

Premature Birth: The answers can't come soon enough

Many known factors are associated with preterm birth. Risk factors for prematurity include, but are not limited to, previous preterm birth, multiple births, anatomical abnormalities, maternal and fetal stress, infection, smoking and substance use. Yet, the cause of preterm labor is unknown in over half of premature births.

Every day in the United States, over 1,280 babies are born prematurely. In California, approximately 1 in 10 infants are born too soon. The average percent of preterm live births from 1997-2000 in San Diego County is 10.1 and Imperial County, 10.9. The goal set in the Healthy People 2010 Objective for preterm births is 7.6% of live births (source: <http://peristats.modimes.org/>).

The emotional and economic toll associated with prematurity is substantial for families and communities. Premature birth is the leading cause of death in the first month of life. And of the preemies who do survive, up to half may have lifelong health problems. Mental retardation, vision and hearing problems, chronic lung disease, asthma, and cerebral palsy are just a few of the possible consequences of premature birth.

The March of Dimes is dedicated to meeting the challenge of premature birth, and in January 2003 launched a major health initiative, the Prematurity Campaign. The goals of the 5-year campaign are

to increase public awareness of prematurity and to decrease the rate of prematurity. To do so, the March of Dimes will raise public awareness, educate pregnant women, assist health care practitioners with educational tools, invest in research into the causes of premature birth, and advocate for access to health insurance.

A major focus of the campaign is to teach women to recognize the signs and symptoms of premature labor. While some women may not have any symptoms, warning signs for preterm labor may include contractions, low dull backache, pelvic pressure, cramps, and increased vaginal discharge. Women are urged to contact their health care provider when they have any signs of preterm labor, because waiting too long may result in the lifelong sequelae of prematurity.

The March of Dimes is an excellent source for answers. The Pregnancy & Newborn Health Education Center provides free, one-on-one, confidential support and information in English (1-888-MODIMES, i.e., 1-888-663-4637, www.marchofdimes.com, or oraskus@marchofdimes.com) and Spanish (1-800-925-1855 or www.nacersano.org) The March of Dimes can also provide materials to educate women about the importance of recognizing the signs and symptoms of premature labor.

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Mental Health Challenges for New Mothers: Identifying and treating patients with postpartum depression and diabetes-related depression

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Most mothers will agree: the joys of motherhood also come with its own set of challenges and frustrations. For some mothers, the onset of postpartum depression and depression from diabetes (Type I, II or gestational) can create a tense and difficult environment that can exacerbate this dynamic.

Postpartum disorders include two distinct diagnoses: 1) postpartum blues or “baby blues” and 2) postpartum depression (PPD). To differentiate, postpartum blues is very common, occurring in up to 80% of new mothers (National Mental Health Association [NMHA], website retrieved December 16, 2002). About two to five days after birth, feelings of depression, anxiety, or anger can surface, but are only temporary and often subside in a few hours or a week without treatment (Medem, website retrieved December 16, 2002).

Postpartum depression occurs among 10-20% of new mothers and is understood to be an affective disturbance characterized by such feelings of anxiety, despair, tearfulness, loss of libido, fatigue, decreased appetite, dependency or irrational fears about the baby’s or one’s own health (Horowitz, Damato, Solon, Von Metzch, Gill, 1995).

Symptoms manifest most often in the 6-12 weeks following delivery and unlike postpartum blues, the PPD period can extend from 6-12 months after the birth with mild or severe symptoms (Medscape, 2002) (Horowitz J.A., et al., 1995). Although the exact causes of PPD are unknown, changes in hormones are believed to play a major role and not every mother will experience the same symptoms (Colino, 2002).

Women with a previous history of depression and/or PPD, or a family history of depression are at an increased biological risk for developing PPD (Medscape, 2002). Studies have shown that the more depressed a new mother is, the greater the delay in the infant’s development (NMHA, 2002).

Along with postpartum disorders, new mothers also face the possibility of experiencing depression stemming from their diabetes (Type I, II or gestational). Diabetics often feel overwhelmed, frustrated, fed up or “burned out” by the daily hassles of diabetes management and the seemingly unending self-care demands (Polonsky & Welch, 1996). The daily rigors of monitoring glucose levels, charting the exact amounts and types of food eaten, along with maintaining their exercise regimen are stressors that can adversely affect the proper treatment of diabetes. Diabetes-related emotional distress is apparently quite common, and approximately 15-20% of adults with Type I or II diabetes suffer from major depression, a rate some three times higher than that observed in the general US population (Polonsky & Welch, 1996) (Lustman & Clouse, 1997).

Symptoms of diabetes-related depression include diminished interest in almost all activities, persistent focus on somatic complaints, chronic pain as a dominant complaint, and feelings of worthlessness or guilt (Lustman & Clouse, 1997). Diagnostic criteria for major depressive disorder are based on the Diagnostic and Statistical Manual of the American Psychiatric Association 5th Edition (DSM – V).

Without proper treatment of diabetes-related depression, mothers put their babies’ health and their own health at great risk. Diabetes complications such as poor glycemic control, macrovascular complications, retinopathy and coronary artery disease are more prevalent in depressed patients compared to those without depression (Lustman, Clouse & Freedland, 1998).

In order to address the issues of PPD and diabetes-related depression, health care practitioners such as OB/GYNs, primary-care physicians, pediatricians, nurses, midwives and mental health professionals such as psychologists and social workers, must be aware of these mental health issues in new mothers. The onset of depression is a very real and common occurrence for our patients.

An effective and easy to administer tool in identifying at-risk patients includes a breadth of mental health evaluation instruments. A sample list of such paper and pencil tools include the following: Problem Areas in Diabetes Survey (PAID), the Beck Depression Inventory (BDI), Zung Depression Scale, Brief Symptom Inventory (BSI), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Adjective Check List (DACL), Edinburgh Postnatal Depression Scale (PPD), Postpartum Depression Screening Scale, and SADS – Pregnancy and Postpartum Guidelines (Horowitz, et al., 1995)(Colino, 2002). For example, utilization of the Problem Areas in Diabetes survey in conjunction with the Postnatal Depression Scale instrument will not only provide an assessment of how a patient is dealing with her diabetes, but will also continue to assess her mental health postpartum. Surveys can be administered while the patient is in the waiting room, and reviewed by the health care professional during the mother’s prenatal, postpartum or well-baby appointments.

Once diagnosed, treatment for depression includes therapies such as psychotherapy and pharmacotherapy. New studies have proven antidepressant medication is safe for nursing mothers, but warns against prescribing sedating medications, such as doxepin, Limictal and lithium (Colino, 2002). However, physicians prescribing anti-depressants should also be aware of medications that can adversely affect blood glucose levels in diabetics.

The key issue in this discussion is identifying patients who may show symptoms of developing depression and then treating the condition. Up to 50% of all PPD goes unrecognized in primary-care practices (Colino, 2002), and major depression in diabetes is recognized in only about one-third of all cases (Lustman & Clouse, 1997). Although pediatricians have not been trained in spotting PPD, they will most likely have more contact with the mother postpartum and are key individuals in being able to refer the mother for care (Colino, 2002). Family and friends also provide significant insight to a mother’s mental health and to how she is coping with the significant changes in her life.

Motherhood is a challenging and rewarding role for many women. Identifying difficult times and seeking help during this process is just part of this exciting continuum in our patients’ lives.

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National Mental Health Association. (2002). Retrieved December 26, 2002, from Web site: www.nmha.org

Polonsky, W.H. and Welch, G.M. (1996). *Listening to our Patients’ Concerns: Understanding and Addressing Diabetes-Specific Emotional Distress*. *Diabetes Spectrum*, Vol. 9, No. 1, 8-11.

Additional information and resources –

- County of San Diego, Mental Health Crisis number Crisis Team Counseling Line (619) 557-0500 or 1-800-479-3339
- County of San Diego, Perinatal Care Network 619-692-8428 or 800-675-2229
- County of San Diego, Public Health Nurses 619-515-4209
- California Diabetes and Pregnancy Program 858-467-4990
www.regionalperinatalssystem.org/sweet_success/htm
- San Diego Postpartum Health Alliance 619-685-7485 or www.postpartumhealthalliance.org
- San Diego Association of Diabetes Educators
- American Diabetes Association 619-234-9897 or 1-888-DIABETES www.diabetes.org
- National Mental Health Association www.nmha.org
- National Institute of Mental Health www.nimh.nih.gov

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The Regional Perinatal System and the San Diego-Imperial Division of the March of Dimes have formed a partnership to explore prematurity prevention strategies for San Diego and Imperial Counties. A Prematurity Prevention Leadership Team is being developed to explore local options and approaches, including the formation of a San Diego and Imperial Counties Collaborative. The Prematurity Prevention Leadership Team and Collaborative will work together to positively influence outcomes in our communities. The answers can't come soon enough to eradicate prematurity, yet together we can make a difference.

For more information and materials, contact:

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Article Provided by Nicole Giangregorio.

The Southern California Dispatch Center Announces New Changes

The Southern California Dispatch Center announces new and exciting changes! Most importantly, the program is changing its name to the **Southern California Perinatal Transport System (CPeTS)**.

The new name will more accurately describe CPeTS' role as a resource to the medical community. CPeTS does not coordinate the transfer of patients; rather, its purpose is to report the available bed space for hospitals to identify medical facilities that are open to accept transported patients.

The Southern California Perinatal Transport System has also relocated to the Regional Perinatal System (RPS). The partnership with RPS and its associate programs is an exciting collaboration that will enhance CPeTS' community outreach and building relationships with perinatal professionals and medical facilities. Furthermore, CPeTS will be recruiting community members to participate in Regional and State Task Forces to implement quality improvement strategies and share best practices.

CPeTS is currently in the process of implementing a web-based, on-line, self-reporting bed space locator system scheduled for completion in Spring 2003. Once completed, hospitals will have the capability of reporting the number of available bed space in their respective NICUs on the Internet.

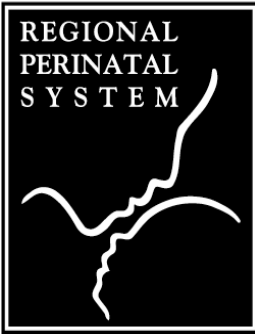
This self-reporting mechanism will ensure the most up to date information is available to medical facilities needing to transport patients to the most risk appropriate hospital. In the interim, CPeTS will continue to conduct weekly telephone calls to individual NICU departments to assess the number of available acute beds in the NICU.

Additionally, CPeTS plans to revise the Infant Transport Record (ITR) forms that are used to document maternal and neonate transports. The revised form will be more "user friendly" to ensure more accurate reporting, as well as collecting new qualitative and quantitative information to track trends in both maternal and infant transports. The Regional and State Task Forces will have an integral role in the ITR form revision process.

The Southern California Perinatal Transport System looks forward to creating new and exciting opportunities for perinatal professionals during its three-year contract period. If you have

any questions or would like more information about CPeTS, please feel free to contact Cathreena San Juan Kang, CPeTS Program Coordinator, at 858-467-4990 or email her at csanjuankang@ucsd.edu.





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UPCOMING CONFERENCES

AWHONN

May 30 – June 4, 2003
Milwaukee, WI

Visit website for Conference information at: www.awhonn.org

UPCOMING CLASSES

AWHONN Advanced Fetal Monitoring - UCSD Medical Center

March 17, 2003
Call (858) 467-4990

Neonatal Respiratory Care in the New Millennium - UCSD Medical Center

April 2, 2003
Contact Mary Hackim @ 619/543-3519

OB Recovery Room Charge - Scripps Mercy Hospital

May 29 & 30, 2003
Contact RPS @ (858) 467-4990 for registration information.

Maternal Newborn Nursing Care – SAVE THE DATE: July/August 2003, call RPS @ (858) 467-4990

