**THE PERIPARTUM DEPRESSION TOOLKIT**

Perhaps the most important thing you can remember about **peripartum depression** is the name: *peri*partum means it can start before, during, or after pregnancy. The screening tools listed here can and should be used at any of these times. (At this point, most screening tools have been validated only in the post-partum period, but they are the best we have.)

SCREENING 🡪 DIAGNOSIS 🡪 FOLLOW-UP

* Screening: **Edinburgh PDS:** *validated in international settings and in low-income, minority groups.*
* Diagnosis: *If screen positive* 🡪 ***PHQ-9,*** *plus In-depth discussion between doctor and patient*
* Follow-up: *Repeat PHQ-9 every 2 weeks (better than “How are things going?”)*
* Bring her back for more frequent visits (prenatal, postnatal, pediatrics).

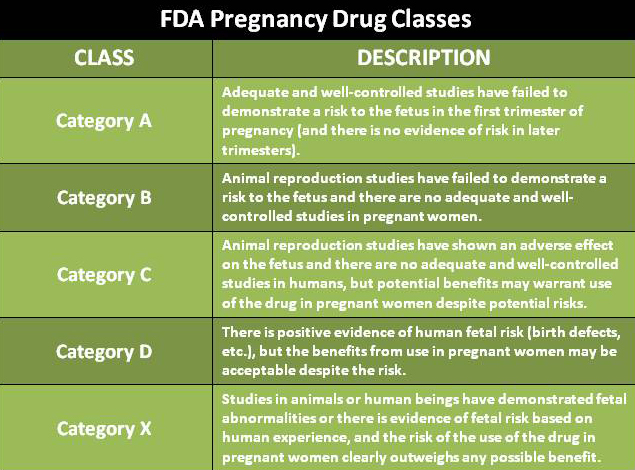
FAST FACTS: Pre-partum & Intrapartum

* Women of reproductive age have higher rates of depression compared to men in age-matched groups, whether or not the woman is pregnant.
* Rates of depression relapse are higher in pregnant women (compared to non-pregnant)
* Just like at any time in the life course: Talk therapy is first-line for all patients. Medications are indicated for any patient not improving with talk therapy or patients with severe depression (weight loss, SI). Combined therapy is most effective (when meds are indicated).

WHAT ABOUT MEDICATIONS?!

* Because of (mostly theoretical) risks of antidepressants to the fetus, initiation of SSRIs warrants a thorough, patient-centered risk/benefit discussion.
* Weaning is an option for the motivated and informed patient. Stopping medications *also comes with risks to the mother and the fetus.*
* Current data suggests that SSRIs are NOT major morphological teratogens. All SSRIs are FDA “Class C”—except for **Paxil**, which is “**Class D”.** Remind your patients (and yourself) what these classes mean. (See table on reverse)
* For medico-legal purposes, though not necessarily safety/health purposes, *many physicians avoid prescribing Paxil during pregnancy.*
* Not all women who will take SSRIs during pregnancy must be co-managed by a psychiatrist.
* Ultimately, it is **always the pregnant woman’s choice.**

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| **THINGS TO THINK ABOUT (BUT NOT TO DISCUSS IN DETAIL WITH YOUR AVERAGE PATIENT)**  **\* First trimester 🡪 congenital malformations**  **\* 2nd/3rd trimesters 🡪 persistant pulmonary hypertension**  **\* 3rd trimester 🡪 Neonatal Withdrawal**   * A few highly publicized studies demonstrated increased risk of heart defects overall in newborns of women who took Paxil during pregnancy (but not other SSRIs). Hence the Class D label. Several other studies have shown no significant association between maternal SSRI use during pregnancy and major birth defects. * PPHTN: Rare, and difficult to study with enough power to demonstrate a reproducible association with SSRIs during pregnancy. * Neonatal withdrawal: in about 30% of infants: jitteriness, irritability, constant crying, inconsolable (mild & transient—disappears w/in 2 weeks—but mothers should be warned) |



FAST FACTS: Postpartum:

**Ddx: Postpartum Affective Disorders**

- The “Baby Blues” (not a true disorder, but still upsetting)

- Postpartum depression

- Postpartum psychosis

* Prevalence 10-15% in postpartum period
* The effectiveness of screening appears to be related to availability of adequate follow-up. *Family doctors are the ideal continuity of care.*
* All SSRI’s are excreted into breast milk. “Without a doubt, the baby will be exposed.”
* “A woman would have to breastfeed for 4½ years for the child to accumulate the exposure of a fetus during one month of pregnancy.” (So if she took an antidepressant in pregnancy and you’re worried about exposure during breastfeeding, you’re worrying a bit late.)
* There have been no reported adverse events in the nursing child exposed to an SSRI.
* There isn’t enough data for clear clinical recommendations as to which SSRI is safest during breastfeeding. Therefore there is really no need to switch SSRIs during the breastfeeding period.

RESOURCES FOR PHYSICIANS:

* **Edinburgh scale:** <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>
* **CES-D:** [http://www.mededppd.org/CES-D, NIMH.pdf](http://www.mededppd.org/CES-D,%20NIMH.pdf)
* **Postpartum Depression Screening Scale (PDSS)** – Costs $65, but it’s another you might hear about.
* *Postpartum Progress.* This website is extremely user-friendly and informational, and it includes resources for patients and doctors: <http://www.postpartumprogress.com/>. (Many of the links on these hand-outs come from this website.)
* Printable hand-out for patients from the AAFP (in addition to the handout I’ve made): <http://www.aafp.org/dam/AAFP/documents/patient_care/nrn/more-than-blues.pdf>
* California Teratogenicity Information Service **1-800-532-3749 (**Based at UCSD. They also have a breastfeeding expert whose number they can give you. )
* Maternal depression and anxiety research (if you’re interested!): <http://www.postpartumprogress.com/scientific-research>

References:

- AAFP 2014 Scientific Assembly Needs Assessment : Postpartum depression. (Internet). <http://www.aafp.org/dam/AAFP/documents/events/assembly/needs/repfem-postpartum-depression.pdf>. Accessed 2/3/2014.

- AAFP Postpartum Depression in Primary Care: Translating Screening and Management (TRIPPD). <http://www.aafp.org/patient-care/nrn/studies/all/trippd.html>; and: <http://www.aafp.org/dam/AAFP/documents/patient_care/nrn/ppd-teaching-slides.pdf>

- **Depression During Pregnancy: Treatment Recommendations** *A Joint Report from APA and ACOG***.** August 21, 2009

**For patients:**

**PREGNANCY AND DEPRESSION: WHAT YOU SHOULD KNOW**

Use of antidepressant medicines (such as Prozac, Zoloft, Paxil) during pregnancy is complicated and controversial. The important thing to know is this: Depression during pregnancy *should* be treated with counseling, medications, or both. While some studies have shown risks to the baby from certain antidepressants, ***healthy babies born to mothers taking SSRIs are the rule, not the exception.***It is generally thought to be riskier for the mother and the baby to leave maternal depression untreated. Therefore you should continue or start taking antidepressants medications if your doctor recommends it. This is a decision you and your doctor can make together.

A few things to know:

* **If you are taking Paroxetine (Paxil)** 🡪 Your doctor will probably recommend that you switch to a different medication, or gradually stop taking meds (if you have other effective ways to manage your depression). This is because a few studies have shown some small increases in heart problems in babies born to mothers taking Paxil.
* **If you take an antidepressant during the end of your pregnancy🡪** Your baby might be slightly more irritable or cry more than other babies. Generally this should be mild and will not last more than a week or two.
* **If you want to breastfeed while taking antidepressants 🡪** There is no evidence to show that this is unsafe for your baby. Babies are exposed to lower levels of these medicines through breastmilk than the levels they are exposed to in utero (in moms who took antidepressants during pregnancy).

**“BABY BLUES?” OR POSTPARTUM DEPRESSION?**

Having a baby can be an overwhelming experience, and it can be hard to tell whether feelings of sadness and exhaustion after childbirth are “normal,” or if you need help.

* **Postpartum depression** typically starts within weeks to months after childbirth. It can become chronic.
* **Women who are at high risk for PPD:** Younger (under 20); use alcohol or other drugs; did not plan their pregnancy or had mixed feelings about having the baby; have had depression or anxiety before becoming pregnant or in a prior pregnancy; had a stressful event during pregnancy (like loss of a loved one or a health emergency); have a close family member with depression or anxiety; have little support from family, partner, or friends; have money or housing problems.
* **Ask for help.** Your doctor can help you sort out what’s normal for you and what might be some signs of depression.

Community resources:

* Oakland — Alta Bates Summit Postpartum Stress Support Group, Tuesday mornings, contact Lee Safran at 510-496-6096
* Lafayette – Postpartum Emotional Recovery Circle at Bay Area Psychotherapy Institute. Meets Sundays,11am to 12:30pm. Contact Meri Levy, M.A. at [925-385-8848](tel:925-385-8848)
* Kensington — Mothers Supporting Mothers PPD Support Group, meets Tuesdays from 12 to 1:30pm, contact Mary Obata at 619-220-4680

Useful websites:

* [www.postpartumprogress.com](http://www.postpartumprogress.com) A widely read blog dedicated to improving diagnosis and treatment of postpartum depression. Full of useful resources
* <http://www.apa.org/pi/women/resources/reports/postpartum-dep.aspx?item=2> Definitions, resources, and tips for women who think they may have postpartum depression
* <http://www.postpartum.net/> - A nonprofit organization dedicated to helping women with postpartum depression find support