Motherisk Update

Taking antidepressants during late pregnancy

How should we advise women?

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ABSTRACT

QUESTION In light of recent negative media attention to antidepressant use during late pregnancy, several of my patients have either discontinued or are considering discontinuing their antidepressant medications. How can I best counsel these patients on taking antidepressants during late pregnancy?

ANSWER Antidepressant use during the third trimester has been associated occasionally with a *transient* neonatal withdrawal-like syndrome characterized by jitteriness, self-limiting respiratory difficulties, and problems with feeding. When counseling patients, the risk of these adverse effects must be weighed against the risks associated with untreated depression during late pregnancy. Abrupt discontinuation of psychotropic medications has been associated with both physical (eg, withdrawal) and psychological (eg, suicidal thoughts) symptoms.

RÉSUMÉ

QUESTION À la lumière des reportages médiatiques défavorables à l'endroit des antidépresseurs durant la fin de la grossesse, quelques-unes de mes patientes ont cessé de les utiliser ou envisagent de le faire. Quels seraient les meilleurs conseils à leur prodiguer concernant l'usage des antidépresseurs durant la dernière étape de leur grossesse?

RÉPONSE L'utilisation des antidépresseurs durant le troisième trimestre a occasionnellement été associée à un symptôme néonatal *transitoire* semblable à celui du sevrage, caractérisé par de l'agitation, des difficultés respiratoires autolimitantes et des problèmes avec l'alimentation. Dans les conseils aux patientes, il faut pondérer ces risques d'effets secondaires en fonction de ceux associés à une dépression sans traitement en fin de grossesse. La discontinuation soudaine des médicaments psychotropes est associée à des symptômes à la fois physiques (par ex. symptôme de sevrage) et psychologiques (par ex. pensées suicidaires).

The World Health Organization has identified depression as a leading cause of morbidity in the 21st century.[1] Depression is expected to become the second largest worldwide cause of disease burden by 2020.[2] Given that depression is about three times more common in women than in men and that its peak prevalence occurs between 25 and 44 years of age,[3] many women will require treatment for depression while pregnant.

A growing body of evidence attests to the fetal safety of antidepressants commonly used during pregnancy. Various prospective controlled studies have examined the physical and neurodevelopmental safety of tricyclic antidepressants, as well as selective serotonin reuptake inhibitor (SSRI) and selective norepinephrine reuptake inhibitor (SNRI) medications during the first trimester and throughout pregnancy.[4]

Some studies have described a poor neonatal adaptation syndrome in newborns whose mothers had been taking tricyclic, SSRI, or SNRI antidepressants near term.[5-9] Although not yet clearly defined, the most common adverse effects associated with this syndrome are transient, mostly self-limiting, jitteriness; grasping muscle weakness; and respiratory difficulties that sometimes require use of a ventilator.[6] Currently, Motherisk recommends that infants born to mothers taking antidepressants

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during late pregnancy be closely monitored for longer than the typical 24 to 48 hours after birth.

Health Canada recently published an advisory suggesting that women and their physicians consider slowly decreasing the dose of these medications during late pregnancy.[10] After this advisory appeared in the media, the Motherisk Program received many calls from concerned women and their health care providers wondering whether it was safe to use antidepressants during late pregnancy. Some women reported having abruptly discontinued their antidepressant medications.[11]

In assessing the risks and benefits of using antidepressants during late pregnancy, physicians need to consider the risks of discontinuing these medications near term and the risks of untreated depression during the third trimester. Neonatal risks appear to be limited to development of "poor neonatal adaptability" in 10% to 30% of babies.[5-9]

Untreated depression during pregnancy has been associated with miscarriage, perinatal complications, increased risk of preeclampsia, low neonatal Apgar scores, and increased admissions to neonatal intensive care units.[12] The most serious maternal ramification of untreated depression during pregnancy is an increased risk of postpartum depression, which can have tragic consequences.[13]

Among pregnant women, abrupt discontinuation of antidepressants has been associated with withdrawal symptoms, including nausea and vomiting, diarrhea, sweating, anxiety and panic attacks, mood swings, and suicidal thoughts.[14] Abrupt discontinuation of medications could also allow the primary psychiatric condition to resurface.[15]

The adverse effects on mothers and babies of untreated depression during pregnancy combined with the known (serious) risks associated with abrupt discontinuation of psychotropic medications appear to outweigh the risk of transient poor neonatal adaptation in only a very few neonates exposed to antidepressants during the third trimester.

After consultation with their physicians, women who decide to discontinue or taper their doses of antidepressants should do so as gradually as possible over several weeks. Women's moods and fetal well-being should be closely monitored during this period, especially after delivery.

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Do you have questions about the safety of drugs, chemicals, radiation, or infections in women who are pregnant or breastfeeding? We invite you to submit them to the Motherisk Program by fax at (416) 813-7562; they will be addressed in future Motherisk Updates.

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