



Association of postpartum depressive symptoms and urinary incontinence. A cohort study



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ABSTRACT

Objective: Our objective was to clarify whether de novo urinary incontinence (UI) in the postpartum period is associated with depressive symptoms or antidepressant drug consumption.

Study design: 2002 pregnant women were recruited between 2003 and 2006 for the EDEN mother–child cohort. This analysis included 1413 women who reported no UI before pregnancy. Severity of UI was assessed by the Sandvik index. At 4 and 12 months postpartum, depressive symptoms were assessed by the Edinburgh Postpartum Depression Scale (EPDS ≥ 10 defines depressive symptoms) and consumption of antidepressant drugs was reported.

Results: At 4 months postpartum, 198 women (14%) reported de novo UI; 74% ($n = 146$) reported mild UI, 26% ($n = 52$) moderate, and none severe; prevalence of depressive symptoms was higher in women with than without UI (22.1% vs. 15.9%, $p = 0.045$), and consumption of antidepressant drugs was more frequent (4.7% vs. 1.4%, $p = 0.005$). At 12 months postpartum, the mean (\pm SD) EPDS score differed between women with than without UI (7.30 ± 3.46 vs. 6.57 ± 3.72 , $p = 0.016$) but was half that at 4 months postpartum. The incidence of new cases of depressive symptoms or antidepressant consumption at 12 months was greater with than without UI (23.8% vs. 15.3%, $p = 0.012$).

Conclusions: Although UI is mild in most cases at 4 months postpartum, it is followed by more new cases of depressive symptoms or antidepressant consumption at 12 months.

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Introduction

Urinary incontinence (UI) is a common symptom after childbirth [1]. Most often postnatal UI is moderate and regresses after a few months [2]. However, it can also persist and lead to deteriorated quality of life and requests for care later in life [3,4]. Fear of postnatal UI can motivate women or obstetricians to request elective caesarean section even without a medical indication [5].

The postnatal period is also a period susceptible to depressive symptoms, sometimes severe, that could impair the relationship between the mother and her baby or even lead to suicide [6]. In the general population, women with UI may be more depressed than others [7]. Postnatal UI appearing de novo in women who were continent before pregnancy may induce or increase a depressive syndrome. The few studies of the postnatal period show that postnatal UI is associated with depressive symptoms [8,9]. However, these investigations did not determine a causal link between the two situations.

A priori, risk factors of postnatal UI and those of postpartum depression differ. The main risk factors for postnatal UI are obesity, maternal age, and vaginal childbirth. Muscle and neurological vaginal birth trauma could explain the postnatal UI [10]. The main risk factors for postnatal depression are personal or family history

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of depression, stressful life events, low partner support, or social isolation [11,12].

We aimed to test whether de novo postpartum UI is related to altered mood or taking psychotropic drugs and whether this association is maintained or increases over time.

Materials and methods

The data were derived from the EDEN cohort (Etude sur les Déterminants pré et postnataux précoces du développement psychomoteur et de la santé de l'Enfant, <https://eden.vjf.inserm.fr/index.php?lang=en>), whose aim was to study the pre- and postnatal determinants of child development and health. Study participation was proposed to all women visiting the prenatal clinic before their 24th week of pregnancy in the university hospitals of Nancy and Poitiers, our aim was to recruit women as early in pregnancy as possible [13]. Exclusion criteria were multiple pregnancies, known diabetes before pregnancy, French illiteracy or planning to move out of the region within the next three years. Among the 3758 women invited to participate, 2002 (53%) accepted to be enrolled in the study. Recruitment started in February 2003 and lasted 27 months in each centre (1034 women from Nancy and 968 from Poitiers). On average, women were included at 15 weeks of pregnancy (range: 8–26). Their mean age was 29 years (range: 18–44) and 30% of the women were pregnant for the first time. Compared to the 2003 Enquête Nationale Périnatale (National Perinatal Survey: a sample of births recruited throughout the country) [14], women included in EDEN and still followed-up at delivery, had a higher level of education.

To be included in this secondary analysis, the women had to complete a questionnaire about UI mailed 4 months after childbirth and declare that they did not have UI before the pregnancy. UI 4 months after birth was defined by a positive response to the question “during the past month have you had involuntary leaking of urine?” The severity of incontinence was assessed by the Sandvik severity index [15]. This index is the product of the frequency and volume of leaks, ranging from 0 to 8. Four classes are defined for UI severity: 0, no incontinence; 1–2, mild incontinence; 3–4, moderate incontinence; 6–8, severe incontinence.

Depressive symptoms were assessed by questionnaires mailed 4 and 12 months postpartum by 2 indicators. The first, the Edinburgh Postpartum Depression Scale (EPDS), is a 10-item questionnaire, responses to each item ranging from 0 to 3 [16]. The overall score ranges from 0 to 30; a score of 10 or higher defining probable depression. The second relates to the consumption of antidepressant drugs in the month preceding the mailed questionnaire.

Anthropometric and socio-demographic characteristics were maternal age at delivery grouped into 4 classes: <25 years, 25–29, 30–34, ≥35 years; educational level in 4 classes: below high school diploma, high school diploma or equivalent, first university degree, above first university degree; occupational group in 5 classes: (1) managers or professionals; (2) middle management; (3) office or clerical workers and civil servants; (4) other employees in shops or services, farmers, and workers; (5) no paid occupation; marital status: married, part of an unmarried couple, or single; and body mass index (BMI). Tobacco use in pregnancy and at 4 months postpartum was described in dichotomic variables as smokers or non-smokers. For obstetric history, we retained the number of deliveries and their mode (caesarean delivery only, at least one vaginal delivery); history of birth of a baby weighing ≥4 kg; and for the last delivery, mode of delivery (caesarean, vaginal spontaneous, vaginal instrumental) and active second phase more than 30 min. Breastfeeding was

considered in 4 modalities: no breastfeeding, ≤10 weeks, 11–17 weeks and still breastfeeding at 4 months at completion of the questionnaire.

UI was described by its incidence. Risk factors were studied by bivariate analysis of the relation of obstetric and socio-demographic data and UI (no, mild, moderate) by chi-square test. The relation between de novo UI and postpartum depressive symptoms was studied by comparing the proportion of depressed women and women consuming antidepressant drugs at 4 and 12 months. We also studied new cases of depressive symptoms at 12 months after excluding cases reporting depressive symptoms at 4 months. The mean change in EPDS score between months 4 and 12 postpartum was compared for women with and without de novo UI at 4 months; we also analysed new cases of consumption of antidepressant drugs. Then to evaluate the relation between UI and several risk factors simultaneously, multivariate analysis was performed by polytomous logistic regression; only variables with $p < 0.20$ on bivariate analysis were introduced in the multivariate model, except for centre and mode of delivery which were forced in the multivariate model. A last analysis restricted to women respondent to follow-up questionnaires (4 and 12 months) was undergone to evaluate the relationship between UI and depressive symptoms or antidepressant consumption, we used chi-square test for nominal variables and t test for continuous variables; adjusted OR for age, occupational group, marital status, parity, and centre were estimated using a logistic regression.

Data were analysed with SAS 9.2 (SAS Inst., Cary, NC). $p < 0.05$ was considered statistically significant.

The EDEN study received approval from the ethics committee (CCPPRB, Comité Consultatif de Protection des Personnes en matière de Recherche Biomédicale) of Kremlin-Bicêtre Hospital on December 12th, 2002. Informed written consent was obtained from mothers for herself at enrolment and for her newborn child after delivery. The data files were registered with the French Data Authority (CNIL, Commission Nationale Informatique et Libertés).

Results

Among the 2002 women recruited during pregnancy, 1413 (71%; mean age 29.5 years ±4.7, range 17–44 years) were included in this analysis; 353 women who had not responded to questions about UI and 236 who reported UI before pregnancy were excluded. Included women were older, with a higher educational level, were more often in couple, and had a lower parity than excluded women (Supplementary Table S1). In total, 14% ($n = 198$) declared de novo UI at 4 months postpartum; 74% ($n = 146$) were mild, 26% ($n = 52$) moderate, and none severe UI. The incontinence was related to stress only (leakage during physical effort, coughing, or sneezing) for 37% ($n = 74$), urge only (leakage related to an urgent need to urinate) for 9% ($n = 18$), mixed (stress and urge) for 47% ($n = 93$) and other 7% ($n = 13$). Table 1 shows the frequency of the postpartum urinary incontinence and its severity by medical and socio-demographic characteristics. Moreover, the frequency of UI and its severity were not at all related to smoking during pregnancy neither at 4 months postpartum.

In the multivariate model of UI (no, mild, moderate), factors contributing to UI were the occupational group, with the lowest risk among the more qualified occupations and a higher risk of moderate incontinence among women without a paid job, as well as duration of the second active phase of the last delivery, with a higher risk among women with a second phase of labour ≥30 min (Table 2).

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