

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

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- ▶ 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. Early intervention produces the best outcomes for mothers and their families.<sup>1</sup> When women first become pregnant, or if they are planning a pregnancy, enquire about any family or personal history of mental illness.<sup>2</sup> All pregnant women should be screened for psychosocial risk factors; mental wellbeing should be considered as important as physical health.<sup>1</sup>

### PROVIDE PRECONCEPTION COUNSELLING FOR YOUNG WOMEN PRESCRIBED ANTIDEPRESSANT MEDICINES

Women who are currently prescribed antidepressants and considering a family should be given preconceptual counselling. It is wise to anticipate potential risks should they become pregnant and proactively discuss these risks with them.<sup>2</sup> Discuss treatment preference, efficacy, tolerability and the risks of continuing or stopping medicines.<sup>2</sup>

The risks of stopping an antidepressant, changing to an alternative, and starting medicines during pregnancy need to be carefully evaluated. Stopping an antidepressant may put the newborn baby at risk if the mother suffers from a relapse and is unable to provide a sufficient level of care to her baby. If women taking antidepressants become pregnant, advise them not to suddenly stop taking their medicine because there is a high risk of relapse (68%).<sup>3</sup> If deemed appropriate withdraw slowly over 1-2 months to reduce the risk of withdrawal symptoms and increase the likelihood of detecting a relapse.

Substitution with another antidepressant is also associated with a risk of relapse,<sup>2</sup> and increases foetal medicine exposure. 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.

**Note:** Lithium therapy should always be managed by a

specialist service during pregnancy; seek immediate advice from a MMH team for these cases.

### CONSIDER NON-PHARMACOLOGICAL INTERVENTIONS

All women presenting with depression during pregnancy or breastfeeding should be managed on a case-by-case basis.<sup>4</sup> Any treatment offered should involve collaborative decision making with the woman and her partner, including a full discussion of the potential risks and benefits.<sup>1</sup> Enhanced social support and psychological therapy should be considered before prescribing medicines, especially if the symptoms are mild or occur during the first trimester.<sup>2</sup>

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.<sup>1</sup> Arrange a plan for follow-up to ensure persistent or worsening symptoms are effectively identified and managed. 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

If pregnant or breastfeeding women have moderate to severe depression, discuss the risks and benefits of antidepressants, and the risks of no antidepressant therapy.<sup>2</sup> Maternal anxiety and depression can have detrimental effects on foetal and infant development, and on mother-infant attachment.<sup>1</sup> 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.<sup>5</sup> Women already receiving antidepressants who are at high risk of relapse are best maintained on antidepressants during and after pregnancy.<sup>5</sup>

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For specific information see the pregnancy summary under individual medicines monographs in [The New Zealand Formulary](#).<sup>6</sup> There is also helpful information from the [Teratology Information Service](#)<sup>7</sup> 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.<sup>6</sup>

For newly diagnosed depression in pregnant women, consider treatment options that are also compatible with breastfeeding. Sertraline<sup>8</sup> or escitalopram are currently the most preferred SSRIs to use during pregnancy and breastfeeding. Venlafaxine and paroxetine in particular have a relatively higher risk of neonatal withdrawal,<sup>6</sup> so are generally not recommended during pregnancy and should only be considered if the woman has not tolerated or not responded to safer options. Involve the family as appropriate and consider consulting with, or referring to a MMH team or other available psychiatric service for advice.<sup>2</sup>

#### Birth defects

There is conflicting information about the risk of birth defects following antidepressant use during pregnancy, and most malformations have no known cause. Individual studies mostly demonstrate no statistically significant increase in the overall risk of any malformation with antidepressants. The studies that do show an increased risk of cardiac malformation suggest an absolute risk of 0.86-2%, compared to the background rate of 0.8%.<sup>7</sup>

Some studies suggest that SSRIs, in the first trimester may be associated with congenital heart defects. Note that these include anomalies such as small ventricular septal defects which often close during childhood.<sup>9</sup>

#### Neonatal withdrawal

If antidepressants are used late in pregnancy, there may be a risk of neonatal withdrawal.<sup>2</sup> Symptoms include behavioural changes and irritability which are generally self-limiting and can also be linked to maternal depression itself.<sup>2</sup> Neonatal withdrawal symptoms should be discussed with the mother in advance; the postnatal midwife (and Plunket nurse) should also be informed.

#### Pregnancy-induced hypertension (PIH)

Antidepressants have been associated with pregnancy induced hypertension (PIH).<sup>10</sup> Other risk factors for hypertension should also be 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.<sup>11</sup>

#### Post-partum haemorrhage

There is some evidence to suggest that SSRIs and other antidepressants decrease platelet function and potentially increase the risk of bruising and bleeding.<sup>5</sup> This includes a slight increased risk of post-partum haemorrhage.<sup>12</sup>

#### Overdose risks

Although TCAs have been widely 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.<sup>2</sup>

### 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, rather than changing medicines at a time when mothers are at their most vulnerable. The amount that an infant is exposed to via breastmilk is less than in-utero, and continuing with the same medicine while breastfeeding may also minimise withdrawal symptoms in the infant.<sup>5</sup> It is advisable to closely observe new mothers for symptoms of depressive relapse post-partum, even if no alterations are made to their medicines.

The extent of exposure to the infant depends on many factors, including protein binding (to maternal plasma) and lipophilicity. Sertraline, escitalopram, paroxetine, nortriptyline and imipramine have low to undetectable infant serum levels when the mother is breastfeeding, with no reports of short term adverse events.<sup>13,14</sup> Sertraline<sup>8</sup> and paroxetine are generally considered the most preferable options if the mother is initiating an antidepressant post-partum.

Fluoxetine is considered the least preferred SSRI during breastfeeding, because it has the highest infant serum levels.

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Although paroxetine is considered one of the safest SSRIs during breastfeeding, it is less favourable during pregnancy. The long-term consequences of exposure to SSRIs via breastmilk to infant neurobehavioural development are unknown.<sup>15</sup> With all medicines, it is advised to prescribe the lowest effective dose possible during breastfeeding.<sup>16</sup>

Although SSRIs are often preferred, TCAs can be a useful option if women have not responded well. TCAs are generally considered compatible with breastfeeding; they have very low transfer into breastmilk.<sup>7</sup> Parents should still be advised to monitor infants for drowsiness, poor feeding, and irritability.<sup>16</sup>

Discuss with Maternal Mental Health team if there are any concerns. **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.

**Note:** Medicines are more likely to accumulate in premature, low birth-weight and unwell infants because clearance is impaired. Choosing medicines with short half-lives and taking the dose immediately after breastfeeding is sometimes recommended to minimise infant exposure,<sup>15</sup> but there is little evidence to support this, and it may make breastfeeding more difficult.

### Medicines use during breastfeeding

Although most medicines are excreted into breast milk, they usually contains less than 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.<sup>16</sup> An up-to-date database of medicine levels in breast milk and possible adverse reactions in the infant is available at [LactMed](#)

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▶ For further information on other high-risk medicines visit our website at : [www.saferx.co.nz](http://www.saferx.co.nz)

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DISCLAIMER: This information is provided to assist primary care health professionals with the use of prescribed medicines. Users of this information must always consider current best practice and use their clinical judgement with each patient. This information is not a substitute for individual clinical decision making. Issued by the Quality Use of Medicines Team at Waitemata District Health Board, email: [feedback@saferx.co.nz](mailto:feedback@saferx.co.nz)