Re: Maternal Depressive Symptomatology: 16-Month Follow-up of Infant and Maternal Health-Related Quality of Life

To the Editor: As a Doctor of Nursing Practice working as Nursing Unit Director in a maternal/newborn setting at an academic medical center, I read with great interest Darcy et al's[1] recent article "Maternal Depressive Symptomatology: 16-Month Follow-up of Infant and Maternal Health-Related Quality of Life." The authors should be commended for researching the long-term effects of postpartum mood disorders after new mothers' transition home from the hospital setting. I am impressed this study is a part of the Weaving Work and Family Project: Implications for Mother and Child.[2] For nurse clinicians and managers, postpartum mood disorders are a challenging aspect of maternal newborn care. Hillerer et al[3] propose that maternal adaptations, such as decreased anxiety and attenuated stress responsiveness, are necessary to enable successful postnatal development of the offspring.

Many devastating consequences of postpartum mood disorder could be avoided with early identification and referral to psychosocial support in the pre- and postnatal settings. There are multiple opportunities for health care providers to monitor and intervene in the prenatal setting when there is evidence of maternal stressors. For example, in the article Darcy et al identify significant depressive symptomatology among African American women aged 18 to 24 years who are impoverished and unwed. Tarantino et al[4] establish that the etiology of complex psychiatric disorders result from both genetics and the environment. No definitive environmental factor has been implicated, but studies suggest that deficits in maternal bonding many be an important contributing factor in the development of anxiety and depression. It is possible that neither race nor socioeconomic statuses are factors in assessing or predicting postpartum mood disorders.

Another aspect discussed in the article is an increase in newborn diarrhea and frequent visits to the pediatrician. Talge et al[5] determined that maternal and antenatal stress is associated with adverse neurobehavioral outcomes in off spring. including both social/emotional and cognitive functioning during childhood and later in life. I recommend that we inform prenatal patients about work and life stressors and how to address them. Some of the most tragic stories in the media pertain to postpartum mood disorders undetected in the pre- and postnatal settings and the outcome of infanticide. Further research is needed to determine if observed research is causal. Such research is beneficial if more interdisciplinary teams study this problem. Regardless of the mother's ethnicity, the prenatal setting is key to the prevention of negative outcomes of postpartum mood disorders in the community, and it is an opportune setting in which to provide counseling and education to assist childbearing women in making informed choices about postpartum mood disorders once the diagnosis is known. Using best practices to support childbearing families is a high priority. Darcy et al[1] are commended for the longitudinal study on postpartum mood disorders and the quality of life for both mother and baby.

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The authors of the original manuscript declined to respond to this letter.

Re: Irritable Bowel Syndrome: A "Mesh" of a Situation

To the Editor: We read with great interest Dr. Barnes'[1] brief report and literature review in the January/February 2012 issue of the *Journal of the American Board of Family Medicine*. He describes a fascinating case in which the symptoms of irritable bowel syndrome (IBS) result from a rare mechanical cause: mesh herniorrhaphy. He demonstrates the value of meticulous history taking, examination, and investigation in patients with IBS, particularly if medical management proves ineffective. Dr. Barnes' case acts as a reminder of the challenges that diagnoses of IBS (and other diagnoses of exclusion) pose, and we believe it is pertinent to briefly elaborate on this.

Well-known examples of diagnoses of exclusion (*per exclusionem*) include IBS, "fever of unknown origin," chronic fatigue syndrome, and fibromyalgia. Although these conditions have well-researched questionnaires and assessment tools (eg, for bowel dysfunction),[2] there is a fundamental lack of understanding of both the underlying pathophysiology and the mechanism of action of their treatments. We do not imply that these conditions are without a pathologic process, nor do we suggest that they are fictitious or "psychological" (an anecdotal opinion of some physicians); rather, we believe that they represent heterogeneous clusters of unknown pathologic processes, grouped by symptoms. Forming these diagnoses occurs without objective verification, often after a crude process of elimination. In reality, we think this highlights an intrinsic desire of doctors to provide a diagnosis for patients. This diagnosis then acts as a basis on which to initiate treatment and provide, to the extent of the abilities of a modern physician, a form of reassurance to both doctor and patient. However, the use of a diagnosis of exclusion unfortunately can be tantamount to saying that a true diagnosis is not known. Herein lies the problem with modern medicine—we can image the functioning brain and examine the deepest recesses of the human body, but we remain uncomfortable uttering 3 words: "I don't know."

To progress as a profession, we need to understand that a diagnosis of exclusion should be seen as a target for research. Individual pathologic processes must be elucidated carefully if we are to understand the myriad conditions that contribute to the aforementioned umbrella terms. Sunderji et al[3] utilized electrocardiography in an attempt to elevate tako-tsubo cardiomyopathy from a diagnosis of exclusion. Ultimately, they failed, further highlighting the difficulty of these diagnoses. We must not be discouraged, but rather, continue the quest to find the best methods of discerning the constituent parts of these diagnoses. After identifying these problems we will be in a position to generate diagnoses of *inclusion* rather than exclusion. We will then be better able to diagnose and treat our patients, which, ultimately, is the *raison d'être* of a doctor.

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Irritable Bowel Syndrome: A "Mesh" of a Situation

To the Editor: I greatly appreciate Drs. Norris and McGowan's correspondence and I share their many concerns. I certainly agree that, as physicians, we should be monitoring constantly those patients with diagnoses of exclusion or we may easily miss the true cause of illness. As providers, I'm sure that we all have seen a similar case of misdiagnosis. Whether it be an autoimmune disease masquerading as a fibromyalgia or pericarditis masquerading as costochondritis, we should never place our complete faith behind a single diagnosis.

The law of clinical inertia often amplifies a diagnostic label. In a busy clinic, the path of least resistance is often the path involving the previous diagnosis as opposed to creating a "fresh look." Neither the provider nor the patient (nor the insurance company) look forward to a brand new work-up with every visit. As such, Newton's corrupted second law seems to reign supreme, unless providers make that herculean effort.

Do I have the energy and patience to revisit a differential with every patient I see? No. But sometimes we all have to break the laws of physics. I challenge all providers to look at their difficult patients with diagnoses of desperation (especially when their treatments just are not working) to take that second look, revisit the work-up, and see if that diagnosis of exclusion has just excluded the diagnosis.

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