AN UPDATE ON THE USE OF ANTIDEPRESSANTS IN PREGNANT AND BREASTFEEDING WOMEN FOR MIDWIVES

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I HAVE NO FINANCIAL RELATIONSHIPS TO DISCLOSE.

DARN.
1) Identify challenges related to interpreting studies of medication use in pregnant and breastfeeding women

1) Recognize limitations of current FDA labeling of medications for use in pregnancy

1) Anticipate future changes to the FDA labeling of medications for both pregnancy and breastfeeding
LEARNING OBJECTIVES

4) Utilize joint guidelines issued by the APA and ACOG, and the existing evidence base, when counseling and treating preconception, pregnant, and postpartum women regarding antidepressant use

5) Describe outcome data related to the use of antidepressant medication classes and specific agents by pregnant and breastfeeding women
LET’S TALK ABOUT DATA...
“Antidepressant Treatment of Depression During Pregnancy and the Postpartum Period”

- Examined the evidence base to discern:

1) Maternal/infant benefits and harms related to antidepressant use in pregnancy
2) Comparative benefits between specific antidepressants
3) Comparative benefits between psychotherapy and medication treatments for maternal depression

- Included 6 RCTs and 124 observational studies after careful analysis of the large existing evidence base
Conclusion:

“Evidence about the comparative benefits and harms of pharmacological treatment of depression in pregnant women was largely inadequate to allow well-informed decisions about treatment. For pregnant women, this was mainly because comparison groups were not exclusively depressed women. For postpartum women, the lack of evidence arose chiefly from a scarcity of studies. These are major limitations, as depression is known to be associated with serious adverse outcomes. Given the prevalence of depression and its impact on the lives of pregnant women, new mothers, and children, new research to fill this informational gap is essential.”

(AHRQ, 2014)
MOST studies have a poor design that does not control for maternal illness, confirm ingestion of meds, or assess response to treatment!

Most studies are not prospective with matched controls. And blinding is not done in pregnancy for ethical reasons - yet.

Initial positive studies about antidepressants and poor outcomes get lots of press. Negative follow-up studies do not!
There is loads of data on antidepressant use in pregnant and breastfeeding women!

Most of the data focuses on SSRI medications

Although most of the data is of questionable quality, the bottom line is quite reassuring
CLINICIAN DILEMMAS AND CHALLENGES
HAS ANYONE ENCOUNTERED THESE?

- Predatory attorney ads regarding AD use in pregnancy and fetal malformations
- Frightening pharmacy labeling and/or counseling
- Conflicting advice from obstetric, primary care, and psychiatric providers

Caring, unbiased counseling, based on an understanding of existing data, in the context of a supportive therapeutic alliance, is the key to helpful treatment planning.
FDA LABELING
A Adequate, well-controlled studies in pregnant women have not shown an increased risk of fetal abnormalities.

B Animal studies have revealed no evidence of harm to the fetus; however, there are no adequate and well controlled studies in pregnant women. Or Animal studies have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus.

C Animal studies have shown an adverse effect and there are no adequate and well-controlled studies in pregnant women. Or No animal studies have been conducted and there are no adequate and well-controlled studies in pregnant women. (65-70% of all medications)

D Studies, adequate well-controlled or observational, in pregnant women have demonstrated a risk to the fetus. However, the benefits of therapy may outweigh the potential risk.

X Studies, adequate well-controlled or observational, in animals or pregnant women have demonstrated positive evidence of fetal abnormalities. The use of the product is contraindicated in women who are or may become pregnant.
BROAD, SWEEPING CHANGES ARE COMING...

Prescription Drug Labeling Sections 8.1 – 8.3 USE IN SPECIFIC POPULATIONS

CURRENT LABELING

> **8.1** Pregnancy
> **8.2** Labor and Delivery
> **8.3** Nursing Mothers

NEW LABELING

(effective June 30, 2015)

> **8.1** Pregnancy includes Labor and Delivery
> **8.2** Lactation includes Nursing Mothers
> **NEW**
> **8.3** Females and Males of Reproductive Potential
Pregnancy Sub-section

- Fetal risk summary
- Clinical considerations
- Review of human data
- Drug registry information
- A general statement regarding background risk of loss and malformations in pregnancy

Lactation Sub-section

- Risk summary
- Clinical considerations
- Review of human data

(FDA, 2014)
But beware of poor studies that:

- Focus on increased risk vs. absolute risk
- Use pharmacy records to assume treatment and cure
- Do not differentiate between the effects of treatment and the effects of the disorder being treated when trying to establish an association or causation
HELPFUL DATA VS. LESS HELPFUL DATA

**Experimental Studies**
- Contain control groups
- Prospective
- Address confounders
- When large, can establish causation

**Observational Studies**
- Do not involve randomization
- Often retrospective
- Under-estimate confounders
- Can only establish associations
FREE SOURCES OF DATA SUMMARIES, LITERATURE, & STATISTICS

- mothertobaby.org
- womensmentalhealth.org
- motherisk.org
- toxnet.nlm.nih.gov
- toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

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TREATMENT GUIDANCE
ACOG & APA JOINT STATEMENT ON DEPRESSION TREATMENT IN PREGNANCY

- Issued in 2009 to address the clinician knowledge gap surrounding implementation of psychiatric treatments

- Acknowledges the complexity of the issue for clinicians and patients and encourages obstetric providers to treat their patients as indicated
Makes specific recommendations for treatment based on psychiatric history/risk of relapse, prior treatment response, symptom severity and type, and patient preferences

Includes several treatment algorithms
ALGORITHM #1: PATIENT IS CONTEMPLATING PREGNANCY AND IS UNDERGOING PHARMACOLOGICAL TREATMENT FOR DEPRESSION

Is the patient acutely suicidal or psychotic?

- No
  - Does the patient have moderate to severe symptoms?
    - No
      - Consider a reasonable period of stability before attempting to conceive
    - Yes
      - Aggressively treat depression.* Consider reasonable period of stability prior to conceiving
  - Yes
    - Did the patient start her antidepressant treatment less than 6 months ago?
      - No
        - Does the patient have recurrent episodes of MDD?
          - No
            - Unless there is strong rationale that psychotherapy alone would be ineffective, or the patient feels she needs to continue medication, she is eligible for trial off medication with a referral for psychotherapy. Non-psychiatric clinicians should consider consultation with a psychiatrist to determine if a trial of psychotherapy alone is reasonable.
          - Yes
            - Did the patient respond to psychotherapy previously?
              - No
                - Consider continuation of medication unless the patient feels that she would like to discontinue medication.
              - Yes
                - Patient recently responded: Consider a reasonable period of stability before attempting to conceive

*Maximize treatment may entail switching medication, adding a medication, psychiatric hospitalization or, for a non-psychiatric clinician, urgent referral to a psychiatrist
** A "reasonable period of stability" has not been empirically defined but is ultimately up to the patient and her clinician, and should take into consideration past episodes of illness and the time period required for her to re-establish normal functioning.
ALGORITHM #2: PATIENT IS IN AN EPISODE OF MDD, IS PREGNANT AND IS NOT TAKING ANTIDEPRESSANTS

Is the patient acutely suicidal or psychotic?

No

Is the patient willing to consider pharmacotherapy?

No

Patient may be eligible for psychotherapy without pharmacotherapy if she is amenable. Non-psychiatric clinicians should consider consultation with a psychiatrist to determine if a trial of psychotherapy alone is a reasonable.

Yes

Aggressively treat depression.* If possible, avoid antiepileptic mood stabilizers in the 1st trimester

Yes

Was the patient treated with psychotherapy in the past?

No

Has the patient failed to respond to a trial of psychotherapy?

No

Is it possible that the patient suffers from mania or bipolar disorder?

No

Does the patient have a comorbid condition such as panic disorder, eating disorder, substance use disorder?

No

Consider treatment with an appropriate antidepressant given full consideration of the risks and benefits to mother and her offspring. (See Text)

Yes

Non-psychiatric clinicians should refer to a psychiatrist for pharmacotherapy. (See Text)

Yes

Non-psychiatric clinicians should refer to a psychiatrist for pharmacotherapy. Psychiatrists are likely to recommend antidepressant therapy and other therapeutic modalities. (See Text)
ALGORITHM #3: PATIENT WITH MDD WHO IS PREGNANT AND CURRENTLY TAKING ANTIDEPRESSANTS

Is the patient acutely suicidal or psychotic?

No

Is the patient willing to consider discontinuation of pharmacotherapy?

No

Continue pharmacotherapy after discussion of risks and benefits; monitor symptoms

Yes

Aggressively treat depression.* If possible, avoid antiepileptic mood stabilizers in the 1st trimester.

Has the patient been treated previously with psychotherapy?

No

Yes

Does the patient currently have moderate to severe symptoms of MDD?

No

Has the patient relapsed after stopping antidepressants?

No

Consider tapering antidepressant, monitor for relapse and refer to psychotherapy if indicated

Yes

Continue antidepressant (see Text) and monitor symptoms

Yes

Has the patient failed to respond to or relapsed immediately after an effective trial of psychotherapy?

No

Consider referring patient for trial of psychotherapy & re-evaluating need for medication after she has responded.

Yes

Continue antidepressants (see Text) and monitor symptoms.
One small study of 50 women with **moderate to severe depression scores and co-morbid anxiety** recruited between 18 and 34 weeks EGA, after making a decision about antidepressant use (Misri et. al., 2013)

Women were more likely to take antidepressants in pregnancy (73% of n=30) if they had taken them before. **This group, which adhered to antidepressant treatment, became significantly less depressed and anxious in pregnancy**

Those who did not take antidepressants in pregnancy (n=20) were less likely to have tried antidepressants previously (only 20% of n=20) **and became more depressed and anxious during pregnancy**
Primary reasons for avoidance of AD use indicated by those who chose not to take them:

1) Fear of fetal exposure
2) Belief that symptoms do not warrant treatment with medication

The women that chose to use medication generally had greater insight into their illness, and a more positive view of antidepressant medications.

This study underscores the importance of counseling based on symptom severity!
1) Look at Personal and Family Psychiatric History

2) Consider any connection between past psychiatric symptoms and hormonal events such as:

- menarche, PMS/PMDD, prior pregnancies and postpartum periods, miscarriages, pregnancy terminations, infertility treatments, and response to oral contraceptive pills
3) If a woman has had mild or no symptoms for 6 months, consider a taper off medication- prior to pregnancy if possible.

4) Educate your patient about other effective treatment strategies that can be implemented PRN (psychotherapy, exercise, etc...)

*Be careful to counsel such that, if your patient requires an AD at some future point in her reproductive cycle, she does not consider this a failure, or a risk out of proportion to what is known.
RELAPSE RISK WITH DC OF ANTIDEPRESSANTS FOR PREGNANCY

In one study, n=201:

- 50% risk of relapse by end of first trimester:
- 90% relapsed by end of second trimester
- Of those treated, 26% relapsed. Was this due to sub-therapeutic dosing???

Prior psychiatric hx is the best indicator of relapse risk!
(Cohen et. al., 2006)
WHAT WOMEN FACE
THE INFORMED CONSENT PROCESS
Informed consent should include the risks of maternal psychiatric symptoms and treatments conferred on pregnancy and childhood outcomes.

Your delivery of this information will influence your patient’s decision-making.

Today, our focus is on medications, which exist among many treatment options...
INFORMED CONSENT DOMAINS RELATED TO POTENTIAL RISKS (AND BENEFITS!) FROM ANTIDEPRESSANT USE IN PREGNANCY

- Miscarriage risk

- Malformation risk

- Effects of AD use on pregnancy outcomes such as preterm birth, mode of delivery, & birth weight

- Effects of maternal AD use on the immediate post-birth transition

- Long-term effects of AD use on infant and childhood development

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MISCARRIAGE AND MALFORMATION RISK
The background risk of SAB in any pregnancy is 8 to 20% in the literature with the majority of SABs occurring prior to 12 weeks.

One prospective (n=937) study with antidepressants from MULTIPLE classes investigated the r/o SAB during AD use.
Reassuring for women treated with antidepressants with loss rates being less than 15% (13% experimental vs. 8% controls). This is consistent with other studies.

This study did not clarify whether sub-therapeutically treated DEPRESSION ITSELF conferred the increased risk in the experimental group.

(Einarson, et. Al., 2009)
One large study (n=1 million) showed similar rates of miscarriage between:

1) Women on SSRIs (12%)
2) And women with depression hx not on SSRIs (11%)

(Kjaersgaard et. al., 2013)
"The authors found a slightly increased risk of spontaneous abortion associated with the use of antidepressants. However, when comparing women with histories of depression, antidepressants in general, or individual SSRIs in particular, they were not associated with an increased risk of spontaneous abortions."

(Freeman, 2014)
The background risk of a major malformation occurring in any pregnancy is 3-5%.

Most studies are on SSRIs. Results are conflicting. Better designed, larger studies and pooled data do not show a significant increased risk of malformations in infants whose mothers took SSRIs during pregnancy.
Antepartum detection of malformations, especially cardiac malformations, has increased DRAMATICALLY with the use of high-resolution ultrasound.

Many MORE malformations are being picked up than 5, 10, or 20 years ago.

Many of these, especially cardiac malformations, resolve SPONTANEOUSLY.
Large cohort study out June, 2014  

- Stats mined from Medicaid database between 2000 and 2007  
- Analysis included a total of 949,504 women with 64,389 using SSRI antidepressants (6.8%)  
- This study attempted to address potential confounders such as depression severity and other maternal medical illnesses  
- “...the authors concluded that there was no substantial increase in the risk of cardiac malformations attributable to antidepressant use during the first trimester of pregnancy.”  
  
  (Nonacs, 2014)
SPECIFIC AD MEDICATIONS AND RISK OF HARM WITH USE IN PREGNANCY
## SPECIFIC ANTIDEPRESSANT AGENTS

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SSRI MEDICATIONS

These ADs have the most data!
Indicated for depression, anxiety-spectrum disorders including OCD, bulimia, PMDD, and PTSD

Most studied AD in pregnancy and breastfeeding, no increased malformation risk shown in pooled data.
SERTRALINE/ZOLOFT

- Indications include depression and anxiety-spectrum disorders, minus bulimia, plus panic

- Often prescribed by obstetric providers

**Loads of data on use in pregnant and breastfeeding women. Does not cross the placenta easily. When found in breast milk, levels are very low.**
Example of positive data findings related to sertraline use in pregnancy and ultimate value in counseling & prescribing:

- “Possible association” with omphalocele, anencephaly, septal cardiac defects- no significant increased risk shown in pooled data

- Highest risk was for omphalocele with a 10-fold increase yielding an absolute risk of 0.2% or 2/1,000

The absolute risk of this malformation was very still small in the experimental group.
Indications are the same as for Prozac, minus bulimia, plus panic

Possible association with PTB

Reassuring pooled data on use in pregnant and breastfeeding women.
Indications include depression and anxiety-spectrum symptoms, minus bulimia, plus panic

Possible association with PTB

Newer drug so less data in pregnancy and lactation. One study (n=213) on escitalopram by itself was largely reassuring.
Indications officially include OCD and social anxiety

Included in studies on the SSRI class. Reassuring data.
Indications include anxiety-spectrum disorders (PMDD, GAD, panic, PTSD, OCD, social phobia) and depression.

Paroxetine use in pregnancy is associated with a greater risk of Neonatal Adaptation Syndrome (NAS)

Much controversy exists around paroxetine...
Early unpublished data *without peer review* + for increased risk of heart defects

In 2005 the FDA changed the pregnancy labeling category from C to D after *preliminary* results became available

F/u prospective data from n=1174 was *negative*
Paroxetine is not absolutely contraindicated in pregnancy especially if this agent is, or has been, the only effective one for a particular individual.

Plan to send a preconception or pregnant patient who may need paroxetine for:

1) Specialty psychiatric consultation
2) And obtain a quality, mid-trimester scan of the fetal heart (with echocardiogram?) to rule out defect, if your patient prefers monitoring.
SSRI+ BENZO IN PREGNANCY

- Very common combo pregnant or not!

- Swedish study published in 2013 showed no increase in malformations between 3 groups:
  - N=10,511 SSRI only
  - N=1000 benzo only
  - N=406 SSRI + Benzo

Reassuring data for our patients!

(Reis & Kalen, 2013)
OTHER ANTIDEPRESSANT CLASSES
- Used for depression, ADHD, smoking cessation.

- Some data. Reassuring regarding malformations.

- Decreases seizure threshold (greater risk of eclampsia???)
- Loads of data. Reassuring regarding malformations

- Poor compliance d/t side effects

- Increased r/o serious adverse reactions compared with new ADs
- Includes venlafaxine/Effexor and newer ADs

- Some data. Reassuring regarding malformations

- Greater risk of NAS with venlafaxine use in pregnancy
- **Monamine oxidase inhibitors (MAOIs)**

- **No data.**

- **Generally avoided in pregnancy due to the risk of a hypertensive crisis with accidental ingestion of tyramine.**
- Trazodone/Oleptro- Some data. Reassuring

- Mirtazapine/Remeron- Little data. Reassuring

- Buspirone/Buspar- No data
NEWER ANTIDEPRESSANTS
NEWER ANTIDEPRESSANT MEDICATIONS

- **Duloxetine- Cymbalta.** One observational study done in 2012 (n=624) was reassuring. Duloxetine has been included in other reassuring studies of multiple antidepressants.  
  (Einarson et. al., 2012)

- **Desvenlafaxine- Pristiq.** New. No data. Does not necessarily rule out use in pregnancy or breastfeeding if it is the only medication that works or a pregnant woman is already taking it. (Avoid switches and multiple exposures to medications)

- **Vilazodone- Viibryd.** New. No data. Does not necessarily rule out use in pregnancy or breastfeeding if it is the only medication that works or the pregnant woman is already taking it.
ANTIDEPRESSANTS AND OTHER PREGNANCY OUTCOMES
May reduce gestation by about 1 week

(Reminick, Cohen, & Einarson, 2014)

Compare with double the r/o PTB for symptomatic women

(Dayan et. Al., 2002)

In general, birth weight, Apgar scores, and C/S rates not clinically different between adequately treated and untreated women not suffering from psychiatric symptoms
“...if we assume the estimates from the Palmsten study are correct, the use of SSRI antidepressants did not dramatically increase the risk of postpartum hemorrhage, measuring a 1.47-fold increase in risk. The authors estimate one additional case of postpartum hemorrhage for every 80 to 100 women treated with antidepressants. Given the inconsistency of these findings and the relatively small increase in risk observed in one of the three studies, we do not have compelling evidence to change our practices regarding the use of SSRIs and other antidepressants during pregnancy. Obstetricians, however, should be alert to the possibility of an increased risk of PP hemorrhage in this population, so that hemorrhage, should it occur, may be managed aggressively, thereby minimizing maternal morbidity.”
MATERNAL ANTIDEPRESSANT USE AND THE NEWBORN
No changes seen in platelet function tests of neonates whose mothers took SSRIs during pregnancy

(Miller, 2008)
Neonatal distress syndrome/newborn adaptation syndrome/poor neonatal adaptation/SSRI discontinuation syndrome

Characterizes symptoms seen in 25-30% of neonates born to mothers on SSRI medications; the same syndrome is seen in 10% of the general population, not on ADs.

Symptoms include jitteriness, hypertonia, feeding issues, mild respiratory distress for an average of 48 hours. Extremely rare seizures.

Unsure if it is r/t toxicity, withdrawal, discontinuation, or depression itself.

(Pearson, 2009 & Reminick, Cohen, & Einarson, 2013)
- Rarely requires treatment except supportive care or observation

- One study showed no decreased risk of NAS with third trimester taper off of SSRIs  
  (Warburton, et. al., 2010)

- But tapering off SSRIs does increase r/o PP illness relapse

- Medications with a shorter half-life or evidence of difficult withdrawal symptoms in adults lead to greater likelihood of neonatal adaptation syndrome in neonates (venlafaxine and paroxetine)
Persistent Pulmonary Hypertension — “...failure of the normal circulatory transition that occurs after birth. It is a syndrome characterized by marked pulmonary hypertension that causes hypoxemia and right-to-left intracardiac shunting of blood.”

PPHN background risk is about 1 in 1,000. Carries 20% r/o death and 20% r/o deficits in survivors

6 studies exist on PPHN and SSRI use in pregnancy

3 negative and 3 positive, of which 2 positive studies used the same patient database
PPHN

- At most, with SSRI use, risk is increased to 2 or 3 in 1,000, up from a baseline r/o 1 in 1,000 infants having PPHN

- No infant deaths occurred d/t maternal SSRI use in studies

- Exposure to SSRIs after 20 weeks EGA, not before, was associated with the possible increased risk of PPHN but DC of antidepressants in the second half of pregnancy confers r/o relapse

- PPHN is more likely to occur following a C/S. C/S rates are elevated in depressed/anxious women!!!!
FDA reversal statement in 2011 after initial warning about SSRIs issued in 2006:

(Nonacs, 2012)

“FDA has reviewed the additional new study results and has concluded that, given the conflicting results from different studies, it is premature to reach any conclusion about a possible link between SSRI use in pregnancy and PPHN. FDA will update the SSRI drug labels to reflect the new data and the conflicting results.”
GESTATIONAL ANTIDEPRESSANT EXPOSURE AND CHILDHOOD DEVELOPMENT
• Not much data but...

• Follow up studies of infants with gestational SSRI exposure show normal development at 2, 4, 6, and 8 months of age

• Small studies (12) with important limitations fail to demonstrate cognitive, behavioral, or emotional fall-out, up to age 6, from gestational SSRI exposure if moms were adequately treated

(Nonacs, 2007)
About 1% of children in the U.S have been diagnosed with an ASD

- In the 1990s, 1 to 2 in 1,000 children were diagnosed with Autism or an ASD
- This is up from 0.5 in 1,000 in previous decades
- That number has increased to 8 in 1,000 in 2008

ASDs are are 4.6 times more likely to be diagnosed in boys

(Oregon Public Health Division, 2012)
The etiology of autism is complex & multifactorial and includes genetic and environmental factors.

Those causes identified thus far include:

1) Low maternal folate levels in pregnancy (which is more likely in women who are depressed or anxious)
2) Advanced parental age, both paternal and maternal
3) Use of Valproate in pregnancy- high or low dose

(Nonacs, 2013 & Andrade, 2014)
The Bottom Line:

“Retrospective, observational studies have shown that exposure to SSRIs during pregnancy is associated with an increased risk of autism. However, observational studies cannot establish causality, and so it is hard to say whether the increased risk is mediated by medication or by other illness-related factors.

(Andrade, 2014)
DO ANTIDEPRESSANTS HAVE A ROLE IN THE PREVENTION OF POOR CHILDHOOD OUTCOMES?
“Antidepressants May Mitigate the Effects of Prenatal Maternal Anxiety on Infant Auditory Sensory Gating”

(Hunter et. Al., 2012)

This study shows mechanism for improved childhood outcomes (decreased attention deficits) when anxious pregnant women are adequately treated with antidepressants.
Inhibition response to repeated stimuli is impaired in ADHD, schizophrenia, PTSD, and bipolar disorder.

In this study, infants with gestational antidepressant exposure showed a decreased response to second auditory stimulus reflecting improved filtering of stimuli (“intact sensory gating”).

Impaired sensory gating has previously correlated with vulnerability to attention deficits.

Might psychotherapy offer the same benefit? Not yet studied...
“Treatment of maternal depression in a medication clinical trial and its effect on children”

(Weissman et. al., 2015)

The study compared 3 groups:

1. Mothers taking escitalopram
2. Mothers taking buproprion
3. Mothers taking escitalopram and buproprion

Conclusion: “Children’s mood and functioning improved when their depressed and highly anxious, distressed, and irritable mothers were treated with escitalopram alone.”
ANTIDEPRESSANT USE WHILE BREASTFEEDING
Well studied; the most data exists for fluoxetine, paroxetine, sertraline, and TCAs

SSRIs present in low levels in breast milk (especially sertraline) therefore, infant exposure is low

In general, choose the treatment agent that is likely to work and has reasonable data, and dose it to sufficiently address symptoms

Consider and discuss the benefits of breastfeeding as well the risks of medication exposure
PRESCRIBING GUIDELINES FOR PRECONCEPTION, PREGNANT AND POSTPARTUM WOMEN
1) Trial a “reasonable” antidepressant before pregnancy if possible, but feel comfortable treating during pregnancy if indicated.

(Reasonable choices include older agents that have some data regarding malformations and other pregnancy and fetal/infant outcomes).

1) Attempt to minimize the number of medication exposures by avoiding switches when possible.
3) In general, don’t discontinue antidepressants for pregnancy or delivery if an individual is more than mildly symptomatic, or at elevated risk for relapse

4) Dose adequately to ensure sustained improvement, and to avoid exposure to anxiety & depression and medication
5) Discuss breastfeeding plans, and concerns regarding medications

(There is rarely a reason to DC an antidepressant used in pregnancy to prevent breastfeeding exposure)

6) Emphasize the importance of adjunctive/non-medication treatments for any woman who has psychiatric symptoms or is at risk for developing psychiatric symptoms
Develop a counseling script for AD medication use in reproductive-age women

Refer your patients to evidence-based websites for additional information:
1. Postpartum Support International: postpartum.net
2. MGH Center for Women’s Mental Health: womensmentalhealth.org

Document care using a general phrase indicating that you covered informed consent domains and referred your patient to additional information
One of the most important things we do as clinicians is to digest data and our experience in order to assist patients in making an informed decision about treatments.

This requires us to stay current, and to have flexible attachment to data outcomes and treatment approaches.

Keep your eye on the literature for more is surely to come on this topic...
THANK YOU FOR YOUR ATTENTION TODAY
SELECT REFERENCES


SELECT REFERENCES


- Miller, L. J. (2008, July). Part 2: Perinatal depression. Presented at the 22nd Annual Door County Summer Institute, Milwaukie, WI.
SELECT REFERENCES


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