Perinatal depression

To the Editor: I applaud Drs. Sayres Van Neil and Payne for their article, "Perinatal depression: A review.[1] It brings to light the understated vulnerability of the postpartum period affecting the majority of women worldwide. I would like to clarify 2 points.

The American College of Obstetricians and Gynecologists (ACOG) states that medical care in the "fourth trimester" should include early communication with obstetric providers.[1] In contrast to the review's recommendation for depression screening during the 6-week postpartum visit, ACOG recommends contact with the obstetric provider within 3 weeks of delivery. We, as medical providers, need to normalize and emphasize the importance of early contact, and to acknowledge that postpartum depression and anxiety are common.

Second, your readers include family medicine physicians trained in the full-spectrum primary care of women desiring pregnancy throughout the preconception, peripartum, and postpartum periods. Drs. Sayres Van Niel and Payne allude to primary care physicians, but remark that it is best to refer a woman requiring pharmacologic treatment of a mood disorder during pregnancy or lactation to a psychiatric specialist.

The family medicine physician has an understated position in the care of women with perinatal mood disorders. We often have developed trusted relationships with women prior to their pregnancies. Screening for depression appears to be more successful when a mother shares a medical home with her child, which is common in a family medicine practice setting.[2] Family physicians should be knowledgeable about the benefits and risks of and alternatives to pharmacologic treatment of perinatal mood disorders, and able to address postpartum depression with concrete interventions in up to 92% of newborn visits.[3] Comfort with prescribing antidepressants for nonpregnant populations increases the likelihood that a healthcare provider will screen a woman for perinatal depression.[4]

Postpartum depression is known to affect maternal-infant bonding, breastfeeding success, childhood development, and partner relationships, which can all be addressed by the family physician.[5] Well-trained in treatment of depression and anxiety disorders, the family physician is prepared to be a useful caregiver in the postpartum period, including initiation of pharmacologic treatments if required.

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In Reply: We thank Dr. Laflamme for her insightful letter regarding our article.

We wholeheartedly agree that earlier contact with obstetric-care providers, such as during "fourth trimester" contact, is ideal. We also encourage all obstetric providers to screen at least at the 6-week in-person postpartum visit.

Her second point, that family medicine physicians are well-positioned to identify and treat perinatal depression, is also excellent. We agree, and we encourage all family medicine physicians to educate themselves on the basics of psychiatric treatment during pregnancy and lactation.

There is a good deal of misinformation on

the safety of psychiatric medications during pregnancy and lactation, and we recommend that all frontline providers, including internal medicine, family medicine, and OB-GYN physicians, as well as pediatricians, receive education on this topic.

To that end, the International Marcé Society for Perinatal Mental Health is supporting a curriculum in reproductive psychiatry. This ongoing project developed by leaders in reproductive psychiatry aims to educate all frontline providers on these important issues.

With more-complex psychiatric issues during pregnancy or the postpartum period, or when there is a complicated history of prior mental illness, reproductive psychiatrists are available for consultations to primary care providers.

Thank you for this addition to the discussion.

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