SAFER
SAFER USE OF HIGH RISK MEDICINES

Waitemata District Health Board
Best Care for Everyone

ANTIDEPRESSANTS DURING PREGNANCY AND BREASTFEEDING - SAFE PRESCRIBING - DELIVER SAFE CHOICES

- PROVIDE PRECONCEPTION COUNSELLING
- DISCUSS NON-PHARMACOLOGICAL INTERVENTIONS
- CONSIDER ANTIDEPRESSANTS FOR MODERATE TO SEVERE DEPRESSION
- BE AWARE THAT ALL ANTIDEPRESSANTS CARRY SOME RISK DURING PREGNANCY
- PROVIDE INFORMATION ABOUT COMPATIBILITY WITH BREASTFEEDING

Mental health problems during the perinatal period are common; antenatal anxiety or depression is experienced by up to 10% of women, increasing up to 16% postnatally. All pregnant women should be screened for psychosocial risk factors; mental wellbeing should be considered as important as physical health.

PROVIDE PRECONCEPTION COUNSELLING FOR YOUNG WOMEN PRESCRIBED ANTIDEPRESSANT MEDICINES

Women prescribed antidepressants and considering a family should be given preconceptual counselling. Discuss treatment preference, efficacy, tolerability and the risks of continuing or stopping medicines.

If women do become pregnant, advise them not to suddenly stop taking their medicine because there is a high risk of relapse (68%). If deemed appropriate withdraw slowly over 1-2 months to reduce the risk of withdrawal symptoms.

If a medicine is working well, it is usually preferable to continue with it rather than risk switching to a medicine that may not be effective. Consider a discussion with, or referral to a maternal mental health (MMH) team.

CONSIDER NON-PHARMACOLOGICAL INTERVENTIONS

All women presenting with depression during pregnancy or breastfeeding should be managed on a case-by-case basis. Any treatment offered should involve collaborative decision making with the woman and her partner. Enhanced social support and psychological therapy should be considered before prescribing medicines, especially if the symptoms are mild or occur during the first trimester.

Up to 80% of mothers experience the 'baby blues' 3-5 days after giving birth. This is generally transient and self-limiting, usually dissipating within 10 days. The Edinburgh depression scale is a useful tool at the 6 week check. This is available as an online questionnaire via Health Navigator.

CONSIDER ANTIDEPRESSANTS FOR MODERATE TO SEVERE DEPRESSION

For moderate to severe depression, discuss the risks and benefits of antidepressants, and the risks of no antidepressant therapy. Untreated antenatal depression is associated with low birth weight and poor self-care of the mother and neonate, which may escalate to self-harm and infant neglect. Women already receiving antidepressants who are at high risk of relapse are best maintained on them.

For specific information see the pregnancy summary under individual medicines monographs in The New Zealand Formulary. There is also helpful information from the Teratology Information Service in the United Kingdom, including links to patient resources.

ALL ANTIDEPRESSANTS CARRY SOME RISK DURING PREGNANCY

Depressive symptoms during pregnancy are associated with foetal growth changes and shorter gestation time. The risks associated with antidepressants may include congenital abnormalities, pre-term birth, neonatal withdrawal symptoms, persistent pulmonary hypertension of the newborn (PPHN) and neurobehavioural effects.

Birth defects

There is conflicting information about the risk of birth defects following antidepressant use during pregnancy, and most malformations have no known cause.

Neonatal withdrawal

If antidepressants are used late in pregnancy, there may be a risk of neonatal withdrawal. Symptoms include behavioural changes and irritability which are generally self-limiting and can also be linked to maternal depression itself.

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Pregnancy-induced hypertension (PIH)

Antidepressants have been associated with pregnancy induced hypertension (PIH). Other risk factors for hypertension should also considered, including smoking, obesity, alcohol, lack of exercise, and untreated depression.

Persistent pulmonary hypertension

Although SSRIs have been associated with persistent pulmonary hypertension of the newborn (PPHN) this is very rare, and some studies show a similar risk in the general population.

Post-partum haemorrhage

There is some evidence to suggest that antidepressants decrease platelet function and potentially increase the risk of bruising and bleeding and post-partum haemorrhage.

Overdose risks

TCAs have been used by pregnant women over many years and are generally considered safe for the foetus, they are often considered second-line because of poor tolerability (eg sedation and constipation) and poor outcome in case of maternal overdose.

PROVIDE INFORMATION ABOUT COMPATIBILITY WITH BREASTFEEDING

If an antidepressant has been used successfully during pregnancy, it is generally most appropriate to remain on the same medicine post-partum. Breastmilk exposure is less than in-utero and may also minimise withdrawal symptoms. Closely observe new mothers for relapse post-partum, even if no alterations are made to their medicines. Sertraline and paroxetine are generally preferred if initiating an antidepressant post-partum.

Weigh potential risk against the known benefits of breastfeeding and the detrimental effects of psychiatric illness on the development of the infant and other children in the home. Discuss with Maternal Mental Health team if there are any concerns.

Medicines use during breastfeeding

Although most medicines are excreted into breast milk, it usually contains less that 10% of the maternal dose, which is generally considered compatible with breastfeeding. This does vary depending on the composition of the breastmilk, and the safety of medicines varies depending on the age and health of the child. An up-to-date database of medicine levels in breast milk and possible adverse reactions in the infant is available at LactMed

KEY REFERENCES

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CLICK HERE FOR FURTHER INFORMATION ON ANTIDEPRESSANTS DURING PREGNANCY AND BREASTFEEDING AND A FULL REFERENCE LIST

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