Specificity 49–100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Postpartum Depression Screening Scale</td>
<td>35</td>
<td>5–10</td>
<td>Sensitivity 91–94% Specificity 72–88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Health Questionnaire 9</td>
<td>9</td>
<td>Less than 5</td>
<td>Sensitivity 75% Specificity 99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 47.8–82% Specificity 85.9–88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Beck Depression Inventory-II</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 56–57% Specificity 97–100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies Depression Scale</td>
<td>20</td>
<td>5–10</td>
<td>Sensitivity 69% Specificity 97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Zung Self-Rating Depression Scale</td>
<td>20</td>
<td>5–10</td>
<td>Sensitivity 45–69% Specificity 77–88%</td>
<td>No</td>
</tr>
</tbody>
</table>


PHQ2 ✤ PH9 if yes to any item of PHQ2

Over the past two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than one-half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>


C-SSRS (Columbia-Suicide Severity Rating Scale)

EVALUATION

• Administration of screening tool
• History and physical exam
  • Mental Status Examination
    • Appearance
    • Speech
    • Behavior
    • Cooperativeness
    • Thought processes
    • Thought content
    • Perceptions
    • Mood
    • Affect
    • Memory
    • Orientation/Attention
    • Insight/Judgment
• Social History
  • Assess safety

Remember: **SIGECAPS**!
  • Sleep
  • Interest
  • Guilt
  • Energy
  • Concentration/Cognition,
  • Appetite
  • Psychomotor symptoms,
  • Suicide (/HI)
MANAGEMENT

• Referral to Social Worker on site, Psychiatrist
• Referral to the ED for inpatient admission in those with acute psychosis, SI/HI
• Counsel patient on the R/B/A of management of depression, R/B/A of common medications used (both during pregnancy and during lactation)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Pregnancy Risk Category¹</th>
<th>American Academy of Pediatrics Rating²</th>
<th>Lactation Risk Category³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trazodone</td>
<td>Desyrel</td>
<td>Cₘ</td>
<td>Unknown, of concern</td>
<td>L2</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Effexor</td>
<td>Cₘ</td>
<td>N/A</td>
<td>L3</td>
</tr>
</tbody>
</table>

Is the patient acutely suicidal or psychotic?

No

Is the patient willing to consider pharmacotherapy?

No

Patient may be eligible for psychotherapy without pharmacotherapy if she is amenable. Non-psychiatric clinicians should consider consultation with a psychiatrist to determine if a trial of psychotherapy alone is a reasonable.

Yes

Aggressively treat depression.*
If possible, avoid antiepileptic mood stabilizers in the 1st trimester

Is the patient willing to consider pharmacotherapy?

No

Was the patient treated with psychotherapy in the past?

No

Has the patient failed to respond to a trial of psychotherapy?

No

Is it possible that the patient suffers from mania or bipolar disorder?

No

Does the patient have a comorbid condition such as panic disorder, eating disorder, substance use disorder?

No

Consider treatment with an appropriate antidepressant given full consideration of the risks and benefits to mother and her offspring. (See Text)

Yes

Non-psychiatric clinicians should refer to a psychiatrist for pharmacotherapy. (See Text)

Yes

Non-psychiatric clinicians should refer to a psychiatrist for pharmacotherapy. Psychiatrists are likely to recommend antidepressant therapy and other therapeutic modalities. (See Text)

TAKE HOME POINTS

• Depression is the most common mood disorder and has significant morbidity/mortality if unrecognized and untreated

• All OB/GYN providers should **screen patients during the postpartum visit for postpartum depression** and at least once during the perinatal period
  - PP depression can be missed due to assumptions that symptoms are secondary to life changes from parenthood

• Screening itself can be beneficial

• Use a validated **screening tool**

• Refer to patient for **psychiatric treatment** as indicated
BILLING AND CODING

• Diagnoses:
  • F53.0, Postpartum depression
  • F32.9, Major depressive disorder, single episode, unspecified

• CPT Code
  • Established outpatient visit: at least 99213 (higher if attending sees patient with you)
  • New outpatient visit: at least 99203 (higher if attending sees patient with you)
EVIDENCE

• Coding for Perinatal Depression, ACOG online supplement, revised 2017. https://www.acog.org/-/media/Departments/Coding/Perinatal-Depression-rev-2017.pdf?dmc=1&ts=20190829T1934226304