Selective serotonin reuptake inhibitor discontinuation during pregnancy

At what risk?

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Abstract

Question I have a patient who discontinued her selective serotonin reuptake inhibitor in pregnancy against my advice owing to fears it might affect the baby. She eventually attempted suicide. How can we deal effectively with this situation?

Answer The "cold turkey" discontinuation of needed antidepressants is a serious public health issue strengthened by fears and misinformation. It is very important for physicians to ensure that evidence-based information is given to women in a way that is easy to understand. The risks of untreated moderate to severe depression far outweigh the theoretical risks of taking selective serotonin reuptake inhibitors.

Discontinuer les inhibiteurs sélectifs du recaptage de la sérotonine durant la grossesse

À quel prix?

Résumé

Question Une de mes patientes a cessé de prendre, à l'encontre de mes conseils, ses inhibiteurs sélectifs du recaptage de la sérotonine de peur qu'ils nuisent à son bébé. Elle a éventuellement tenté de se suicider. Comment pouvons-nous agir efficacement dans une telle situation?

Réponse La cessation du jour au lendemain d'antidépresseurs nécessaires est un grave problème de santé publique exacerbé par des craintes et des informations erronées. Il est très important que les médecins transmettent aux femmes des renseignements fondés sur des données probantes et faciles à comprendre. Les risques de ne pas traiter une dépression de modérée à grave surpassent largement les risques théoriques de prendre des inhibiteurs sélectifs du recaptage de la sérotonine.

Depression is a common medical condition that can be exacerbated during periods of stress and that can result in devastating consequences if left untreated. Up to 1 in 5 pregnant women experience depression. Treatment in this subpopulation is particularly challenging, partially secondary to discomfort with medication use during pregnancy.[1] While there have been conflicting reports regarding the safety of antidepressant use during pregnancy, current data do not show any substantial clinical adverse outcomes caused by their use.[2] Pregnant women and health care professionals continue to debate the use of antidepressants, such as selective serotonin reuptake inhibitors, often at medical risk to the women.[3]

We report the experience of a pregnant woman with a history of depression who abruptly stopped taking her selective serotonin reuptake inhibitor medication, sertraline. Her presentation underscored the importance of appropriately treating depression to minimize adverse effects to the mother and, consequently, the fetus.

Case

A 30-year-old woman who was pregnant for the second time after a previous termination of pregnancy presented to the Motherisk clinic at the Hospital for Sick Children in Toronto, Ont, to discuss the safety of sertraline use during pregnancy. She was at 6 to 7 weeks' gestation and had stopped taking her sertraline 1 week previously, following confirmation of her planned pregnancy. She also used alprazolam occasionally for anxiety or difficulty sleeping, and had alcohol once per month. She was not exposed

to any other chemicals, herbal medicines, infections, or recreational drugs. She had been diagnosed with depression at age 23 outside of Canada and, since then, she reported intermittent use of sertraline based on personal recognition of symptoms, typically during periods of stress or change. She had no psychiatrist in Canada.

Since discontinuation of her sertraline, which she had been taking for the past 6 months, she reported a substantial increase in her depressive symptoms. She developed ambivalent feelings about her pregnancy, difficulty sleeping, anhedonia, and episodes of uncontrollable crying. Her Edinburgh Postnatal Depression Scale score was 25; scores greater than 14 necessitate comprehensive psychosocial assessment for depression.[4] She reported thoughts of harming herself via attempts to terminate her pregnancy.

Counseling was provided regarding the safety of sertraline and antidepressants during pregnancy. It was emphasized that there was no strong evidence for clinically meaningful risk of fetal malformation.[5] It has been noted that there is a statistically significant risk of spontaneous abortion, preterm birth, or low birth weight ($P<.05$), but it is uncertain whether this risk is related to medication use or to depression itself.[6-8] The rare possibility of poor neonatal adaptation syndrome, a period of self-limiting signs requiring monitoring of respiratory rate, feeding, and irritability, was also discussed.[9] Before the counseling, the woman reported a 75% tendency toward pregnancy termination using the Motherisk visual analogue scale. After counseling, the tendency decreased to 60%.

Discussion

A healthy pregnancy requires an emotionally and medically healthy mother. The resurgence of severe depressive symptoms places women at risk of developing suicidal thoughts and poor health outcomes.[10,11] Our team has encountered a number of cases in which pregnant women died by suicide following abrupt discontinuation of their antidepressants.[12] Moreover, a large study found that women who discontinued antidepressants during pregnancy were nearly 3 times more likely to have a major depressive relapse or to be hospitalized than their counterparts who continued treatment were.[13] Worsening or re-emergence of depression can also affect a woman's attitude toward her pregnancy, as observed in this case.

Conclusion

This case highlights the need for ongoing education in the public and medical spheres regarding continuing antidepressant use during pregnancy, where the benefits of continuing use usually outweigh the risks. This is especially true in cases of severe depression. Pregnant women receive conflicting information from the Internet, media, and medical clinics, making it challenging for them to make a well-informed decision on controlling their symptoms. By equipping patients who have depression with evidence-based knowledge on antidepressant safety, health care professionals can ensure that the personal decisions the women subsequently make are grounded in science and support, as opposed to uncertainty and fear.

Competing interests
None declared

References

1. Yonkers KA, Wisner KL, Stewart DE, Oberlander TF, Dell DL, Stotland N, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2009;114(3):703-13.
2. Koren G, Nordeng H. Antidepressant use during pregnancy: the benefit-risk ratio. *Am J Obstet Gynecol* 2012;207(3):157-63. Epub 2012 Feb 21.
3. Mulder E, Davis A, Gawley L, Bowen A, Einarson A. Negative impact of non-evidence-based information received by women taking antidepressants during pregnancy from health care providers and others. *J Obstet Gynaecol Can* 2012;34(1):66-71.
4. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1987;150:782-6.
5. McDonagh MS, Matthews A, Phillipi C, Romm J, Peterson K, Thakurta S, et al. Depression drug treatment outcomes in pregnancy and the postpartum period: a systematic review and meta-analysis. *Obstet Gynecol* 2014;124(3):526-34.
6. Andersson L, Sundström-Poromaa I, Wulff M, Aström M, Bixo M. Neonatal outcome following maternal antenatal depression and anxiety: a population-based study. *Am J Epidemiol* 2004;159(9):872-81.
7. Rahimi R, Nikfar S, Abdollahi M. Pregnancy outcomes following exposure to serotonin reuptake inhibitors: a meta-analysis of clinical trials. *Reprod Toxicol* 2006;22(4):571-5. Epub 2006 May 23.
8. Källén B. Neonate characteristics after maternal use of antidepressants in late pregnancy. *Arch Pediatr Adolesc Med* 2004;158(4):312-6.
9. Byatt N, Deligiannidis KM, Freeman MP. Antidepressant use in pregnancy: a critical review focused on risks and controversies. *Acta Psychiatr Scand* 2013;127(2):94-114. Epub 2012 Dec 14.
10. Andersson L, Sundström-Poromaa I, Wulff M, Aström M, Bixo M. Implications of antenatal depression and anxiety for obstetric outcome. *Obstet Gynecol* 2004;104(3):467-76.
11. Christian LM. Effects of stress and depression on inflammatory immune parameters in pregnancy. *Am J Obstet Gynecol* 2014;211(3):275-7. Epub 2014 Jun 20.
12. Chan J, Natekar A, Einarson A, Koren G. Risks of untreated depression in pregnancy. *Can Fam Physician* 2014;60:242-3.
13. Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA* 2006;295(5):499-507.

MOTHERISK

Motherisk questions are prepared by the Motherisk Team at the Hospital for Sick Children in Toronto, Ont. **Ms Ejaz** is a visiting trainee with, **Dr Leibson** is a clinical fellow with, and **Dr Koren** is Director of the Motherisk Program. Dr Koren is supported by the Research Leadership for Better Pharmacotherapy during Pregnancy and Lactation.

Do you have questions about the effects 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**. Published Motherisk Updates are available on the *Canadian Family Physician* website (**www.cfp.ca**) and also on the Motherisk website (**www.motherisk.org**).