According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), postpartum depression (PPD) is defined as an episode of major depression with onset of symptoms within four weeks after delivery.

In general, the clinical features of PPD are similar to the symptoms of non-postpartum depression and may include panic attacks, obsessions and excessive worrying. PPD must be differentiated from other forms of mood disturbance after delivery, including the postpartum blues and postpartum psychosis.

The postpartum blues are quite common within the first week to 10 days after delivery and are characterized by transient symptoms, such as crying, sadness, anxiety, irritability and mood lability. Postpartum psychosis, on the other hand, constitutes a psychiatric emergency due to risk of suicide and infanticide. Typically, the symptoms include delusions, hallucinations, confusion and disorganized behaviour.

How should screening and diagnostic evaluation be approached?

It is important to identify women who are at an elevated risk of developing PPD. The most commonly used screening instrument is a 10-item, self-report questionnaire known as the Edinburgh Postnatal Depression Scale. Each item is scored on a four-point scale from zero to three, yielding a maximum score of 30. A cut-off score of 13 or higher signifies the presence of depressive symptoms. Screening instruments, however, are not a substitute for a thorough diagnostic interview aimed at eliciting information about safety issues, psychiatric and physical co-morbidity and personal and family history of depression and functional impairment.
Thyroid function should be assessed to rule out hypothyroidism and hyperthyroidism, both of which can be associated with mood symptoms. Since the postpartum period is a high-risk period for the onset or exacerbation of bipolar disorder, women with PPD should be asked about symptoms of (hypo) mania. Postpartum psychosis can begin with rather vague mood symptoms during the prodrome; therefore, it is also vital to rule out psychosis.

How should patients be treated?

The choice of treatment modality depends on symptom severity, response to treatment during previous episodes, patient preference and polarity of the disorder (e.g., major depressive disorder versus bipolar disorder). Various non-biologic interventions, including cognitive therapy and interpersonal psychotherapy, have been studied in the treatment of PPD.

Pharmacologically, a selective serotonin reuptake inhibitor, such as fluoxetine, paroxetine or sertraline, or a serotonin-norepinephrine reuptake inhibitor, such as venlafaxine, is generally recommended as the first-line treatment. The usual duration of treatment is a minimum of six months, following a full resolution of depressive symptoms; however, patients with a history of recurrent depression should be considered for prophylactic use of medication for the prevention of recurrences.

References