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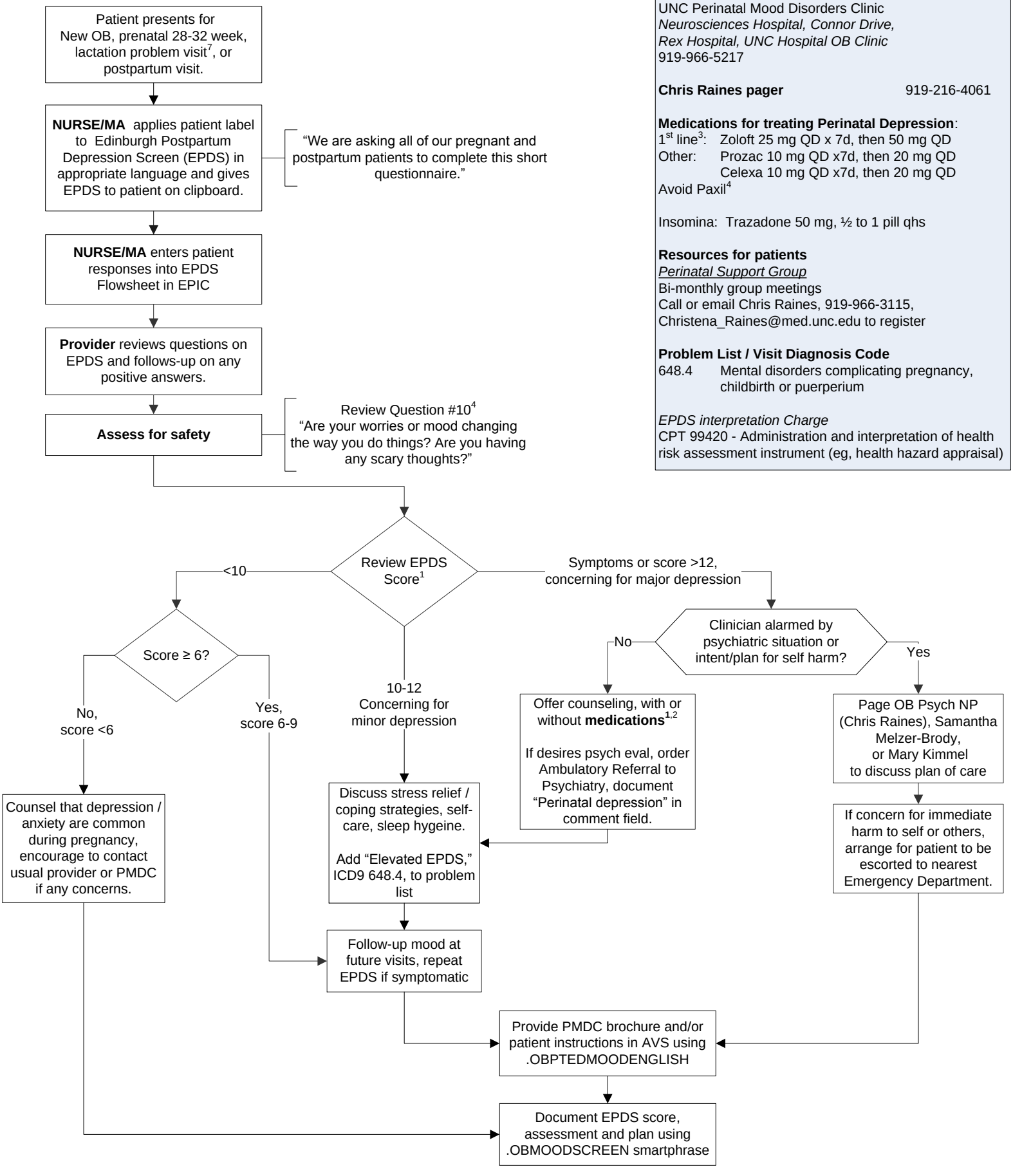
Perinatal Depression Screening and Treatment



Services offered through UNC Psychiatry:
UNC Perinatal Mood Disorders Clinic
Neurosciences Hospital, Connor Drive,
Rex Hospital, UNC Hospital OB Clinic
919-966-5217

Chris Raines pager 919-216-4061

Medications for treating Perinatal Depression:
1st line[3]: Zoloft 25 mg QD x 7d, then 50 mg QD
Other: Prozac 10 mg QD x7d, then 20 mg QD
Celexa 10 mg QD x7d, then 20 mg QD
Avoid Paxil[4]

Insomina: Trazadone 50 mg, ½ to 1 pill qhs

Resources for patients
Perinatal Support Group
Bi-monthly group meetings
Call or email Chris Raines, 919-966-3115,
Christena_Raines@med.unc.edu to register

Problem List / Visit Diagnosis Code
648.4 Mental disorders complicating pregnancy, childbirth or puerperium

EPDS interpretation Charge
CPT 99420 - Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)

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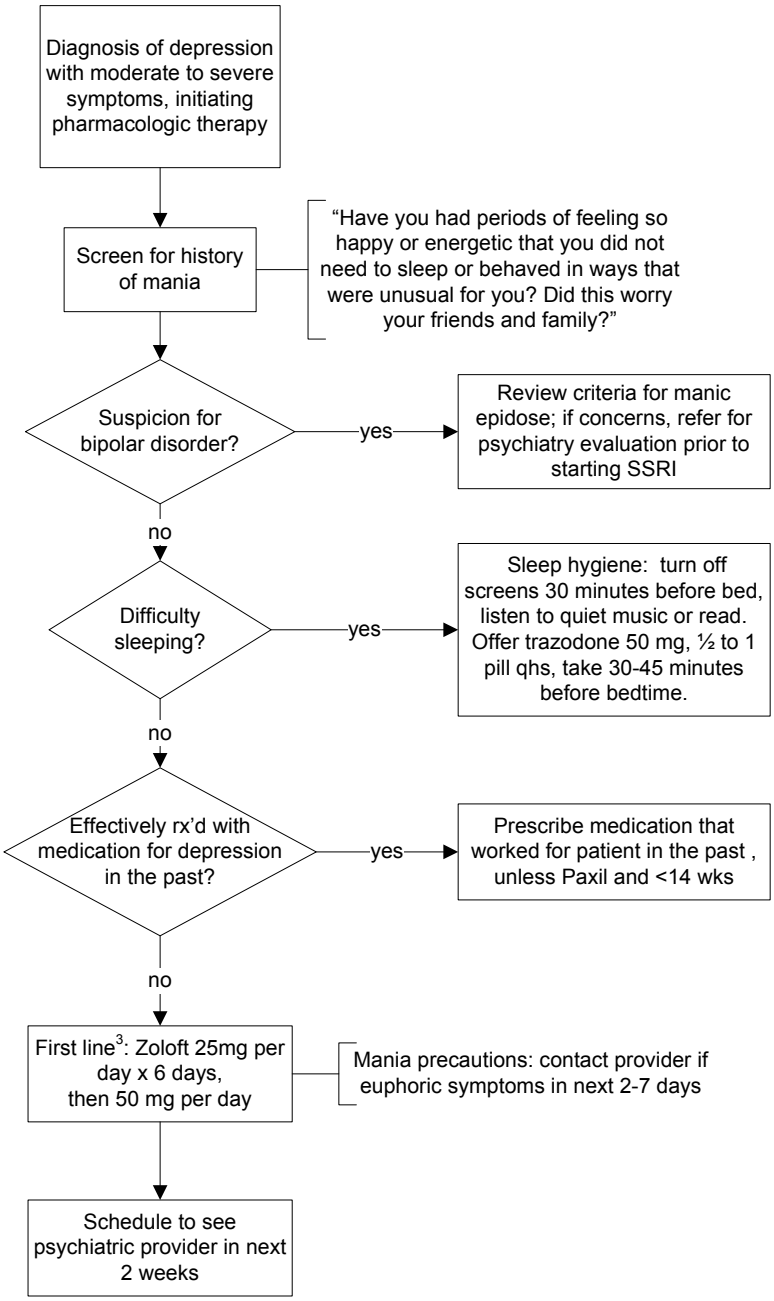
Initiating medication for perinatal depression and anxiety



Counseling regarding SSRI exposure during pregnancy

"If their psychiatric condition necessitates pharmacotherapy, the benefits [for pregnant women] of such therapy by far outweigh the potential, marginal risks of VSD and other cardiac malformations, PPHN, and poor neonatal adaptation syndrome."

Koren, G. and H. Nordeng, *Antidepressant use during pregnancy: the benefit-risk ratio.* Am J Obstet Gynecol, 2012.[6]

Screening for Mania History

Because SSRI therapy can trigger mania or psychosis in women with bipolar disorder, screening for history of manic symptoms is recommended prior to initiating therapy.

Mania symptoms include[8]:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or subjective experience that thoughts are racing.
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Additional resources for screening for bipolar are available at http://www.cqaimh.org/tool_bipolar.html

Considerations for Perinatal Mood Disorders in breastfeeding mothers

When initiating medical therapy, copy the LactMed monograph for medication(s) into Patient Instructions of the After Visit Summary. Encourage patient to share this information with the infant's pediatric provider.

Breastfeeding difficulties are often comorbid with perinatal mood symptoms[7]. Consider lactation consult to discuss concerns and develop strategies for both ensuring consolidated sleep & maintaining milk supply. Page or call the outpatient LC to arrange a consultation.

Outpatient Lactation Consultation

Clinic pager	347-1562
Mobile phone	445-7305

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References

[1] Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, et al. Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evid Rep Technol Assess (Summ) 2005 Feb(119):1-8.
Gaynes et al reviewed literature regarding appropriate cut-points for the EPDS and other depression screening instruments. With a cut-off of >12, authors found the EPDS has a sensitivity of 91% and a specificity of 95% for major depression. Using a cutoff of 10 for minor depression, the EPDS has a sensitivity of 68% and a specificity of 80%.

The authors also reviewed interventions for preventing or treated postpartum depression, and found that peer support and CBT-based interventions reduced depressive symptoms.

[2] Stuart, S. and H. Koleva (2014). "Psychological treatments for perinatal depression." Best practice & research. Clinical obstetrics & gynaecology **28**(1): 61-70.
The authors reviewed validated psychological treatment for perinatal depression. Both interpersonal psychotherapy and cognitive behavioral therapy have been shown to be effective. They conclude that interpersonal psychotherapy should be a first-line treatment for perinatal depression.

[3] Lactmed. Sertraline. [cited 11/02/2014]; Available from: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
Zoloft is the preferred agent in mothers who are breastfeeding. From the LactMed summary:
Because of the low levels of sertraline in breastmilk, amounts ingested by the infant are small and is usually not detected in the serum of the infant, although the weakly active metabolite desmethylsertraline is often detectable in low levels in infant serum. Rarely, preterm infants with impaired metabolic activity might accumulate the drug and demonstrate symptoms similar to neonatal abstinence. Most authoritative reviewers consider sertraline one of the preferred antidepressants during breastfeeding. Mothers taking an SSRI during pregnancy and postpartum may have more difficulty breastfeeding and may need additional breastfeeding support.

[4] Williams M, Wooltorton E. Paroxetine (Paxil) and congenital malformations. CMAJ 2005 November 22, 2005;173(11):1320-1.
In some studies, Paxil is associated with a higher risk of congenital malformations than other SSRIs. Because of the potential for concerns about

drug exposure in a future pregnancy, Paxil is not a preferred agent for treatment of mood disorders among women of childbearing age.

[5] Question 10 of the EPDS asks, “The thought of harming myself has occurred to me.” Regardless of the total EPDS score, an answer other than ‘never’ to this item should trigger a discussion with the patient about whether she has a plan or intent to harm herself. If she reports a plan or intent, she should be immediately referred to psychiatry. If a patient reports passive thoughts of self harm, it may be helpful to ask what has stopped her from acting, and support them with their answer.

[6] Koren, G. and H. Nordeng, Antidepressant use during pregnancy: the benefit-risk ratio. Am J Obstet Gynecol, 2012.
" Antidepressants are used commonly in pregnancy. Physicians who provide health care for pregnant women with depression must balance maternal well-being with potential fetal risks of these medications. Over the last decade, scores of original and review articles have discussed whether selective serotonin reuptake inhibitors-selective serotonin norepinephrine reuptake inhibitors possess risks to the fetus; however, very little has been done to integrate these potential risks, if they exist, into an overall context of a benefit:risk ratio. This review aims at presenting an updated analysis of fetal and maternal exposure to selective serotonin or norepinephrine reuptake inhibitors to allow an evidence-based benefit:risk ratio. When a psychiatric condition necessitates pharmacotherapy, the benefits of such therapy far outweigh the potential minimal risks of cardiac malformations, primary pulmonary hypertension of the newborn infant, or poor neonatal adaptation syndrome."

[7] Watkins, S., S. Meltzer-Brody, D. Zolnoun and A. Stuebe (2011). "Early breastfeeding experiences and postpartum depression." Obstet Gynecol **118**(2 Pt 1): 214-221.
The authors used data from the Infant Feeding Practices Study II to quantify the association between early breastfeeding difficulties and depression symptoms at 2 months postpartum. Women with severe breastfeeding pain in the first two weeks had a two-fold risk of depression symptoms at 2 months, adjusting for sociodemographic confounders. Women presenting with lactation concerns should be screened for depression, and women with depression symptoms should be offered breastfeeding support.

[8] Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
http://dsm.psychiatryonline.org/

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Web Resources

Postpartum Support International
http://www.postpartum.net

PSI has an online directory of local resources throughout the state of North Carolina available at http://j.mp/PSI_NC

Moms Supporting Moms (Raleigh)
http://pesnc.org/get-help/moms-supporting-moms/
Support Line: 919.454.6946

Mother-to-Mother Postpartum Depression Network
www.postpartumdepression.net

Postpartum Progress, Rated #1 Postpartum Blog in the nation
http://www.postpartumprogress.com