Postpartum Depression Is Linked to Prior Obesity

BY PATRICE WENDLING
Chicago Bureau

DALLAS — Obese women may be at increased risk for postpartum depression, new research suggests.

In a prospective analysis of 1,282 women who gave birth to singleton infants at term, nearly 30% of women with a prepregnancy body mass index (BMI) of 30 kg/m^2 or more screened positive for postpartum depression 8 weeks after delivery.

The study is the first to use a validated screening tool to evaluate the risk of postpartum depression (PPD) by maternal BMI strata, according to the researchers, who used a score of 12 or more on the Edinburgh Postnatal Depression Screen to define a positive PPD screen.

Women at the extremes of BMI and those with greater weight gains in pregnancy were also at increased risk for PPD, Dr. Yvette LaCoursiere and colleagues at the University of Utah, Salt Lake City, reported in a poster at the annual meeting of the Society for Maternal-Fetal Medicine.

A positive PPD screen was reported in 18.7% of underweight women (BMI below 18.5), 12.7% of normal-weight (BMI 18.5-24.9), 15.9% of overweight women (BMI 25-29.9), 17.6% with class I obesity (BMI 30-34.9), 28% with class II obesity (BMI 35-39.9), and 29.4% with class III obesity (BMI greater than or equal to 40). The number of women in each BMI stratum was: 115, 724, 256, 116, 43, and 31, respectively, with incomplete data available on 3.

BMI remained a risk factor for PPD even after the researchers controlled for maternal age (mean 27 years), race (86% white, 9% Hispanic), parity (two children), education (mean 14 years), and stressors including financial, traumatic, partner associated, and emotional.

"We're not screening women aggressively for postpartum depression, in general," Dr. LaCoursiere said in an interview. "When I look at how this changed my practice, if I have women who are obese before delivery I have them come back at a 2-week visit and make sure they get a screening test because they have a very high chance of developing depression."

Weight gain during pregnancy also influenced a woman's chance of becoming depressed. A positive PPD screen was observed for 9.6% of normal-weight women who gained 24 pounds or less, 11% of those who gained 25-34 pounds, and 16% of those who gained more than 35 pounds. The rates were similar in overweight women (12%, 13.6%, and 20%, respectively), but did not increase in a stepwise fashion in the mildly obese (23%, 9%, and 21%, respectively). There were too few women with class II and III obesity to analyze.

Contrary to expectations, normal-weight women are more likely than are obese women to exceed the recommended pregnancy weight gain of 25-35 pounds, with obese women typically gaining only about 16-24 pounds during pregnancy, Dr. LaCoursiere said.

The modified Body Shape Questionnaire (BSQ) was also used, and revealed that poor body image was associated with obesity and weight gain during pregnancy. Scores on the BSQ increased significantly with increasing BMI strata (32, 39, 44, 48, 51, and 49; *P* less than .05).

Only 54% of physicians discussed mood during the postpartum visit, and 26% addressed weight, Dr. LaCoursiere said. Fewer than 30 women reported that their evaluation of mood was conducted with a written tool. During pregnancy, 77% of providers addressed weight and 53% discussed mood. "We [should] make this part of the nursing system so a woman has to answer a survey when she first comes through the door, so the doctor has the information in hand. Another thing that's tough for OBs is what to do with that result when you find it. Most should feel comfortable treating at least mild depression and knowing what resources are available and whom to refer to."

In all, 50 women (4%) reported using alcohol during pregnancy, 224 (17.4%) had a history of depression, 109 (8.5%) had a history of PPD, 23 (2%) had a history of other psychiatric diagnoses, and 175 (14%) had a family history of other psychiatric diagnoses. The percentage of women with a history of depression or PPD seems high, but the data may be inflated because they are self-reported and thus do not necessarily reflect those who accessed care and were treated, Dr. LaCoursiere said. ■

Antidepressant, Behavioral Tx May Ease Poststroke Depression

BY JEFF EVANS
Senior Writer

NEW ORLEANS — Individuals with poststroke depression may respond best in the short term to a combination of a brief psychosocial and behavioral intervention and an antidepressant, Pamela H. Mitchell, Ph.D., reported at the International Stroke Conference 2008.

Patients with two alleles of a common polymorphism in the serotonin transporter gene (SERT) seemed to benefit most from the combination treatment, Dr. Mitchell said at the conference, sponsored by the American Stroke Association.

Recent meta-analyses of pooled data from clinical studies of poststroke depression have estimated that 33% of patients may be clinically depressed after having a stroke. Poststroke depression has been associated with poor rehabilitation and quality of life and may be a predictor of a subsequent stroke and death.

Very-short-duration clinical trials of selective serotonin reuptake inhibitors (SSRIs) have provided mixed results in terms of clinical response, and there is little evidence on the effectiveness of variants of cognitive-behavioral therapy or socially supportive interventions in treating poststroke depression. However, a variant of cognitive-behavioral therapy and pleasant events therapy, the "Seattle Protocols" was successful in reducing depression in Alzheimer's disease patients and in their caregivers, said Dr. Mitchell, of the school of public health and community medicine at the University of Washington, Seattle.

She and her colleagues randomized 101 patients to treatment with the Seattle Protocols intervention plus an SSRI prescribed by their own providers or to a control group of usual care (SSRI prescription with provider follow-up). Both groups recieved written materials from the American Stroke Association about stroke and depression. The subjects had a mean age of 57 years; about 70% had a history of depression before their stroke.

The nine-session, 8-week intervention is designed to increase the level of pleasant social events and activities and physical activity that may improve mood. Patients are taught behavioral strategies that reduce or prevent the behavioral and mood disturbances that are characteristic of stroke and depression. Patients and their caregivers (if present) also learn individualized problem-solving approaches.

At 9 weeks, 48 patients who received the intervention had significantly greater mean improvement on the Hamilton Depression Rating Scale (48%, from 20.4 at baseline to about 10.6) than did 53 control patients (19%, from 19 to about 15.4). More than half of those in the intervention group entered clinical remission (a score of 9 or less on the HDRS) by 1 year.

In 61 patients genotyped for polymorphisms in SERT, those with two "short" alleles for the 5-HTTLPR polymorphism of SERT were significantly more likely to respond to treatment in the intervention arm than if they had only one short allele or other versions of the polymorphism. The short allele seems to be associated with increased risk for depression and other mental disorders, she said. No such responses according to SERT genotype were seen in patients in the control arm.

Dr. Mitchell said she had no conflicts of interest to disclose. ■

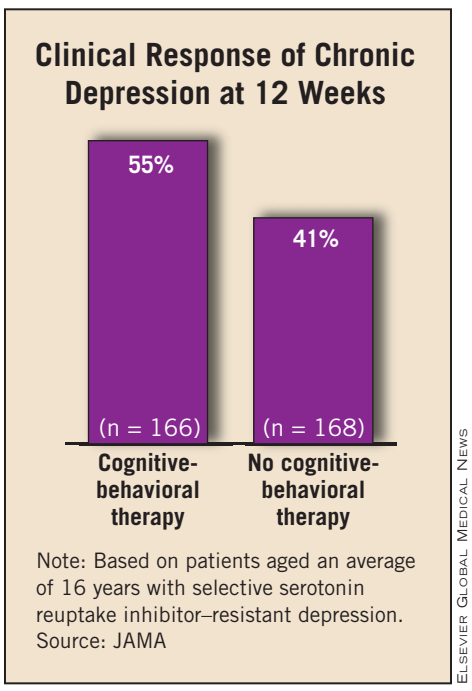
In SSRI-Resistant Depression in Teens, Switch to CBT, New Drug

BY MARY ANN MOON
Contributing Writer

Adolescents with depression that fails to respond to a selective serotonin reuptake inhibitor show more improvement with a switch to cognitive-behavioral therapy and another medication regimen than with a switch to a medication regimen alone, according to a multicenter study.

The Treatment of SSRI-Resistant Depression in Adolescents trial, funded by the National Institute of Mental Health, is the first to evaluate teens with the chronic symptoms and significant suicidal ideation that are typically seen in community practice but are excluded from most studies.

The 334 study subjects had failed to respond to at least 8 weeks of an initial SSRI (40 mg of fluoxetine or the equivalent of another agent), wrote Dr. David Brent of the University of Pittsburgh and colleagues.



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The average age of the subjects was 16 years, and 82% were white. Most had moderately severe symptoms, with a median duration of 17 months. About 59% showed clinically significant suicidal ideation, and half had at least one comorbid disorder.

The subjects were randomly assigned to receive a different SSRI alone, venlafaxine (Effexor) alone, a different SSRI plus cognitive-behavioral therapy (CBT), or venlafaxine plus CBT. The CBT focused on "cognitive restructuring and behavior activation, emotion regulation, social skills, and problem solving" and included parent-child sessions as well.

After 12 weeks, 55% of those receiving CBT showed an adequate clinical response, compared with 41% of those who had not received it. There were no significant differences in response between a second SSRI or venlafaxine, nor were there differences in responses to the various SSRIs used, the authors said (JAMA 2008;299:901-13).

"The slightly higher rate of cardiovascular effects associated with venlafaxine and the relatively modest treatment effects in adolescent depression … support the choice of another SSRI over venlafaxine as a second-line antidepressant," they added.

A significant difference was found in the response to CBT according to which study site administered it, a finding that will be further explored in a future report. However, the overall positive effect of CBT was robust in sensitivity analyses, even after controlling for site factors. The study limitations include the absence of ethnic diversity in the patients. Dr. Brent reported no financial disclosures. ■