Perinatal Mood and Anxiety Disorders (PMADs)

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Learning Objectives

• Define various types of PMADs and how they present clinically.
• Identify tools to help make decisions regarding medication use in pregnancy and lactation.
• Discuss and document informed consent when prescribing to pregnant and lactating women.
Types of Perinatal Mood & Anxiety Disorders (PMADs)

- Baby blues
- Antenatal depression
- Postpartum depression
- Perinatal anxiety
  - OCD
  - PTSD
  - Panic Disorder
  - Tokophobia
- Postpartum mania/hypomania (Bipolar disorder)
- Postpartum psychosis
PMADs and Obstetrical Outcomes

• Contribute to 12% of all maternal deaths
• Leading cause of maternal mortality 1 year PP
• Higher rates of unplanned pregnancy
• Consistently linked to pregnancy related medical disorders (obesity, HTN and GDM) and poor obstetric outcomes (IUGR, Low Apgar, congenital malformations)
  – Increased inflammatory markers
  – Increased cortisol levels, HPS axis dysfunction
Biological Etiology PMADs

- Rapid shifts in hormones which acutely affect neurotransmitters in the brain
  - Estrogen
  - Progesterone
  - Oxytocin
- Thyroid disorders
- Sleep Deprivation
- Physical discomfort
- Genetic factors
Edinburgh Postnatal Depression Scale (EPDS)

- 10 item scale –self administered.
- Validated during pregnancy as well.
- Provider scored -5 minutes.
- Screening is recommended by Bright Futures, AAP Mental Health Task Force and American College of Obstetrics Gynecologists
Screening for Bipolar disorder – Consensus Bundle on Maternal Mental Health AJOG 2017

Recommends Bipolar screening prior to starting an antidepressant.

1. MDQ Mood Disorder Questionnaire – sensitivity 58% to 73%.

2. WHO Composite International Diagnostic Interview based Bipolar Disorder Screening Scale (CIDI 3.0)
   - 3 core questions and 9 symptom questions.
   - If either 2 stem question is positive, the third question is then asked.
   - Only if the third question is answered positively does the clinician proceed to the remaining questions.
   - 67% to 96% sensitivity

If positive = don’t start antidepressant and/or refer

ECHO IDAHO
Postpartum Depression

- Prevalence 10%-13%
- Onset: 2 weeks – 12 months postpartum
- Peak incidence 8 weeks
- DX/Screening: EDPS
- Other symptoms
  - Feeling inadequate as a parent
  - Obsessive thoughts or compulsions (57%)
  - Ego-dystonic thoughts of harming the infant (10-30%)
  - Suicidal thoughts
  - Panic Attacks
Pregnancy and Bipolar Disorder: Postpartum Period

Postpartum period clearly destabilizes mood

- BP women have 100-fold higher risk than women without a psychiatric illness history of experiencing postpartum psychosis (1) (10-25%)
- 40%-67% of the female BP subject population experienced postpartum mania or depression within 1 month of delivery (2)
- 70 times higher rate of suicide in the first month postpartum
- 50% of women with bipolar disorder are first diagnosed in postpartum period

“When a psychiatric condition necessitates pharmacotherapy, the benefits of such therapy far outweigh the potential minimal risks.”


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Risk of Untreated Antenatal Depression

- Decreased prenatal care, poor nutrition
- Increased maternal use of tobacco, alcohol or cocaine
- Maternal suicidal/homicidal behavior increased
- **Premature delivery, lower birth weight and smaller head circumference** (Fields 2006, 2011)
- Increased risk of preeclampsia, diabetes, cesarean delivery
- Developmental delays in the child
- Poor maternal infant bond and infant attachment
- Decreased rates of breastfeeding
- Increase in affective disorders in children and adolescents (Buss 2012)
- Alterations in the right amygdala of the neonate (Graboi 2013)
- Maternal Treatment of antenatal depression appears to help normalize cortisol levels (O’Hara 2013)
Medication Safety in Pregnancy and Lactation

- Reprotox: [www.reprotox.org](http://www.reprotox.org) access through Micromedex
- Motherisk.org: [www.motherisk.org](http://www.motherisk.org) 1-877-439-2744
- [www.infantrisk.com](http://www.infantrisk.com) ; (806) 352-2519; phone app also available
- Organization of Teratology Information Services: [www.mothertobaby.org](http://www.mothertobaby.org) good handouts
- MGH Women’s Mental Health Program: Newsletter updates [www.womensmentalhealth.org](http://www.womensmentalhealth.org)

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Antidepressant AD medications during pregnancy

- Selective Serotonin Reuptake Inhibitors (SSRIs) are by far the most studied medication in pregnancy than any other class of medication
  >200,000 pregnancy outcomes studied.
- Antidepressants are the 2nd most prescribed class of drugs in the world. *50% pregnancies in the U.S. are unplanned
- Increased use of SSRI in pregnancy in US: 6.0% of pregnant women 1999 to 10-13% in 2003

Boukhis JAMA ped 2015
<table>
<thead>
<tr>
<th>SSRI</th>
<th>Dosing</th>
<th>Clinical Pearls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram (Celexa)</td>
<td>Starting dose: 10 mg</td>
<td>• EKG above 40mg due to concern over QTC prolongation</td>
</tr>
<tr>
<td></td>
<td>Range: 20-40+ mg</td>
<td></td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>Starting dose: 5 mg</td>
<td>• Works a little faster than other SSRIs</td>
</tr>
<tr>
<td></td>
<td>Range: 10-20+ mg</td>
<td>• Not as activating for some patients</td>
</tr>
<tr>
<td>Fluoxetine (Prozac/Sarafem)</td>
<td>Starting dose: 10 mg</td>
<td>• Longest half life</td>
</tr>
<tr>
<td></td>
<td>Range: 20-80 mg</td>
<td>• Minimal withdrawal effect if missed dose</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>Starting dose: 50mg</td>
<td>• Dose at bedtime</td>
</tr>
<tr>
<td></td>
<td>Range: 100-300mg</td>
<td>• Used for OCD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not indicated for anxiety, panic</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>Starting dose: 10 mg</td>
<td>• Short half life</td>
</tr>
<tr>
<td></td>
<td>Range: 20-40+ mg</td>
<td>• Notable withdrawal effects if late/missed dose</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>Starting dose: 25 mg</td>
<td>• Most commonly prescribed in pregnancy and postpartum</td>
</tr>
<tr>
<td></td>
<td>Range: 50-200+ mg</td>
<td>• GI distress common at initiation</td>
</tr>
</tbody>
</table>

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Antidepressant medications during pregnancy – Summary of outcome data

- Not considered to be teratogenic
- Other associations have been noted and debated in the literature. Overall small relative risk and low absolute risk.
  - Autism
  - Neonatal distress syndrome/newborn adaptation syndrome/poor neonatal adaptation/SSRI discontinuation syndrome
  - Persistent Pulmonary HTN of Newborn (PPHN)
  - Miscarriage risk
  - Preterm birth and decreased birth weight
Psychotropics in Pregnancy - Basic Principles

- If you are going to treat – TREAT. Don’t expose women to medication and illness state.
- Preconception counseling - Gold Standard
- Reconfirm diagnosis
- Maximize non-psychopharm approach
- Avoid polypharmacy if possible
- Consider dose increase in third trimester
- Do not wean at 38 weeks
- Define and discuss R/B ratio
- Older medications over newer medications
- Animal studies tell us very little. Look for human data.
- Unknown does not mean safe.
Informed Consent- Perinatal Population

- Clearly discuss R/B ratio
- Document potential risks
- Involve partner if possible
- Document all other exposures including Tobacco, ETOH, Obesity, Co morbid conditions, other medications.
Psychotropics in Lactation - Basic Principles

- All Psychotropics are excreted in the breast milk.
- SSRI’s considered the most well studied agents in lactation of any class of medication.
- SSRI exposure (infant serum level) during lactation is generally lower than transplacental exposure. (30% in utero) vs (0-10% postnatal)
- Other psychotropics less predictable
  - Lithium, Lamictal: M/Infant serum ratio 30%-150% maternal dose
  - Premature and medically ill infants more vulnerable
- Generally, if a woman has been on medication in pregnancy she can continue it in lactation as exposure decreases.
Key Points

• Risk of untreated psychiatric illness generally outweighs the risk of psychopharmacologic treatment to mother and infant.

• Women with Bipolar disorder are at particularly high risk for postpartum relapse including postpartum psychosis.

• Do not wean medications at the end of pregnancy.
References

• Reprotox: www.reprotox.org access through Micromedex
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• LactMed: www.lactmed.nlm.nih.gov Free APP
• E-Lactania: http://www.e-lactancia.org/ingles/inicio.asp
• Tox Net www.toxnet.nlm.nih.gov