A Potential Gap in the Perinatal Depression Treatment Cascade

To the Editor: In the September 2016 issue of the *Journal*, Cox et al[1] carefully examined and quantified gaps in the treatment cascade that occurs from the development to remission of depression during the perinatal period. Their thoughtful elucidation of the problems that occur at each step of their model provide not only an excellent summary but also helpful recommendations for improving care at each of these steps. This publication will no doubt enhance clinical guidelines aimed at recognizing and treating perinatal depression.

In addition to the helpful recommendations contained in this work, we wish to also highlight the importance of screening for medical comorbidities associated with depressive symptoms in women experiencing perinatal depression. The inclusion of this suggestion is supported by a recent review article[2] published in the *Journal* that discussed the importance of recognizing and treating other medical conditions as a means of improving the prognosis in those with depression. The clinical recognition of physical comorbidities during the screening process for perinatal depression should be considered, because these comorbidities are not only common but also may increase the risk for various complications in women and their offspring.[3–6] Of particular interest to women and their health care providers are both postpartum iron deficiency and thyroid dysfunction.

Indeed, work cited in the guidelines[5,6] for the American College of Obstetricians and Gynecologists support that both iron deficiency anemia and postpartum thyroiditis can play a role in the development of depressive symptoms in the postpartum period. Furthermore, clinicians and researchers in primary care and endocrinology have recommended that clinicians examine thyroid indices in women presenting with postpartum depression, acknowledging the strong association noted between hypothyroidism and depressive symptoms.[7–9] The consideration of these medical comorbidities during the initial step of screening for perinatal depression could further enhance the development of optimal treatment plans for patients and potentially improve remission rates as well.

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Manish Dama, BSc[a]
manish.dama@mail.utoronto.ca
Ryan J. Van Lieshout, MD, PhD, FRCP(C)[b]
Meir Steiner, MD, PhD, MSc, FRCP(C)[b,c]

[a]Department of Public Health Sciences, University of Toronto, Canada
[b]Department of Psychiatry and Behavioural Neurosciences, McMaster University, Canada
[c]Department of Obstetrics and Gynecology, McMaster University, Canada

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Dr Cox and Colleagues Reply

To the Editor: We thank Mr Dama and Drs Van Lieshout and Steiner for their response to our article the Perinatal Depression Treatment Cascade: Baby Steps Toward Improving Outcomes.[1] We appreciate their thoughtful comments and suggestions for additional screening recommendations. We fully agree that consideration of potential medical concerns, such as thyroid dysfunction and iron deficiency anemia, that can manifest as psychiatric illness, including major depression, ought to be considered when screening and evaluating all patients, particularly pregnant and postpartum women. In addition, a full evaluation for other medical causes of depression could also include examining levels of vitamin B_{12}, electrolytes, liver function, blood urea nitrogen, creatinine, and blood alcohol and screening for urine toxicology, HIV, and rapid plasma reagin. Thank you all for pointing out this gap; we agree that a full laboratory work-up for new-onset depression may be important to ensure that causal or comorbid medical issues do not go undiagnosed or untreated, thereby improving treatment outcomes for patients.

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Elizabeth Q. Cox, MD[a]
elizabeth_cox@med.unc.edu
Nathaniel A. Sowa, MD, PhD[a]
Samantha E. Meltzer-Brody, MD,MPH[a]
Bradley N. Gaynes, MD, MPH[a]

[a]Department of Psychiatry, University of North Carolina at Chapel Hill, Chapel Hill

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