TO THE EDITORS: We read with great interest Miller et al’s report on the association between antenatal depressive symptomatology and adverse pregnancy outcomes. In this large, multisite prospective cohort of nulliparous women across the United States, the depressive symptoms were measured using the Edinburgh Postpartum Depression Scale (EPDS), a 10-item self-report scale at 2 study visits—the first between 6 and 14 weeks of gestation and then again between 22 and 30 weeks—where women with depressive symptoms that worsened as the pregnancy progressed had greater odds of preterm birth.

These findings are clinically relevant, because despite advances in medical care, rates of preterm birth have increased in the last few decades, and antenatal depression has been identified as a risk factor for postpartum depression and adverse neonatal outcomes including preterm labor, low birthweight, and neonatal complications associated with increased morbidity and mortality in infants.

However, we feel it is also necessary to bring attention to some considerations emerging from the method used for this original analysis. Firstly, EPDS is a widely used instrument for the screening of depressive symptoms, but its 3-factor structure, that is, "depression" (items 7–10), "anxiety" (items 3–6), and "anhedonia" (items 1–2) might also help elucidate the spectrum of maternal gestational psychological problems and the contributing role of the anxiety and anhedonia dimensions. Secondly, the existence of separate anxiety and depression dimensions within the EPDS has been reported previously. Symptoms related to anxiety during gestation and immediately after delivery are frequent, and several studies have suggested that anxiety may also be associated with both negative pregnancy outcomes and the etiology of preterm birth. Theoretical models have been developed to explain the biologic effect of prenatal maternal mental health problems such as the physiological stress response of the hypothalamic-pituitary axis that is regulated by the corticotrophin-releasing hormone. The pathways by which the maternal mental health problems initiate a physiological sequence of events that promote early labor, however, remain largely unknown.

We strongly agree with their recommendation for future research to optimize and implement effective prevention, screening, and treatment protocols for antenatal depression as a strategy to prevent preterm birth. Along the same line of thought and considering the role of psychological distress conditions such as depression and/or anxiety during pregnancy as risk predictors for adverse birth outcomes and preterm birth, we suggest that the EPDS anhedonia, anxiety, and depression subscales be considered separately in the overall prematurity risk calculation to guide future clinical and research practices.

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