

## The Edinburgh Postnatal Depression Scale in routine screening: errors and cautionary advice



**TO THE EDITORS:** We read with interest the recent article by Venkatesh et al<sup>1</sup> regarding the implementation of routine antenatal and postnatal screening for depression for women in the perinatal period in Massachusetts, using the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al<sup>2</sup>). We would like to make some observations about this study and its wider implications for other services considering the use of this self-report scale.

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1. As the authors correctly state, many studies use a cut-off score of  $\geq 12$  on the EPDS.<sup>2</sup> This, however, is often due to an error in these studies reporting the validation study by Cox et al,<sup>2</sup> in which  $\geq 13$  was in fact the validated cut-off score for English-speaking women in the postpartum period. This error has previously been shown to be frequent, and that a difference of just 1 point in the cut-off score does indeed have a significant impact on findings and is not just trivial.<sup>3</sup> Unfortunately this mistake is often still being made, and thus gives the impression that  $\geq 12$  is the validated cut-off score for English-speaking postpartum women, when it is not.

Indeed, it is somewhat concerning that the authors themselves have made a similar type of error. They cite Murray and Carothers<sup>4</sup> as evidence for studies using  $\geq 12$  as the cut-off score, when that article does not in fact make any recommendation for this score, but highlights (without making any specific score recommendations) the scores of  $\geq 11$  and  $\geq 13$ , and discusses that Cox et al<sup>2</sup> found  $\geq 13$  to be the optimal cut-off score.

2. Venkatesh et al<sup>1</sup> used the same EPDS cut-off score for the antenatal and postnatal periods, without commenting on the research showing that different cut-off scores are required for the 2 time periods.<sup>3</sup> In addition it is important that services know that there is considerable evidence that different cut-off scores on the EPDS are required for women (and men) from different cultures.<sup>3</sup>
3. While Venkatesh et al<sup>1</sup> report that the EPDS data were successfully entered into the electronic medical record, this does not necessarily mean that the score that was entered was in fact correct. Services need to be aware that the accuracy of clinicians scoring the EPDS has been shown to be very poor,<sup>5</sup> even among those who provide training in the use of this scale. ■

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### REFERENCES

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### REPLY



We thank Dr Matthey and colleagues for their interest in our work, and for highlighting the impact of varying cut-off scores of the Edinburgh Postnatal Depression Scale (EPDS) and its implications for depression screening. The authors highlight the impact of using a higher cut-off score to screen positive for depression used in some earlier validation studies of the EPDS (ie,  $\geq 13$  rather than  $\geq 12$ ), as well as evidence suggesting different cut-off scores may be optimal for the antepartum and postpartum periods, and in women of different sociocultural backgrounds. We note that the authors have a recent publication indicating that in their population, they transitioned from using a cut-off of  $\geq 10$  to  $\geq 13$  for EPDS administered at the time of the first prenatal visit and found that they were able to decrease resource utilization without measuring a significant impact on patient care.<sup>1</sup> We agree that with the implementation of any screening program, it is important to recognize the tradeoffs in sensitivity