

EDITORIAL

Towards improving recognition and management of perimenopausal depression

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“Sorrow which has no vent in tears
May make other organs weep.”
—Henry Maudsley (1835-1918)

In their study of obstetrician-gynecologists’ (ob-gyns’) screening and management of depression during perimenopause, Raglan et al¹ in this issue of *Menopause* found that, based on a survey of 500 practicing ob-gyns who were fellows of the American College of Obstetricians and Gynecologists and members of the collaborative Ambulatory Research Network, over a third of respondents reported that they did not regularly screen perimenopausal women for depression. Those individuals who reported higher rates of screening had higher quality education about depression, were more likely to be female, and have a personal experience of depression. A majority (85.7%) of respondents believed that they could recognize depression in perimenopausal women, but only slightly more than half (55.8%) were confident in their ability to treat this condition. The most commonly cited barriers to screening were insufficient time and inadequate training.

Some 6,000 US women reach menopause every day—more than 2 million women per year.² Currently, 41 million US women are postmenopausal (US Census Bureau). By the year 2030, more than 1.2 billion women in the world will be at least 50 years old.³ The menopause transition is a time of increased risk for new onset and recurrence of mood and other disorders⁴⁻⁶: In the 24 months surrounding women’s final menses, the risk was 14 times higher than for a 31-year premenopausal time period. Subsyndromal or untreated affective lability or depression may develop into a major depressive disorder, becoming more refractory to treatment, and increasing risks for insomnia,⁷ suicide, osteoporosis, and cardiovascular disease.⁸⁻¹⁸ Depression is the number one-ranked disease worldwide in women aged 5 and older, and the leading cause of disease burden.^{19,20} In the United States, almost 12.4 million women experience a depressive disorder each year—nearly

twice the rate for men.²¹ Untreated menopausal depression exacerbates psychiatric and medical illness, potentially becoming more severe and disabling, developing into suicidal²² or psychotic depression, and increasing the risk for insomnia (associated with a more persistent, and recurrent course of depression),⁷ osteoporosis, bilateral oophorectomy,²³ cardiovascular disease, and Alzheimer’s disease.⁸⁻¹⁶ In middle-aged women, depression increases the risk of dying from heart disease by 50%.²⁴ Poor sleep, fatigue, and low energy characterize depression, are the most common residual symptoms after treatment, and the best predictors of relapse and recurrent episodes.²⁵

Thus, there is a need for early recognition and treatment of an emergent depression. According to the model of conditioning, sensitization, and kindling for mood disorders, it is important to initiate interventions early in the course of a depressive episode to prevent progression of its severity, frequency, and recurrence.²⁶ This clinical phenomenon underscores the need for ob-gyns and other primary care physicians, who usually are the first-line practitioners for perimenopausal women, to receive adequate training in the recognition and initial treatment of depression in this otherwise underserved population. Respondents in the study survey who reported more comprehensive residency training or who had completed Continuing Medical Education in recognizing, diagnosing, or treating depression were more likely to screen for depression among perimenopausal women. Such training tends to be more available to physicians in a university setting, and those respondents to the survey who practiced in such a setting were the most likely to report that they screen perimenopausal patients for depression. As fewer than half of providers surveyed reported referring to or consulting with mental health providers when working with depressed patients, these findings stress the need not only for improved training especially to groups practicing outside of a university-based setting, but also for an ongoing mental health professional or consultation-liaison service to be part of the clinical team in both academic medical centers and other practice types. Although inadequate reimbursement was cited as a barrier to screening for perimenopausal depression in a third of the respondents, the high benefit and low risk for early recognition, treatment, or referral of perimenopausal depression would justify its expense. That it was female practitioners, who were younger, more frequently identified themselves as generalists, and who reported more personal

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experiences with depression, who were more likely to screen for perimenopausal depression lends credence to the finding of a large study from the Harvard Chan School of Public Health in 1.5 million patients that morbidity and mortality are decreased when patients are under the care of a female physician.²⁷ Female physicians also are more likely to offer preventative care.²⁸ Of note, from the study of Angst et al, is that men who previously were diagnosed with a depression in Zurich, Switzerland, subsequently “forgot” that they had experienced a depression in follow-up reports.²⁹

Presenting symptoms of depression may include sleep disturbance or hot flashes in perimenopausal women.³⁰ Perimenopausal depression also may present with more anxious, agitated features with more mood lability, and selective norepinephrine reuptake inhibitors may be indicated for those women not on estrogen hormone therapy.^{31,32} Also, because progesterone hormone therapy, in particular, may exacerbate depression in predisposed women with a previous personal or family history of depression, a risk factor for perimenopausal depression,³³⁻³⁵ practitioners caring for perimenopausal women would be advised to be on the alert for depressive symptoms in these women especially. Because depression can be a manifestation of underlying thyroid disease exacerbated in the perimenopause, it is worthwhile to check thyroid function tests at this time.³⁶ Although simply asking about depressed mood, sleep, energy, appetite, and anhedonic symptoms, cognitive disturbances or suicidal ideation is the best way to screen patients, given time limitations; an alternative method would be to administer a screening instrument such as the Beck Depression Inventory,³⁷ as long as a clinician provides prompt follow-up for anyone who has elevated ratings (>10) or who endorses suicidal ideation.

Thus, towards preventing the adverse consequences of depression in perimenopausal women, more comprehensive training in its recognition, diagnosis, treatment, and referral, when appropriate, should be encouraged amongst ob-gyns and other primary care physicians. As Henry Maudsley observed in the opening quote, “Sorrow (depression) which has no vent (expression) in tears (or other forms of release) may make other organs weep.”

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