CLINICAL PRACTICE GUIDELINES FOR POST-NATAL DEPRESSION MANAGEMENT

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Purpose:

Scott & White Health Plan's (SWHP) Post-natal Depression (PND) Guideline is designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients. Identifying and managing patients appropriately that are at risk or have PND will improve the mental health of women who were pregnant. These recommendations are not intended as a substitute for the reasonable exercise of independent clinical judgement by providers.

Scope:

Postpartum women of all ages

Introduction:

Depression is very common during pregnancy and the postpartum period. Based on data from the Pregnancy Risk Assessment Monitoring System (PRAMS), reported by the Centers for Disease Control (CDC), the prevalence of postpartum depression varies by age, ranging from 10.3% among women aged 30–39 years to 23.3% among women aged ≤19 years. [1]

Inconsistent screening practices exist, and postpartum depression screening is not standard care across the board.[2] The U.S. Preventive Services Task Force recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening for depression has the potential to benefit a woman and her family and should be strongly considered. Because genuine depression, of a more serious nature than postpartum "blues" may develop, screening in certainly appropriate in patients at apparent risk; women with current depression or a history of major depression warrant particularly close monitoring and evaluation. [3]

Pregnancy and the postpartum period represent an ideal time during which consistent contact with the health care delivery system will allow women at risk to be identified and treated.

Guideline:

I. Screening

A. Recommend that all women be routinely assessed during the antenatal period for a history of depression or other mental health history.

a. There are multiple depression screening tools available for use. These tools usually can be completed in less than 10 minutes. Examples of highly sensitive screening tools include the

Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, and Patient Health Questionnaire. [3]

Edinburgh Postnatal Depression Scale: Individual items are totaled to give an overall score.
IN THE PAST SEVEN DAYS:

1. I have been able to laugh and see the funny side of things:
- ❑ 0 As much as I always could.
- ❑ 1 Not quite so much now.
- ❑ 2 Not so much now.
- ❑ 3 Not at all.

2. I have looked forward with enjoyment to things:
- ❑ 0 As much as I ever did.
- ❑ 1 Somewhat less than I used to.
- ❑ 2 A lot less than I used to.
- ❑ 3 Hardly at all.

3. I have blamed myself unnecessarily when things went wrong:
- ❑ 0 No, not at all.
- ❑ 1 Hardly ever.
- ❑ 2 Yes, sometimes.
- ❑ 3 Yes, very often.

4. I have felt worried and anxious without a very good reason:
- ❑ 3 Yes, often.
- ❑ 2 Yes, sometimes.
- ❑ 1 No, not much.
- ❑ 0 No, not at all.

5. I have felt scared or panicky without a very good reason:
- ❑ 3 Yes, often.
- ❑ 2 Yes, sometimes
- ❑ 1 No, not much at all.
- ❑ 0 No, not at all.

6. I have been feeling overwhelmed:
- ❑ 3 Yes, most of the time I haven't been able to cope at all.
- ❑ 2 Yes, sometimes I haven't been coping as well as usual.
- ❑ 1 No, most of the time I have coped well.
- ❑ 0 No, I have been coping as well as ever.

7. I have had difficulty sleeping even when the baby is asleep:
- ❑ 3 Yes, most of the time.
- ❑ 2 Yes, sometimes.
- ❑ 1 Not very often.
- ❑ 0 No, not at all.

8. I have felt sad or miserable:
- ❑ 3 Yes, most of the time.
- ❑ 2 Yes, quite often.
- ❑ 1 Not very often.
- ❑ 0 No, not at all.

9. I have been so unhappy that I have been crying, or fighting to keep from crying:
- ❑ 3 Yes, most of the time.
- ❑ 2 Yes, quite often.
- ❑ 1 Only occasionally.
- ❑ 0 No, never.

10. The thought of harming either myself or my baby has occurred to me:
- ❑ 3 Yes, quite often.
- ❑ 2 Sometimes.
- ❑ 1 Hardly ever.
- ❑ 0 Never.

Scoring:
0-8 points - low probability of depression
8-12 points - most likely just dealing with life with a new baby or a case of baby blues
13-14 points - signs leading to the possibility of PPD; take preventive measures
15 + points - high probability of experiencing clinical postpartum depression

II. Management

A. PND should be managed in the same way as depression at any other time, but with additional considerations regarding the use of antidepressants when breast-feeding and in pregnancy. (See SWHP's "Depression Management" Clinical Practice Guideline)

B. Psychosocial interventions should be considered when deciding on treatment options for a mother diagnosed as suffering from PND.

Note: Patients with bipolar or psychotic symptoms should be referred to Psychiatry. Also suicidal patients should be evaluated for admission, as well as patients who express fears of hurting their baby.

III. Prescribing

A. Establish a clear indication for drug treatment.

B. Use treatments in the lowest effective dose.

C. Drugs with a better evidence base (generally more established drugs) are preferable.

D. Assess the benefit/risk ratio of the illness and treatment for both mother and baby/fetus, including consideration of:

- 2X increased risk of congenital heart defects with paroxetine

- 30% risk of neonatal abstinence syndrome after Selective Serotonin Reuptake Inhibitors (SSRI) exposure in late pregnancy

- 6X increased risk to neonate of persistent pulmonary hypertension with SSRI exposure after 20 weeks

E. The risks of stopping tricyclic or SSRI antidepressant medication should be carefully assessed in relation to the mother's mental state and previous history. There is no indication to stop tricyclic or SSRI antidepressant medication (EXCEPT PAROXETINE) as a matter of routine in early pregnancy.

F. There is no clinical indication for women treated with TCA's, paroxetine, sertraline, or fluoxetine to stop breast feeding, provided the infant is healthy and its progress monitored. Other modern antidepressants are probably also safe during lactation.

Antidepressant Drug information : [4]

Medication	Rating for use in pregnancy *	Adverse effects on breast-fed infants (NA=Information not available)	Dosage range (mg per day)+
Selective Serotonin reuptake inhibitors (SSRI)			
fluoxetine (Prozac)	C	Gastrointestinal effects, irritability, insomnia	20-40

paroxetine (Paxil)	D	NA	20 to 50
sertraline (Zoloft)	C	None	50-200
citalopram (Celexa)	C	Somnolence, decreased feeding, weight loss	20 to 60
escitalopram (Lexapro)	C	NA	10 to 20
Tricyclics (tertiary)			
amitryptyline (Elavil)	C	None	75 to 300
imipramine (Tofranil)	D	None	75 to 300
Tricyclics (secondary)			
desipramine (Norpramin)	C	None	75 to 300
nortriptyline (Pamelor)	D	None	25-150
protriptyline (Vivactil)	C	NA	15-60
Miscellaneous			
Bupropion (Wellbutrin)	C	None	200-450
mirtazapine (Remeron)	C	NA	15 to 45
trazodone (Desyrel)	C	NA	150 to 600
venlafaxine (Effexor XR)	C	NA	75 to 225
Duloxetine (Cymbalta)	C	NA	40-60

***--U.S. Food and Drug Administration drug rating for use of drugs in pregnancy: A=No risk in controlled human studies B=no evidence of risk to fetus; C=risk to fetus cannot be ruled out; D=evidence of risk to human fetus; + Adult daily dosages are adapted from AHCPR and women may need lower daily dosages. Guideline based on Recommendations of the Royal College of Physicians, Scotland; US Preventive Health Task Force; and other expert recommendations from the American Academy of Family Physicians. Scott and White Physicians from Dept. of Psychiatry, OB-GYN, and Family Medicine participated in the development and review of this guideline. 2007 reviewed by OB-GYN and Family Medicine physicians of the Scott and White Health Plan Prenatal Team. 2009 reviewed by OB-GYN and Family Medicine physicians of the SWHP Prenatal Team, as well as Dept. of Psychiatry, Scott & White Clinics and Health Integrated, Inc.**

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Sources:

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