

Treatment of Depression in Pregnancy

The lifetime risk for depression in women ranges from 10-25% with the highest prevalence during the childbearing years.¹ Although drug therapy is a mainstay of treatment, available data indicate a potential for increased risk of rare fetal malformations and neonatal adverse effects.²⁻⁴ Despite this, uncontrolled depression during pregnancy likewise has been associated with significant risks, including substance abuse, poor prenatal care, postpartum depression, and suicide attempts.⁴⁻⁶

The American College of Obstetrics and Gynecology (ACOG) released an opinion statement in December 2006 regarding depression in pregnancy and its treatment with selective serotonin reuptake inhibitors (SSRIs).⁷ While potential harm to the fetus must be a consideration, a number of additional factors are also important including the mother's severity of symptoms, past responsiveness to treatments, concern for postpartum symptoms, and the possibility of breast feeding.

KEY POINTS

- Women with a history of severe, recurrent depression, who are being successfully treated with an antidepressant and become pregnant, should continue treatment throughout pregnancy.⁸
- Women with milder depression, who are being effectively treated with an antidepressant and become pregnant, should be made aware of the risks associated with recurrent depression and postpartum depression if contemplating discontinuing therapy.^{8,9}
- While drug therapy should be individualized, it is usually not indicated for patients with mild or infrequent symptoms; SSRIs are generally recommended first-line for moderate-to-severe depression in treatment-naïve pregnant women.^{7,8}
- The ACOG recommends avoiding the use of paroxetine (Paxil) in pregnant women and women planning on becoming pregnant; a fetal echocardiography should be considered for women exposed to paroxetine in early pregnancy.⁷
- Monitor depression closely throughout pregnancy as symptoms may worsen, especially in the second and third trimesters.^{1,9}

To date, the FDA has not approved any specific antidepressant for use in pregnancy and most drugs used in the treatment of depression are pregnancy category "C". Although pregnancy categories are commonly used to guide clinical decisions, their therapeutic utility has been widely questioned, given the limitations that have been observed when this system is applied to practical medicine (see table on next page).¹⁰

FDA Pregnancy Categories

CATEGORY	DESCRIPTION
A	Controlled studies in women fail to demonstrate a risk to the fetus in the first trimester, and the possibility of fetal harm appears remote.
B	Animal studies do not indicate a risk to the fetus and there are no controlled human studies, OR animal studies do show an adverse effect on the fetus but well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus.
C	Studies have shown that EITHER the drug exerts animal teratogenic or embryocidal effects, but there are no controlled studies in women, OR no studies are available in either animals or humans.
D	Positive evidence of human fetal risk exists, <u>but benefits in certain situations</u> (eg, life-threatening situations or serious diseases for which safer drugs cannot be used or are ineffective) <u>may make use of the drug acceptable despite its risks.</u>
X	Studies in animals or humans have demonstrated fetal abnormalities or there is evidence of fetal risk based on human experience, or both, and the <u>risk clearly outweighs any possible benefit.</u>

While fluoxetine (Prozac) and sertraline (Zoloft) have been studied most during pregnancy, the ACOG recommends that antidepressant treatment be individualized; however, paroxetine (Paxil) should be avoided due to increased risk of congenital cardiac malformations.⁷ Bupropion (Wellbutrin) may be considered as an alternative to SSRIs, especially for patients who have responded to it in the past and/or for patients unable to stop smoking. Although less commonly employed, tricyclic antidepressants (TCAs) are also a viable option, as they have not been shown to cause harm in pregnancy.⁴

Monitoring depression symptoms is critical during pregnancy as studies have shown that many women with major depressive disorder may be sub-optimally treated. It is common for depression symptoms to increase in the second or third trimester, and increased doses of antidepressant medications may be necessary. Marital conflict, younger age, and limited social support are risk factors for increased symptoms.¹

References

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