

Pharmacologic Treatment of Depression During Pregnancy

Wisner KL, Gelenberg AJ, Leonard H, et al.

Depression is a common illness among women of childbearing years. Nevertheless, few data suggest treatment guidelines for depression during pregnancy. The prospective trials considered in this review were identified through MEDLINE and Health STAR searches for the terms *antidepressant during pregnancy* and *depression during pregnancy*. Additional articles were identified through manual searches of review bibliographies and queries of researchers for 1989–1999. Four studies published since 1993 compared health outcomes of mothers and infants exposed to antidepressants with those for unexposed controls and were chosen for analysis. Identifying subjects, comparison groups, pregnancy, and birth outcomes, the analysis focused on 5 elements of reproductive toxicity: intrauterine fetal death, morphologic teratogenicity, growth impairment, behavioral teratogenicity, and neonatal toxicity. The analysis yielded data for tricyclic antidepressants (TCAs) as a group, fluoxetine, and selective serotonin reuptake inhibitors as a group, revealing that none of these medications increased the risk of intrauterine death or major birth defects. One study found decreased birth weight in infants who were exposed to fluoxetine during the third trimester. Infants exposed to TCAs or fluoxetine during pregnancy developed at the same rate as controls. Direct drug effects and withdrawal syndromes were found in some newborns whose mothers had been exposed to antidepressants near term. Data gleaned from prospective trials, although scarce, are preferable to those from nonprospective sources. Patients with identified risks such as poor weight gain should be monitored and necessary interventions employed.

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Conjugal Loss and Syndromal Depression in a Sample of Elders Aged 70 Years or Older

Turvey CL, Carney C, Arndt S, et al.

This prospective longitudinal cohort study examined the relationship between conjugal loss and both syndromal depression and depressive symptoms in people aged 70 years or older. The administration of the short-form Composite International Diagnostic Interview (CIDI)—a measure of syndromal depression—and a revised version of the Center for Epidemiologic Studies-Depression Scale (CES-D Scale) to 5449 elders allowed comparison of the rates of syndromal depression (CIDI diagno-

sis) with depressive symptoms (6 CES-D Scale symptoms) in married subjects and those who had lost spouses between the first and second assessments. Syndromal depression appeared in newly bereaved subjects at almost 9 times the rate for married subjects; the rate of depressive symptoms in those who had sustained recent conjugal losses was nearly 4 times that of married subjects. A higher percentage of bereaved subjects had scores above threshold on the revised CES-D than did married subjects 2 years after the loss, and this was true regardless of age, sex, prior psychiatric history, and whether the death was expected in both depressed and nondepressed newly bereaved subjects. Recently bereaved elders are at significant risk for syndromal depression and can experience depressive symptoms at a high rate up to 2 years after their loss regardless of demographic variables or variables surrounding the nature of the spouse's death.

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Minor and Major Depression and the Risk of Death in Older Persons

Penninx BWJH, Geerlings SW, Deeg DJH, et al.

How depression and mortality are associated in older community-dwelling populations has yet to be discovered. This study established the role of both major and minor depression in mortality and assessed the function of confounding and explanatory variables in the relationship. A cohort of 3056 Dutch men and women aged 55 to 85 years were followed for 4 years. DSM-III criteria were used to define major depression according to the Diagnostic Interview Schedule. Minor depression was defined as clinically relevant (a Center for Epidemiologic Studies Depression score of ≥ 16) without fulfilling diagnostic criteria for major depression. After accounting for sociodemographic and health status confounders, men with major depression had a risk of death that was 1.80 times higher (95% CI, 1.35 to 2.39) than that in nondepressed men during follow-up. The risk of mortality was not significantly increased in women with minor depression. Gender did not affect the higher association of major depression with mortality risk (95% CI, 1.09 to 3.10) when sociodemographics and health status had been adjusted for. The extra risk of mortality associated with depression was accounted for only in small part by health behaviors such as smoking and physical inactivity. Minor depression in older men and major depression in both older men and women increase the risk of dying even after sociodemographics, health status, and health behaviors have been taken into account.

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