



# PHYSICIANS' NEWSLETTER

## DEPRESSION during pregnancy

Tragic news headlines of recent years (think Andrea Yates of Texas or Toronto doctor Suzanne Killinger-Johnson) have brought the issue of post partum mood disorders to the forefront as a focus of concern. Negative outcomes of untreated post partum depression are well documented in the medical literature: family breakdown, self-harm, suicide and/or homicide. But by far, neglect of the infant and other children is the more common consequence of maternal illness. Children of depressed mothers are more likely to exhibit emotional and behavioural problems, and cognitive delay.

A long-held belief was that pregnancy provided some protection from depression for the mother. Evidence indicates that this is not true. Post partum depression may likely be part of a continuum of illness that begins during pregnancy or even prior to pregnancy. Because the focus has been on identifying women with post partum depression, many women who are depressed during pregnancy may be missed in the screening process.

Canadian Family Physician published an article in the August 2005 issue titled, "Depression during pregnancy," by Ryan, Milis and Misri.

### Abstract

**Objective:** To review existing literature on depression during pregnancy and to provide information for family physicians in order to promote early detection and treatment.



**Quality of Evidence:** MEDLINE was searched from January 1989 through August 2004 using the key words depression, pregnancy, prenatal and antenatal. Articles focusing on depression during pregnancy were chosen for review. These articles were based on expert opinion (level III evidence) and prospective studies (level II evidence).

**Main Message:** Pregnancy does not safeguard women against depressive illness. The Edinburgh Postnatal Depression Scale is an effective screening tool for identifying women with depressive symptoms during pregnancy. Once diagnosed with major depression, these patients need to

be monitored closely for up to one year after delivery. Patients with mild to moderate illness should be referred for psychotherapy. More severely ill patients might require additional treatment with antidepressants. The most commonly used antidepressants are selective serotonin reuptake inhibitors and the serotonin and norepinephrine reuptake inhibitor, venlafaxine. For each patient, risk of treatment with an antidepressant needs to be compared with the risk of not treating her depressive illness.

**Conclusion:** Early detection of depression during pregnancy is critical because depression can adversely affect birth outcomes and neonatal health and, if left untreated, can persist after the birth. Untreated post partum depression can impair mother-infant attachments and have cognitive, emotional and behavioural consequences for children.

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#### Insert with This Edition:

- Post Partum Support Reference Guide
- T-ACE Questionnaire

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When a patient is offered treatment for illness, please also consider referring her for some type of "talk" therapy, either cognitive behavioural or psychotherapy, in conjunction with antidepressant medications. The enclosed table provides a guide to finding an appropriate community support.

Many women also have access to EAP programs and private insurance, allowing them to access care with no wait times.

Screening using the Edinburgh Postnatal Depression Scale is an effective way of identifying women experiencing depression in pregnancy, thus establishing treatment prior to birth and minimizing the negative effects of depression in the post partum period.

A copy of this scale can be found at: [www.depressionafterdelivery.com/EdinburghDepTool.asp](http://www.depressionafterdelivery.com/EdinburghDepTool.asp)

#### References:

Murray L., Sinclair D., Cooper, P., Ducournau P., Turner P., "The socio-emotional development of 5 year olds with postnatally depressed mothers," *Journal of Child Psychology and Psychiatry*, 1999, 40:1259-71.

Evans J., Heron J., Francomb H., Oke S., Golding J., "Cohort study of depressed mood during pregnancy and after childbirth," *BMJ*, 2001, 323:257-60.

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## REGISTER NOW for Upcoming Workshop

### Prenatal and Postnatal MOOD DISORDERS WORKSHOP Wednesday, Nov. 1, 2006



This workshop is presented by the Reproductive Health Committee for health professionals, social services staff and anyone else working with pregnant women and new mothers. This year's focus is on mood disorders, no longer just a postpartum concern. Increasing evidence suggests there is onset of mood disorders during pregnancy and value in early diagnosis.

This workshop will increase attendees' knowledge and understanding of mood disorders in ante- and postpartum clients. Attendees will learn about relevant statistics, screening, treatment options, practice guidelines and local resources.

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# Working TOGETHER to prevent FASD

## The context of the problem

Alcohol is the most widely used teratogen among women of childbearing age and can have tragic consequences during pregnancy. Prenatal exposure to alcohol is a leading cause of preventable birth defects and developmental delays in Canadian children (Health Canada, 1996). There is no safe amount or safe time to drink alcohol during pregnancy.

The national rate of Fetal Alcohol Spectrum Disorder (FASD) is estimated at one per 100 live births (Public Health Agency of Canada, 2005). For this reason, education for pregnant women and community professionals is vital in order to aid in early identification of alcohol abuse and to reduce the risk of children being born with FASD.

## Physicians can make a difference

FASD is preventable. Alcohol use during pregnancy is the only cause of this lifelong disability. Therefore, physicians have an important role in asking women about their alcohol use and advising them that no alcohol during pregnancy is the safest choice. Physicians are the fundamental link in helping women change drinking behaviour.

## Pregnancy is an opportunity for change!

*Before pregnancy*, physicians can ask women of childbearing age about their alcohol use and state the importance of stopping drinking prior to pregnancy. Posters and patient handouts can be used to support clinical practices.<sup>1</sup>

*During pregnancy*, physicians can screen to identify "at risk" pregnant women and subsequently make referrals to appropriate programs and services if necessary to reduce the duration and severity of maternal drinking.<sup>2</sup> When asking women about alcohol use, it is important to use open-ended questions that do not suggest a negative response (e.g., "How much do you drink?" opposed to "You don't drink, do you?") Please see the T-ACE (Tolerance, Annoyance, Cut down, Eye opener) questionnaire included in this newsletter. It is an effective tool designed to guide questioning about women's alcohol use.

*After delivery*, physicians can look for signs of prenatal exposure to alcohol and make referrals for early diagnosis to improve long-term outcomes. Early diagnosis and appropriate intervention can make an enormous difference in the prognosis for the child.

## Community Support for Prevention

<sup>1</sup> The Haldimand-Norfolk Health Unit has public education resources available free of charge. If you are interested in ordering posters, brochures, or tear-off pads, please contact

Michelle Pasichnyk, Health Promoter at 519.426.6170 ext. 3274.

<sup>2</sup> Women requiring treatment and ongoing support can be referred to the Starting Point Program offered by Addiction Services, Haldimand-Norfolk Health Unit at 519.428.1805 ext. 3302. This program provides assessment, outpatient counselling, support and referral for pregnant and parenting women.

**BE SAFE . . .**

**Promote  
Alcohol-Free Pregnancies**



University of Toronto Study:

## Early Childhood Caries and infant oral health: Paediatricians' and family physicians' knowledge, practices and training

Early Childhood Caries (ECC) is a virulent, yet common, form of dental decay affecting the primary or "baby" teeth of infants and toddlers. Prolonged bottle-feeding with sugar-containing liquids, especially at bedtime, and delayed weaning are frequently regarded as ECC risk factors. Epidemiological studies have also recognized low socio-economic status, minority status, low birth weight and transfer of microbes from mother to child through the sharing of spoons and soothers as ECC factors. Children with ECC have difficulty chewing and eating. These children often require dental treatment under general anesthesia, resulting in large costs to the family and the health care system.



residency. Respondents who felt confident and knowledgeable and who considered their role in promoting oral health as "very important" were significantly more likely to carry out oral health-related practices.

Checklists, such as the Rourke Baby Record, endorsed by CPS and College of the Family Physicians of Canada recommend the first dental visit for children between two and three years of age. The findings of this study were consistent with this recommendation. However, earlier visits – within six months of the first tooth's

eruption or before one year of age – are now recommended by the American Academy of Paediatric Dentistry, the Canadian Academy of Paediatric Dentistry and the Canadian Dental Association.

Not all children have access to professional dental care. A child's first visit with a family physician or paediatrician typically occurs earlier than a child's first visit to the dentist. Guidelines advise primary health care providers to counsel families on teething and dental care, and to recommend the timing of the first dental visit. However, little is known about the preventive dental care practices of Canadian family physicians and paediatricians, the extent of oral health education and training they receive during medical school and residency training, and what knowledge of ECC and its preventive aspects these health professionals actually possess.

A recent Canadian study was conducted at the University of Toronto to assess the knowledge of early childhood caries and to examine the current preventive oral health-related practices and training among Canadian paediatricians and family physicians who provide primary care to children younger than three years. A cross-sectional, self-administered survey was mailed to a random sample of 1928 paediatricians and family physicians who provide primary care to children younger than three years.

### Results

A total of 1,044 physicians met the study eligibility criteria and, of those, 537 returned completed surveys, resulting in an overall response rate of 51.4% (237 paediatricians and 300 family physicians). Six questions assessed knowledge of Early Childhood Caries. Only 1.8% of paediatricians and 0.7% of family physicians answered all of these questions correctly. In total, 73.9% of paediatricians and 52.4% of family physicians reported visually inspecting children's teeth, while 60.4% and 44.6%, respectively, reported counselling parents or caregivers regarding teething and dental care. In addition, 53.2% and 25.6%, respectively, reported assessing children's risk of developing tooth decay, while 17.9% and 22.3%, respectively, reported receiving no oral health training in medical school or

There was also a perceived need for oral health information. The statistics show 85% of paediatricians and 92% of family physicians reported needing more information and resources on oral health topics. The most frequently requested topics were identifying ECC, dental caries prevention, and topical fluorides and fluoride supplements.

### Conclusion

The findings of the study suggest physicians are knowledgeable about some aspects of ECC and infant oral health, but not the identifications of ECC. The majority of paediatricians and family physicians considered their role in children's oral health as important and reported including certain aspects of oral health in well child visits. However, a reported lack of dental knowledge and training appeared to pose barriers, limiting physicians from playing a more active role.

### Reference:

P. Prakash, H.P. Lawrence, B.J. Harvey, W.J. McIsaac, H. Limeback, J.L. Leake, Early Childhood Caries and infant oral health: Paediatricians' and family physicians' knowledge, practices and training. *Paediatrics and Child Health* 2006; 11(3):151-157.

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