

Treatment of Postpartum Depression

Postpartum depression (PPD) occurs in 10-20% of women after childbirth and is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a major depressive episode that begins within the first four weeks after delivery. Postpartum depression differs from postpartum blues (baby blues) in that it is more intense, must be present for at least two weeks, and usually requires counseling and treatment. Postpartum depression increases a woman's risk for development of major depression and also may impair her child's emotional development, attention, and cognitive skills. A woman is at risk for developing PPD after pregnancy, regardless of the number of deliveries she has had. The most important risk factor is personal history of PPD; women with a PPD history have a 50-62% risk of a subsequent episode.^{1,2}

KEY POINTS

- Postpartum depression (PPD) is under diagnosed and undertreated.
- PPD affects 10-20% of women after delivery; those with a postpartum depression history have a 50-62% risk of a subsequent episode.
- PPD increases a woman's risk for development of major depression and also may impair her child's emotional development, attention, and cognitive skills.
- **Screening for PPD with validated screening tools should be standard of practice at postpartum office visits.***
- The risk and severity of antidepressant adverse effects are low in nursing infants; sertraline and paroxetine have the fewest number of reported infant adverse effects.
- For asymptomatic women with a previous moderate-to-severe postpartum episode, initiating antidepressant medication and psychotherapy immediately after delivery is recommended; however beginning these therapies 2-4 weeks before the due date is also appropriate.
- For severe PPD antidepressant medication, preferably SSRIs, and psychosocial interventions are recommended regardless of breastfeeding.

More than half of women with PPD go unnoticed and many others are either untreated or inadequately treated. Identification of PPD through standard postpartum care visits is poor with diagnosis rates of 3-6%. Obstetrician-gynecologists, pediatricians, and family physicians conduct most well-child and/or postpartum care visits, and few routinely screen for PPD with validated tools such as Edinburgh Postnatal Depression Scale*, Postpartum Depression Screening Scale, DSM-IV based depression interview, etc.³ Although a pediatrician's scope of practice does not typically include adults, the

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American Academy for Pediatrics states that pediatricians should assess family and parental environmental factors that potentially affect a child's health. During well-child visits, pediatricians may be able to identify postpartum depression in mothers that otherwise may not receive timely postpartum care. Regardless of the type of provider screening for PPD, diagnosis is necessary for appropriate management.

Due to limited data in women with PPD, pharmacologic treatment with antidepressants is based on treatment of major depression with special consideration given to women who breastfeed, as most antidepressants are excreted into breast milk. Combination psychotherapy and antidepressant medication is recommended in nursing mothers with severe depression or for women not breastfeeding with mild depression. Psychotherapy alone is recommended for breastfeeding women with mild postpartum symptoms.²

Data regarding the optimal timing of initiation of prophylactic treatment in asymptomatic women with a previous postpartum episode is conflicting. While waiting to initiate therapy until immediately after delivery is the preferred approach by many practitioners, beginning psychotherapy 2-3 months prior to delivery and starting antidepressant medication 2-4 weeks before the due date is also rational. Treatment of PPD should generally continue for at least 6-12 months after depression symptoms have resolved.^{2,4}

Most antidepressants are associated with low risk of adverse effects in nursing infants.^{1,5} Sertraline and paroxetine are the most studied in lactation and have the fewest number of reported infant adverse effects. A single case report described a seizure in an infant possibly induced by bupropion. Although the American College of Obstetrics and Gynecology recommends avoiding the use of paroxetine (Paxil) in pregnant women and women planning to become pregnant due to increased risk of congenital cardiac malformations, the drug can safely be used for postpartum depression, even when initiated the few weeks prior to delivery. Pharmacologic treatment of postpartum depression should be individualized, with preference given to medications that patients have responded well to in the past.

*Edinburgh Postnatal Depression Scale can be accessed at:

<http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>

References

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