

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 al¹ 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 al²). 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 ≥ 12 on the EPDS.² This, however, is often due to an error in these studies reporting the validation study by Cox et al,² in which ≥ 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.³ Unfortunately this mistake is often still being made, and thus gives the impression that ≥ 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 Carothers⁴ as evidence for studies using ≥ 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 ≥ 11 and ≥ 13 , and discusses that Cox et al² found ≥ 13 to be the optimal cut-off score.

2. Venkatesh et al¹ 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.³ 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.³
3. While Venkatesh et al¹ 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,⁵ even among those who provide training in the use of this scale. ■

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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, ≥ 13 rather than ≥ 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 ≥ 10 to ≥ 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.¹ We agree that with the implementation of any screening program, it is important to recognize the tradeoffs in sensitivity

and specificity that are inherent in utilizing a specific threshold for further evaluation, and understanding the resources available in a particular clinical context helps to inform these decisions.

In the current study, we employed a cut-off score of ≥ 12 for further mental health evaluation to increase sensitivity both antepartum and postpartum, and to minimize missing women at risk. Women only underwent further treatment for depression following a formal psychological assessment after screening positive. Importantly, this study demonstrated the feasibility to implement a universal depression screening program within the context of existing clinical resources devoted to routine antepartum and postpartum obstetrical care. We agree that accurate scoring of the EPDS is critical to any screening program. Beyond routine implementation of EPDS administration, we agree that there is a need to enhance the efficacy, equity, and efficiency of screening by optimizing provider training and gaining a greater understanding of the best timing for administration as well as the optimal cut-offs for different populations. ■

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Urinary incontinence after hysterectomy



TO THE EDITORS: We read with interest the article of Bohlin et al¹ about urinary incontinence (UI) after hysterectomy. Based on a large cohort study, the authors stated that several factors, including vaginal delivery, body mass index, and preoperative urgency, influenced the rate of UI after hysterectomy. However, the authors did not underline the confusion made between urge UI (UUI) and stress UI (SUI). It is mandatory to comment on this point, because the absence of distinction between UUI and SUI can be misleading for several reasons.

First, distinguishing SUI and UUI (and their association, called mixed incontinence) is of importance because both are highly prevalent and often associated. The prevalence of overactive bladder (OAB), ie, urgency with or without incontinence, is estimated to be 11.8%,² varying from 1.8-30.5% in a recent article by Milsom et al.³ Separating SUI and UUI would thus have led to groups of similar size based on patient characteristics and would have likely influence the results in a logistic regression analysis.

Then, the pathophysiology of UUI and SUI is completely different, as are the therapeutic resources.⁴ While SUI has a complex but known interaction with pelvic organ prolapse, UUI belongs to the field of OAB and has very unclear links with pelvic organ prolapse and other gynecologic disorders, based on low-level inconsistent evidence.⁵

Lastly, the authors consider “daily urge” as a criterion in their logistic regression analysis. As a component of OAB, but not necessarily associated with UUI, this parameter cannot be interpreted correctly in the current context. Indeed, this

category can reflect OAB without incontinence, that is idiopathic in the vast majority of cases and would not be impacted by hysterectomy. On the other hand, this category of “daily urge” surely includes all patients with UUI, but their proportion can only be postulated. Unfortunately, this “daily urge” status is not available in the postoperative setting. Furthermore, the absence of data regarding antimuscarinic therapy is also another important caveat.

Not taking into account that UUI and SUI are 2 different diseases blurs the analysis and limits sound conclusions. ■

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