Postpartum Depression (PPD) on the Inpatient Unit

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Introduction: Postpartum depression (PPD) is surprisingly common, affecting 10%–20% of new mothers in the first year after giving birth. Severe cases may require inpatient psychiatric hospitalization. Here we review key principles in the diagnosis and treatment of PPD.

Diagnosis of PPD

The diagnosis of PPD follows criteria similar to those for major depression, with the specification that onset occurs within the first four weeks after childbirth. However, clinical practice recognizes symptoms can emerge any time within the first year postpartum. The key symptoms include:

- Persistent sadness or low mood
- Marked loss of interest or pleasure in activities previously enjoyed
- Significant weight loss when not dieting, weight gain, or decrease or increase in appetite
- Insomnia or excessive sleep
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, suicidal ideation, or a suicide attempt or plan

Screen for bipolar disorder also since many cases of PPD reflect bipolar depression.

Differentiating from Baby Blues

Don't confuse PPD with the "baby blues," a transient state of emotional disturbance occurring in up to 80% of mothers in the first two weeks postpartum. Unlike PPD, the baby blues are characterized by mild mood swings, irritability, and tearfulness, resolving without medical intervention. In contrast, PPD presents with more severe, persistent symptoms that can impair a mother's ability to care for her child and herself.

Use of Screening Tools

To aid in diagnosis, use the Edinburgh Postnatal Depression Scale (EPDS), an easy-to-use, 10-item questionnaire (see FS on Edinburgh Postnatal Depression Scale).

Treatment considerations

- If a patient was breastfeeding before being admitted to the hospital, ensure she has access to a breast pump. This will prevent breast engorgement and help maintain her milk supply. The patient may wish to collect the milk so it can be picked up and given to the infant during the patient's hospitalization.
- Make use of perinatal psychiatry-focused partial hospital programs or inpatient units in your area if they're available (www.tinyurl.com/mrxk7dnh).

Treatment options

Nonpharmacologic approaches

- Encourage patients to participate in individual and group psychotherapy and peer support groups if available on the unit.
- Postpartum Support International offers a wide array of free, virtual, facilitator-led peer support groups that patients may be able to access while on the unit and after discharge (1-800-944-4773; www.postpartum.net).

Pharmacologic approaches

- Select antidepressant medications based on past response, side effects, cost, etc.

● Breastfeeding is not a contraindication for starting or continuing an antidepressant, as adverse events in the infant are extremely rare
● Sertraline is often favored due to undetectably low levels in breastfeeding infants, but don't switch from an effective regimen to sertraline to prevent destabilizing the parent's mental health.
● Sometimes patients want to know when antidepressant levels peak in breast milk so they can "pump and dump" to minimize the baby's exposure, but since exposure to antidepressants in breast milk does not adversely affect the baby, all this does is waste milk.
● Intravenous brexanolone is FDA approved for PPD and works quickly but requires a 60-hour infusion in a health care setting and enrollment in a REMS program due to safety concerns of excessive sedation and hypoxia. Its high cost limits its use.
● Zuranolone, a neurosteroid like brexanolone, recently received FDA approval for PPD. It's costly but seems to work faster than traditional antidepressants. It's prescribed in a 50 mg evening dose, taken with a fatty meal, for 14 days. Its main side effects are drowsiness and dizziness.