UNICARE.

Preferred Practice Guideline

Identification and Treatment of Antenatal Depression (AND), Postpartum Depression (PPD) and Postpartum Psychosis (PPP)

The practice guidelines included/referenced in this document are not intended to be required treatment protocols. Physicians and other health professionals must rely on their own expertise in evaluating and treating patients. Practice guidelines are not a substitute for the best professional judgment of physicians and other health professionals. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited.

With respect to the issue of coverage, each patient should review his/her Policy or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The practice guidelines do not supersede the Policy or Certificate and Schedule of Benefits.

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Rationale:

Postpartum Depression (PPD) is also known as Postnatal Depression or Depression with Postpartum Onset. Antenatal Depression (AND) signifies depression during pregnancy, and may be considered synonymous with the terms antepartum, prenatal or pre-partum depression. These terms are reserved for women with significant Depressive Disorders, and should not be applied to normal mood changes. Postpartum Psychosis (PPP) is less common, but should be considered a **life-threatening medical emergency**.

A recent systematic review of AND reveals depression prevalence rates of 7.4%, 12.8% and 12.0% during the first, second and third trimesters, respectively. [1] In addition to pointing out the significance of AND, this suggests that at least some PPD could be prevented by timely identification and treatment of AND.

The American College of Obstetricians and Gynecologists (ACOG) has also estimated that the "baby blues" affect 70% to 85% of new mothers. PPD is much less common with prevalence rates (of clinically significant depression) ranging from 10% to 20% (in the postpartum period). [3] It is important that physicians understand that PPD is a significant, treatable medical disorder, with very high morbidity and significant mortality if untreated. ACOG has noted that an important strategy for physicians in diagnosing and treating PPD is to identify women at risk during pregnancy and immediately following delivery. [2] ACOG also notes "one of the best ways for physicians to recognize the symptoms of depression early on is to simply ask their patients specifically about their mood and adjustment to motherhood."

Physicians may find it useful to use a simple depression screening scale, such as the Edinburgh Postnatal Depression Scale (EPDS) to identify patients suspected of having significant depression. [4] "The US Preventive Services Task Force has recommended adult depression brief screening by health providers. [5] Pediatrician involvement in the identification and management has been emphasized in recent literature. [6, 15]

According to ACOG "Postpartum psychosis (PPP) affects only about 1 in 1,000 women and most often occurs during the first four weeks after delivery. Patients with PPP are severely impaired and may have paranoia, mood shifts, or hallucinations and delusions that frequently focus on the infant's dying or being demonic. The hallucinations often command the patient to hurt herself or others. This condition requires immediate medical attention and, usually, hospitalization." [7]

Identification:

Screening for Antenatal Depression and vulnerability to Postpartum Depression should be done as part of normal prenatal care. Screening for the presence of postpartum depression and postpartum psychosis can be done as part of postnatal care, both of the mother and of the child. Providers should have a high index of suspicion regarding a significant psychiatric disorder in the presence of known risk factors such as: [6,7,8,9]

1. Depression or anxiety during pregnancy
2. Personal history of prior depression, bipolar disorder or eating disorder. This is a greater indicator of risk if there is a personal history of treatment for depression in the past 2 years, especially if the patient stopped taking antidepressant medication to become pregnant or during pregnancy
3. Family history of depression, bipolar disorder, eating disorder, or psychosis, especially in the postpartum period
4. Maternal youth (under age 18)
5. Substance abuse
6. Tobacco use during pregnancy
7. Lack of perceived support
8. Stressful life events
9. Complications during pregnancy, such as hyperemesis, premature contractions
10. High number of visits for prenatal care
11. Sick leave during pregnancy
12. Child care stress
13. Immigration in the last five years

Any personal history of psychosis should serve as an indicator that the patient should be followed very closely, with frequent reassessment of risk.

Screening:

As noted by AGOG, specific inquiry by the physician about mood is particularly important.

The Edinburgh Postnatal Depression Scale (EPDS) has been widely used in screening for PPD. Use of the EPDS is recommended by the Scottish Intercollegiate Guidelines Network Guidelines for Postnatal Depression and Puerperal Psychosis. [10] The EPDS has also been validated as a tool for screening for AND. [11] Several variations have been adapted specifically for antenatal use. The Maternal Mental Health Survey, an Americanized adaptation of the EPDS developed by Scott Stewart, M.D at the University of Iowa, is commonly used in the clinical setting in this country. It can be obtained from the University of Iowa web site noted below. It is also included in the Maternal Depression Brochure, which can be obtained by calling 866-785-2789 and requesting a copy.

The physician should also be very attentive to any signs or symptoms that could represent psychosis, including paranoia, mood shifts, hallucinations, delusions, unusual speech patterns,

unusual thought patterns or unusual behavior. This screening relies on the physician's history and examination on an ongoing basis, not on screening instruments.

Diagnostic Criteria:[12]

The diagnosis of AND is based on the presence of a Major Depressive Episode, with onset during pregnancy. The diagnosis of PPD is based on the presence of a Major Depressive Episode, with onset within four weeks postpartum.

A diagnosis of Major Depressive episode is made when five (or more) of the following diagnostic criteria are present during the same two week period and represent a change from previous functioning, and at least one of the criteria is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day.
- Markedly diminished interest or pleasure in all, or almost all, activities.
- Significant weight loss when not dieting, or weight gain or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or self-recrimination
- Diminished ability to think or concentrate.
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Patients with Bipolar Disorder (Manic-Depressive Disorder) should be differentiated from patients with Unipolar Depression by a past history of manic or hypomanic episode. A family history of such symptoms is highly suggestive of a Bipolar Disorder. Identification must be based on historical information since their clinical presentation may look the same as a Major Depressive Episode. This is of particular importance because these patients should not be treated with an antidepressant alone as this may lead to a manic episode. Clinicians should be alert to potential bipolarity in postpartum depressed patients, particularly since the treatment selection implications are substantial. There is also evidence that a high percentage of these "unipolar post partum" patients will actually "convert" and meet bipolar criteria when followed for several years. Accordingly, the evaluation of a patient with postpartum depression must always include bipolar spectrum disorders in the differential diagnosis." The complexity of antenatal or postpartum bipolar patients always warrants referral to a specialist. Please refer to UniCare's Clinical Practice Guidelines for Bipolar Disorder for additional information.

The diagnosis of PPP is based on the presence of a psychotic disorder during the postpartum period. The most common presentation is that of a Brief Psychotic Disorder, which is diagnosed by the presence of **any one** of the following symptoms:

- Delusions

- Hallucinations
- Disorganized speech
- Grossly disorganized or catatonic behavior

Special diagnostic considerations during pregnancy: In addition to the published diagnostic criteria for the depressive and psychotic disorders, the physician should be aware that there are certain "red flags" identified in the literature, such as:

- Failure to bond with the new baby
- Severe anxiety, often focused around fears about the baby and/or guilt about not bonding
- Separation and distancing from family members.

Treatment:

Treatment approaches to AND and PPD should be guided by UniCare's Preferred Practice Guidelines for Identification and Treatment of Depressive Disorders, with special emphasis on the unique issues of these disorders in the antenatal and postpartum periods. All treatment with medication should take into consideration the Pregnancy Category of the medication, recent literature and the balance of risks and benefits of these medications. This information should be discussed thoroughly with the patient, father of the baby (as appropriate), and her support system. Treatment of AND and PPD should take into account the differences in psychosocial issues during and after pregnancy, as well as the different pharmacological considerations of transplacental and breast milk transfer of medications. Psychotherapy alone is appropriate for mild or moderate degrees of depression. Consideration should be given to avoiding medications in the first trimester and also for the mother's preference for treatment.

The significant risks of untreated depression include impaired social, occupational and parenting function; impaired maternal bonding; suicide; and danger to the child. These risks must be carefully weighed against the risks to the child of intrauterine or transplacental exposure to pharmacological agents.

Prenatal exposures to selective serotonin reuptake inhibitor antidepressants have not identified a risk for major congenital anomalies, however several reports have described perinatal complications, including jitteriness, irritability, and respiratory difficulties after third-trimester exposure to these antidepressants. [13] Therefore, it is useful to taper these medications just prior to birth. There is a Black Box warning regarding the use of Paxil in pregnancy due to an increased risk for birth defects. This is an active area of research with changing recommendations, so physicians should consult currently published studies for guidance.

Third trimester exposure to benzodiazepines has been associated with sedation, respiratory depression and low Apgar scores in some reports.

Postnatal exposure to medications in breast milk must also be considered. A pooled analysis published by a team from the University of Iowa suggests that nortriptyline and sertraline may be

preferred choices in breast-feeding women. [14] Familiarity with recent literature and consultation are encouraged when prescribing for breast-feeding mothers.

Women who are at high risk for a post partum depression should be considered for prophylactic antidepressant medication. This includes those with a prior history of a postpartum depression, a prior major depression or bipolar disorder.

It cannot be overemphasized that **Postpartum Psychosis should be considered a medical emergency requiring immediate and aggressive treatment. As noted above, PPP requires immediate medical attention and, usually, hospitalization**." [2] The risks of medication rarely, if ever, outweigh the risks of the psychosis.

Specialist Referral Criteria:

Although many patients with depressive symptoms can be successfully treated within a primary care setting, it is essential that the physician consider the type, complexity and severity of the symptomology as well as their own comfort level when determining if a referral to a specialist is required. Clinical consultation or referral to a specialist should be considered in the following situations:

- Patients with current or prior history of bipolar disorder
- Patients with a prior history of onset or worsening of any significant psychiatric disorder during pregnancy or in the postpartum period
- Patients with current or prior history of psychosis or risk of harm to self or others should be considered for immediate consultation. Emergency consultation and/or hospitalization is indicated for any patient with current psychosis or risk of harm to self or others.
- Patients with current or prior history of recurrent or severe depression
- Patients with antenatal depression that is worsening or failing to respond to current treatment, regardless of severity
- Patients with co-morbid chemical dependency, severe personality disorders or anxiety disorders who require complex therapeutic management of all issues
- Patients with mild depression who prefer a "non-pharmacological" approach to treatment and request a trial of psychotherapy.

Patients with AND and patients at increased risk of PPD should be considered to have complicated pregnancies. **Any psychosis during pregnancy** is a major complication of pregnancy. AND and PPD can be associated with other medical complications of pregnancy, which may well require specialty assessment and treatment by an Obstetrician/Gynecologist. If the obstetrical care is being provided by other than an Obstetrician/Gynecologist, clinical consultation or referral to an Obstetrician/Gynecologist should be considered and is strongly encouraged to ensure that medical complications are appropriately managed.

The pediatrician, or other physician providing the medical care of the child, should be consulted if AND, PPD or PPP is likely to have any adverse health effects on the child. This includes, but

is not limited to cases in which psychotropic medications are prescribed for a breastfeeding mother.

It is essential for the health of both mother and child that the management of the pregnancy, the management of any medical complications, and the management of psychiatric disorders be coordinated among the providers involved.

Behavioral Health Treatment Coordination:

UniCare strongly supports efforts directed at the coordination of care between all professionals involved in providing treatment to a member. Communication between the various disciplines is essential in order to avoid conflicting treatment plans, eliminate duplicated efforts and decrease the risk of medication errors. This type of dialogue is especially important between the Primary Care Physician (including Obstetrician/Gynecologist and Pediatrician), Psychiatrist and/or Therapist when treatment is being provided for AND or PPD. Coordination of prescribing of medications should consider both positive and adverse effects on both the mother and the child. Cross-consultation is strongly encouraged in the prescribing of psychotropic medications. Toward that end, we ask that all practitioners take an active role in coordinating behavioral health treatment by requesting authorization, ensuring that communication occurs and then documenting the results. Primary Care Physicians are encouraged to communicate the rationale and any relevant medical information when a member is referred to a psychiatrist or therapist. Likewise, Psychiatrists and other Behavioral Health Specialists are encouraged to establish an ongoing dialogue with the Primary Care Physicians.

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Where to Obtain Antenatal and Postpartum Depression Screening Materials:

The Maternal Depression Brochure may be obtained by calling 866-785-2789.

The Edinburgh Postnatal Depression Scale (EPDS) is available from the Utah Department of Health at http://health.utah.gov/rhp/pdf/EPDS.pdf

The full text of Postnatal depression and puerperal psychosis. A national clinical guideline is available at http://www.sign.ac.uk/pdf/sign60.pdf

Additional resources can be found at www.womensmentalhealth.org