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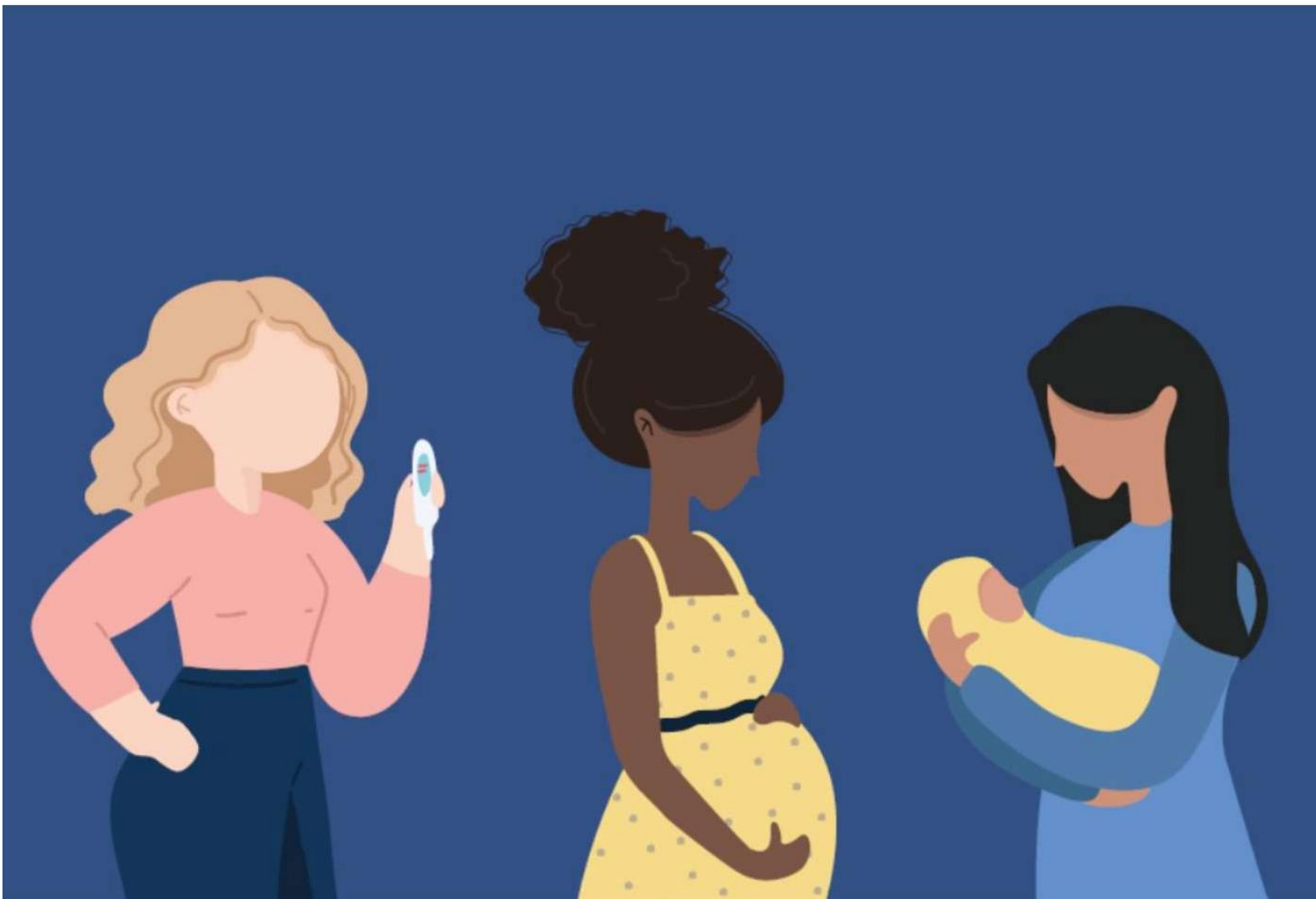
Perinatal Mental Health Network

Guidance for clinicians on prescribing antidepressants in the perinatal period



Introduction

This guide is intended to provide some initial information for colleagues considering antidepressant treatment for women who are planning a pregnancy, pregnant or in the postnatal period. This guide does not provide detailed information about individual antidepressants. Prescribers should refer to the reference sources contained within this guide for information about individual antidepressants.

This guide is not intended for women with a serious mental illness (SMI) diagnosis.

Women with an SMI diagnosis, or women currently taking an antipsychotic or mood stabiliser, should be referred to specialist perinatal mental health services.

Women prescribed an antipsychotic or mood stabiliser who do not have SMI diagnosis can be referred to the specialist team that initiated the antipsychotic or mood stabiliser for advice.

Background

Approximately **10%** of pregnant women develop or have a pre-existing depressive illness[1]. Women who have had a previous episode of depressive illness are at higher risk of further episodes during pregnancy and postpartum.

Relapse rates are higher in those with a history of depression who discontinue medication compared to those who continue. One study found that 68% of women who were well on antidepressant treatment and stopped during pregnancy relapsed, compared with 26% who continued antidepressant treatment[2]. Risk is likely to be the highest for women with a history of severe and/or recurrent depression[3].

The mental health of the mother influences foetal well-being, obstetric outcome, and child development. Risks of not treating depression include harm to the mother through poor self-care, lack of obstetric care, self- harm and harm to the foetus or neonate.

Some data suggest that antidepressants may increase the risk of spontaneous abortion, pre-term delivery, low birth weight, respiratory distress in the neonate, a low APGAR (Appearance, Pulse, Grimace, Activity and Respiration) score at birth and admission to a Special Care Baby Unit. However, most studies are observational and did not control for maternal depression.

Untreated maternal depression has itself been associated with an increased risk of spontaneous abortion, low birth weight, small for gestational age and pre-term birth[4].

Selective serotonin reuptake inhibitors (SSRIs) do not appear to increase the risk of stillbirth or neonatal mortality[5,6]. Some antidepressants have been associated with specific congenital malformations, many of which are rare and most of these potential associations remain unreplicated in further studies. SSRIs are **not** thought to be major teratogens.

Longer-term developmental outcomes with antidepressants are poorly studied. Maternal SSRI use has been associated in some small studies with autism spectrum disorders[7-9]. However, large studies have failed to show this association after accounting for maternal illness[10-12], or have found it to be no longer significant[13,14].

Recommendations for antidepressant use in women who are pregnant or are planning a pregnancy

Women currently prescribed an antidepressant:

- If a woman is currently prescribed an antidepressant and it is effective and well-tolerated, continue it unless it is either contraindicated in pregnancy or the woman wishes to stop the antidepressant. Before stopping the antidepressant, consider the risk of relapse of maternal mental illness and the risk of untreated maternal depression on the foetus or infant.

- **It is not usually advisable to abruptly stop antidepressants.**

- If a woman is currently prescribed an antidepressant and it is not effective or not well-tolerated, treatment should be reviewed, considering their psychiatric history and past response to antidepressants.

Women not currently prescribed an antidepressant:

- For a new episode of **less severe** depression, non-pharmacological options may be considered first-line. But also consider the risk of untreated maternal depression on the foetus or infant.

- For a new episode of depression which is **more severe**, consider prescribing the antidepressant which was previously effective and

discuss referral to your specialist perinatal mental health team (contact details below). If no previous antidepressant has been tried, then Sertraline may be considered. Other options are available. Resources and information can be found in the 'Links to information' section below.

Ensure patients are involved in all decisions about their medication.

Some basic principles of antidepressant use in pregnancy and after birth

- For women at high risk of relapse, it is usually best to maintain on the same antidepressant during pregnancy and after birth.
- For new antidepressant prescriptions use the lowest dose that is effective.
- Remember to screen for smoking, alcohol, substance misuse and inform the woman of the known risks associated with these.
- Consider whether their needs would best be supported by the specialist perinatal mental health team - you can call your team to discuss whether a referral would be appropriate.
- Liaise with the relevant midwifery and/or health visiting team antenatally and postnatally.

Some basic principles of antidepressant use in breastfeeding

- It is usually advisable to continue the antidepressant which has been used during pregnancy. Switching for the purpose of breastfeeding is not usually sensible.

- Women should be supported to breastfeed if this aligns with their individual feeding goals. Antidepressant medication is very rarely a reason to interrupt or stop breastfeeding, and this advice should NOT be given unless clinically essential.

- When initiating a drug postpartum it is important to consider the mother's previous response to treatment.

- For new prescriptions postpartum, consider **Sertraline** first-line if no previous antidepressant has been tried. Other SSRIs and Mirtazapine can be used whilst breastfeeding. Fluoxetine is not first- line in breastfeeding due to its longer half-life and higher amount passing into breast milk, however there may often be cases where it is sensible to continue or consider starting.

- Monitor babies for adverse effects, including abnormalities in feeding patterns and growth and development.

- In the rare case that adverse effects or toxicity in the neonate are suspected, refer to neonates or paediatric team depending on the age of the baby, and advise the woman to stop breastfeeding and switch to formula.

- Women receiving sedating medication (e.g. Mirtazapine) should be strongly advised to NOT co-sleep in bed/sofa, as they may fall asleep and roll onto the baby, with a potential risk of hypoxia for the baby. Visit lullabytrust.org.uk for safe sleep advice.

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Further information

- Monoamine oxidase inhibitors (MAOIs) should be avoided in pregnancy because of a suspected increased risk of congenital malformations and risk of hypertensive crisis. For women currently prescribed an MAOI, discuss with the local specialist perinatal mental health team or medicines information services.

- An association between SSRIs and an increased risk of postpartum haemorrhage has been reported. Obstetricians and midwives need to be aware of this possible increase in risk and monitor for blood loss after labour.

- Exposure to SSRIs or serotonin and noradrenaline reuptake inhibitors (SNRIs) during pregnancy is associated with an increased risk of persistent pulmonary hypertension of the new-born. The absolute risk appears to be small and may exist only in late pregnancy exposure and may be lower with Sertraline than with other SSRIs.

- Poor neonatal adaptation syndrome (PNAS) has been reported in some neonates exposed to antidepressants during pregnancy. Symptoms are usually mild and self-limiting. They typically include irritability, sleeping difficulties, poor feeding, crying and tremor. Treatment is not usually required, but maternity units may wish to monitor babies in hospital for a period of time after birth. Please liaise with the woman's midwife for further information on local practice.

Acknowledgements

This document was adapted with permission from NHS South East London Integrated Care System. Please see link below for original:

https://www.selondonics.org/icb/healthcare-professionals/medicines/sel-imoc/sel-imoc-adult-guidelines-and-pathways/

Useful links

British Association for Psychopharmacology (BAP) guidance on use of psychotropic medication in the perinatal period
https://www.bap.org.uk/pdfs/BAP_Guidelines-Perinatal.pdf

Bumps (Best Use of Medicine in Pregnancy) leaflets
https://www.medicinesinpregnancy.org/leaflets-a-z/

Drugs and Lactation Database (LactMed®) – NCBI Bookshelf
https://www.ncbi.nlm.nih.gov/books/NBK501922/

Mental Health and Medication Wales Home
https://www.choiceandmedication.org/

NICE Guidance CG 192 Antenatal and postnatal mental health
https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789

Specialist Pharmacy Service – The first stop for professional medicines advice
https://www.sps.nhs.uk/

Useful contacts

UK Teratology Information Service (UKTIS)	0344 892 0909
The UK Drugs in Lactation Advisory Service	0116 258 6491

Specialist perinatal mental health teams

Betsi Cadwaladr	BCU.MHLDPerinatal@wales.nhs.uk
Powys	powys.perinatalMH@wales.nhs.uk
Hywel Dda	Perinatal.Service.HDD@wales.nhs.uk
Swansea Bay	Sbu.pramswest@wales.nhs.uk
Cwm Taf Morgannwg	CTT_Perinatal_MentHe@wales.nhs.uk
Cardiff and Vale	Perinatalcommunity.Mentalhealthservicereferral@wales.nhs.uk
Aneurin Bevan	ABB_PerinatalReferrals@wales.nhs.uk

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