

Comments on “Does the Mode of Conception Influence Early Postpartum Depression? A Prospective Comparative Study from South India”

We read with interest the article titled “Does the Mode of Conception Influence Early Postpartum Depression? A Prospective Comparative Study from South India.”¹ However, we opine that the following aspects should be looked into:

First, the term “postpartum depression” (PPD) in the title is confusing because the first screening interview, done in the first week after delivery, often tends to overlook the depressive symptoms which could have been present before the delivery itself, screening of which was not done in this study. Reflection of a similar reason has been mentioned in *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, resulting in the change of the term to “peripartum onset,” also citing that almost 50% of previously termed “postpartum” depressive episodes might have their origin during pregnancy itself.

Second, this article has not taken into consideration the possibility of “postpartum blues” while stating that seven out of the 103 patients had postpartum depression. This is all the more possible because most of their symptoms abated after six weeks, which is far less than the modal distribution of a depressive episode, using only psychological means of management. Also, considering the far higher prevalence of postpartum blues, which ranges from 30% to 75% globally,² all the patients scoring ≥ 10 in Edinburgh postnatal depression scale (EPDS) are labeled as postpartum depression which seems incorrect. The threshold score for considering depressive illness and using diagnostic assessments has been judged to be 12 or 13 by Cox et al., questioning the threshold score of ten used in this study.³

Third, the rate of lower segment caesarean section (LSCS) in normal conception and assisted reproductive technologies (ART) groups has been found to be 72.7% and 96.3%, respectively. The higher rate of LSCS in the ART group is understandable considering at-risk mothers and valued pregnancies; however, normal vaginal delivery of only 27.3% in the normal conception group is significantly less than usual,⁴ an explanation of which is not provided, suggesting that most mothers were in the high-risk group. Furthermore, it has been seen that the prevalence of PPD is higher in patients with LSCS.^{5,6} Thus, had the LSCS rate been at par with normative data, a lower PPD occurrence was possible in the normal conception group, leading to a possible significant difference with that of the ART group. In other words, the LSCS rate might have acted as a relative confounder in this case. There is also a glaring error in Table 2 of this article, acting as a source of potential confusion in the minds of the readers, where one column heading is “Assisted Delivery,” which should have been probably “Assisted Reproductive Technologies” or “Assisted Conception.”

Fourth, the article does not name the structured assessments done to reach a diagnosis of depressive disorder and lacks clarity on the definition and severity of such disorders. Also, the fact that the details of the interviewer have not been mentioned puts a question mark over the competence of such an interviewer diagnosing depression using any assessment method.

Lastly, the family history of PPD has a significant role in its genesis, which was not assessed in the article.


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