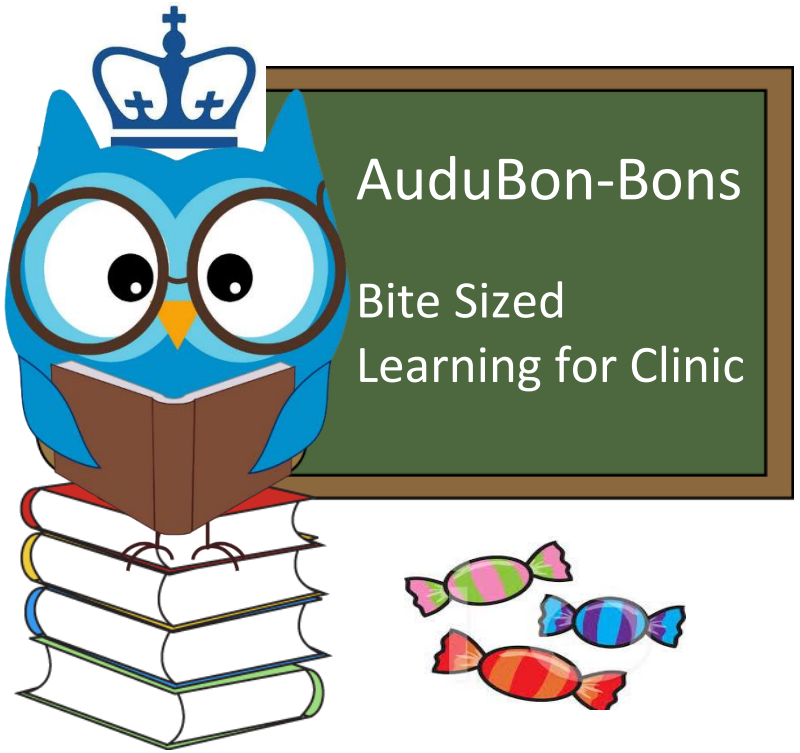
POSTPARTUM DEPRESSION



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

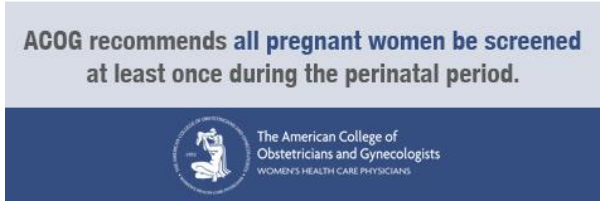
PERTINENT PHYSICAL EXAM FINDINGS

- **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**

Postpartum Depression: Background

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

SCREENING RECOMMENDATIONS

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 1. Depression Screening Tools

Screening Tool	Number of Items	Time to Complete (Minutes)	Sensitivity and Specificity	Spanish Available
Edinburgh Postnatal Depression Scale	10	Less than 5	Sensitivity 59–100% Specificity 49–100%	Yes
Postpartum Depression Screening Scale	35	5–10	Sensitivity 91–94% Specificity 72–98%	Yes
Patient Health Questionnaire 9	9	Less than 5	Sensitivity 75% Specificity 90%	Yes
Beck Depression Inventory	21	5–10	Sensitivity 47.6–82% Specificity 85.9–89%	Yes
Beck Depression Inventory-II	21	5–10	Sensitivity 56–57% Specificity 97–100%	Yes
Center for Epidemiologic Studies Depression Scale	20	5–10	Sensitivity 60% Specificity 92%	Yes
Zung Self-Rating Depression Scale	20	5–10	Sensitivity 45–89% Specificity 77–88%	No

Screening for perinatal depression. ACOG Committee Opinion No. 757. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e208-12.

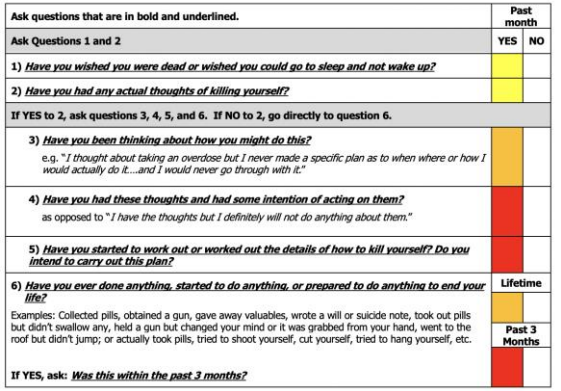
COLUMBIA | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

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?	*Not at all*	*Several days*	*More than one-half the days*	*Nearly every day*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Kroenke, K., Spitzer, R.L., Williams, J.B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care, 41:1284–92.

C-SSRS (Columbia-Suicide Severity Rating Scale)



Ask questions that are in bold and underlined.	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime** / **Past 3 Months**	
If YES, ask: ***Was this within the past 3 months?***		

Posner, K. (n.d.). Columbia-Suicide Severity Rating Scale (C-SSRS) Columbia University Medical Center; Center for Suicide Risk Assessment. Retrieved from http://www.cssrs.columbia.edu/

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**!

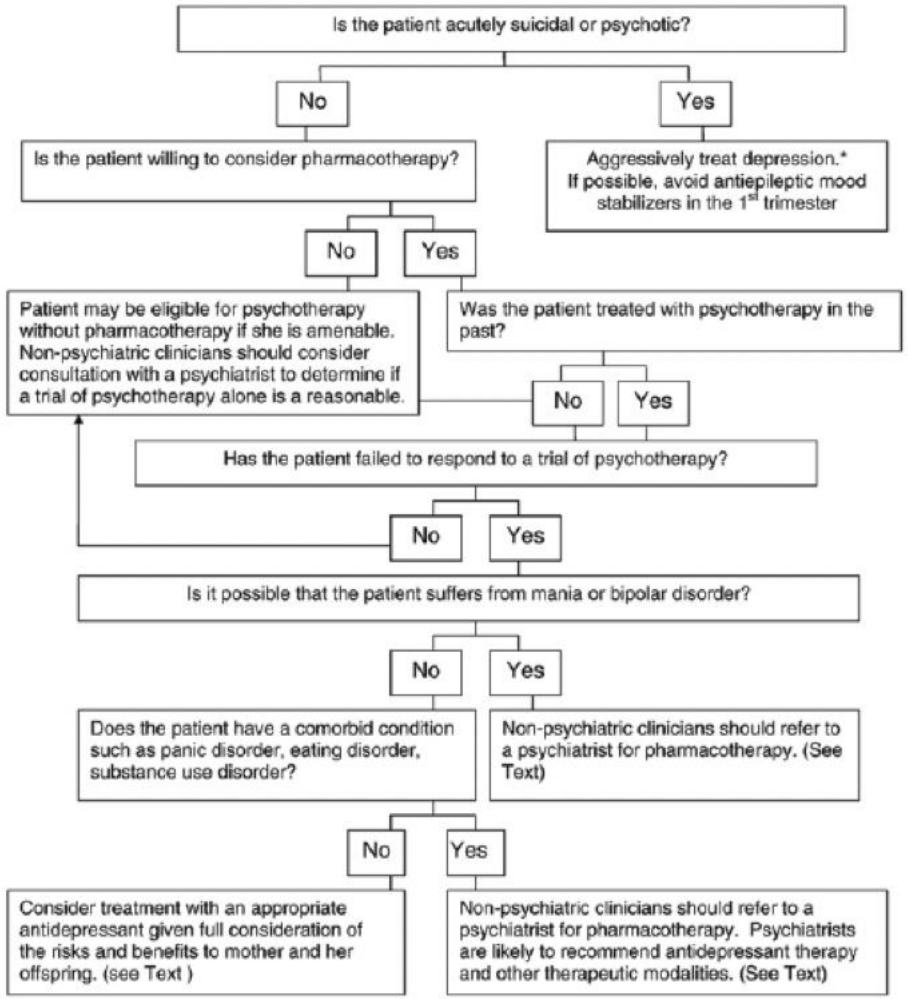
Sleep
Interest
Guilt
Energy
Concentration/**C**ognition,
Appetite
Psychomotor symptoms,
Suicide (/HI)

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)

Generic Name	Trade Name	Pregnancy Risk Category†	American Academy of Pediatrics Rating‡	Lactation Risk Category§
		Antidepressants *(continued)*		
Other Antidepressants (continued)				
Trazodone	Desyrel	C_m	Unknown, of concern	L2
Venlafaxine	Effexor	C_m	N/A	L3

Use of psychiatric medications during pregnancy and lactation. ACOG Practice Bulletin No. 92. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:1001–20.



Yonkers K et al. "The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetrician and Gynecologists." Obstet Gynecol 2009 (reaffirmed 2014); 114 (3): 703-713.

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

- Screening for perinatal depression. ACOG Committee Opinion No. 757. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e208-12.
- Use of psychiatric medications during pregnancy and lactation. ACOG Practice Bulletin No. 92. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:1001–20.
- Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50.
- Yonkers K et al. "The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetrician and Gynecologists." Obstet Gynecol 2009 (reaffirmed 2014); 114 (3): 703-713.
- Bonari L et al. "Perinatal risks of untreated depression during pregnancy." Can J Psychiatry 2004; 49(11): 726-735.
- 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