Educational Topic 29: Anxiety and Depression

Rationale: Pregnancy may be accompanied by anxiety and depression especially in the postpartum period. Recognition of psychological disturbance is essential for early intervention.

Intended Learning Outcomes:

A student should be able to:

- List risk factors for postpartum blues, depression, and psychosis
- Differentiate between postpartum blues, depression, and psychosis
- Compare and contrast treatment options for postpartum blues, depression, and psychosis
- Recognize appropriate treatment options for mood disorders during pregnancy and lactation

TEACHING CASE

CASE: Ms. Davis is a 22-year-old G3P2Ab1 woman who reports that in addition to being overwhelmed by having a newborn baby, her 2 ½-year-old daughter recently experienced a severe illness.

During her visit, Ms. Davis describes feeling sleep deprived, guilty, and inadequate. She also admits to occasional crying spells and decreased appetite. She notes that her sister has depression and is treated with fluoxetine. She denies suicidal ideation or homicidal ideation. Her mother is assisting with caring for the children.

She is a stay-at-home mom who has been married for five years. Her pregnancy was uncomplicated, and she had a normal vaginal delivery at term. She initially tried to breast feed but stopped after 3 days because of “sore nipples.”

COMPETENCY-BASED DISCUSSION & KEY TEACHING POINTS:

Competencies addressed:

- Patient Care
- Medical Knowledge
- Systems-Based Practice
1. What are the most important symptoms to look for in a patient like Ms. Davis and why?

   • It is essential to ascertain if there is any suicidal or homicidal ideation or symptoms of postpartum psychosis. If any of these symptoms are present, immediate intervention is necessary. Postpartum psychosis is an emergency and typically requires hospitalization and inpatient treatment.

2. Are her symptoms consistent with postpartum blues, postpartum depression, or postpartum psychosis?

   • There is a wide range of responses to pregnancy and delivery from transient postpartum blues (referred to in lay terminology as "baby blues") to postpartum depression. The most extreme response is postpartum psychosis.
   • Symptoms for postpartum blues include mild insomnia, tearfulness, fatigue, poor concentration, depressed affect, and irritability. There is a 50% to 80% incidence rate with resolution in 10 days. If symptoms last two weeks, rule out postpartum depression.
   • Symptoms for postpartum depression include labile mood, irritability, difficulty falling asleep, phobias, and anxiety that increases in the evening. Incidence is 10% or greater with resolution in 3 to 14 months.
   • Symptoms for postpartum psychosis are similar to organic brain syndrome and include confusion, attention deficit, distractibility, and clouded sensorium. The onset is dramatic in the first 48 hours to two weeks after delivery and may resemble a rapidly evolving manic episode. There may be delusional beliefs and auditory hallucinations. Incidence is 0.1 to 0.2 percent and the resolution variable.
   • This patient's symptoms could be consistent with postpartum blues if they occur in the first one or two weeks postpartum and resolve. However, if the symptoms occur beyond the first two weeks postpartum and persist, they would be consistent with postpartum depression.

3. What would a treatment plan for Ms. Davis include?

   • Treatment must be tailored to the patient's situation and based on the severity of her illness. ACOG recommends, whenever possible, multidisciplinary management involving the patient's obstetrician, mental health clinician, primary health care provider, and pediatrician to facilitate care. Treatment may include pharmacologic and/or non-pharmacologic therapy. Non-pharmacologic treatment such as individual or group psychotherapy (cognitive-behavioral and interpersonal therapy) may be useful for mild-to-moderate depressive symptoms. Pharmacologic therapy is indicated for moderate-to-severe depressive symptoms or with failure to respond to non-pharmacologic therapy. An optimal response may be achieved with combined pharmacologic and non-pharmacologic therapies.

4. Which pharmacologic agents could be included in her treatment plan and how would lactation affect the agents selected?

   • SSRIs are first-line choices. SNRIs are effective for depression and anxiety. Tricyclic antidepressants (e.g., nortriptyline) may be beneficial for sleep disturbance, because of their sedation. There are limited data on a hormonal approach involving estrogen. However, at this time, prescribing estrogen for this purpose is not standard of care and is off-label, and, therefore, should be considered experimental.
   • Every patient who is breastfeeding must be informed that irrespective of class (SSRI, SNRI, or TCA), these medications may appear in small amounts in breast milk, and the concentration of medication in breast milk varies widely. There are rare reports of adverse effects of these medications in breast-fed infants, and there are no adequate long-term studies on the exposure to these medications via breastfeeding. Adverse effects of these medications may be avoided by not breastfeeding premature infants or those infants...
with hepatic insufficiency. The benefits and risks of using these medications during lactation must be considered and documented in discussions and the decision-making process.

REFERENCES


ACOG Committee Opinion 453: Screening for Depression During and After Pregnancy, February 2010; Reaffirmed 2012.