Screen Pregnant Women For Depression Risk

BY SHERRY BOSCHERT
San Francisco Bureau

San Francisco — Screen pregnant women to identify those who are at increased risk for postpartum depression, and plan home visits by a nurse with the at-risk group 10-14 days after delivery, Dr. Andrea J. Singer said at Perspectives in Women's Health sponsored by Ob.Gyn. News.

"Don't wait for the 6-week postpartum visit" in this at-risk group, advised Dr. Singer, director of women's primary care at Georgetown University Medical Center, Washington.

Approximately one in every eight pregnant women will develop postpartum depression, which generally appears within 3-4 months after delivery and affects roughly 560,000 U.S. women per year. Check a patient's history for clues to postpartum depression risk, she said.

Half of pregnant women with a history of postpartum depression will develop it again, she noted. Consider prophylactic therapy in this group, starting at the end of the third trimester or immediately following delivery.

One-third of women with major depression during pregnancy develop postpartum depression, as do one-fourth of women with a history of major depression before pregnancy.

Stressful events during pregnancy or the postpartum period, a history of mood disorder in a first-degree relative, or conflicts with the baby's father or the woman's primary partner increase risk for postpartum depression.

Women with shorter time intervals between pregnancies (who have other young children at home) or who deliver low-birth-weight infants or infants with frequent health problems also are at higher risk.

At the very least, ask each mother to complete the Edinburgh Postnatal Depression Scale at the first postpartum visit, she urged. Any woman whose total score is greater than 10 or who indicates that "the thought of harming myself has occurred to me" on the questionnaire is likely to be depressed and needs an assessment.

Dr. Singer and staff try to review the depression scale results during the visit. As a backup, her office works with a psychiatrist who reviews patients' results and flags those at risk for depression.

Postpartum depression is not the same as postpartum "blues," which affect 30%-75% of new mothers but resolve spontaneously in 4-10 days after delivery. If the "blues" continue past 2 weeks postpartum, "we're dealing with something else," she said.

The standard treatments for depression are used to treat postpartum depression.

Dr. Singer is on the speakers bureau of Pfizer, which makes an antidepressant drug. ■

Breast-Feeding's Benefits Outweigh Risk of Antidepressant Exposure

BY SHERRY BOSCHERT
San Francisco Bureau

San Francisco — All psychotropic medications are excreted into breast milk, but the benefits of breast-feeding generally outweigh the relatively small risks to the baby from antidepressants, Dr. Andrea J. Singer said.

The nutritional advantages and the bonding that occurs between mother and child during breast-feeding outweigh concerns about antidepressant effects on the infant, she said at Perspectives in Women's Health sponsored by Ob.Gyn. News.

The dose of antidepressant that the infant receives from the mother during breast-feeding is much lower than the dose received in utero because the drug crosses the placenta. If a mother and fetus have done well on an antidepressant during pregnancy, stick with that therapy after delivery. "The decision is easy—just continue," said Dr. Singer, director of women's primary care at Georgetown University Medical Center, Washington.

SSRIs are first-line therapy for lactating women with depression because they have the most data supporting safe use during breast-feeding and efficacy in treating postpartum depression. The aminoketone drug bupropion is a "not unreasonable alternative," but the amount of data on it is far more limited, she said.

Combining an SSRI with other supportive services is recommended for severe postpartum depression. There is no consensus for treatment of mild postpartum depression, Dr. Singer added. Consider psychotherapy either alone or with an SSRI for mild depression in lactating women.

Dr. Singer is on the speakers' bureau of Pfizer, which makes the SSRI sertraline.

Generally, sertraline is the treatment of choice for depressed lactating women because of the amount of data available on its use. The SSRIs paroxetine or fluvoxamine are first-line alternatives. Second-line treatment choices include citalopram and fluoxetine. Start with monotherapy when possible, she advised.

The long-term impact of trace levels of antidepressants in infants is unknown.

Most SSRIs and bupropion are rated Pregnancy Category C by the Food and Drug Administration. Tricyclic antidepressants fall in Category C or D.

"Most of my psychiatric colleagues don't look at labels so much as the amount of clinical trial data. There is far more experience with the SSRIs, particularly sertraline," she said. ■

Drugs, Pregnancy, And Lactation

ACOG's View on SSRIs

The multiple recent reports regarding the reproductive safety of the selective serotonin reuptake inhibitors have raised concerns about a spectrum of potentially adverse outcomes associated with SSRI use during pregnancy. But these reports have produced conflicting results and have been confusing for many patients and clinicians.

To date, no professional medical association has issued formal guidelines regarding treatment with SSRIs during pregnancy. However, in December, the American College of Obstetricians and Gynecologists Committee on Obstetric Practice published an opinion on this topic, which is noteworthy in its clarity and balanced review of the existing data. The opinion artfully underscores the relevant issues for reproductive-age women who suffer from depression and who are being treated with antidepressants (Obstet. Gynecol. 2006;108:1601-3).

BY LEE COHEN, M.D.

The ACOG committee makes clear there is no specific treatment algorithm for this population, recommending that "treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy be individualized" and that decisions about treating depression "should incorporate the clinical expertise of the mental health clinician and obstetrician, and the process should actively engage the patient's values and perceptions when framing the discussion of the risks and benefits of treatment."

The committee points out that many studies have not identified an increased risk for major congenital malformations associated with SSRI use during pregnancy. This is noteworthy, since more is known about the teratogenic risk of SSRIs than about most medications prescribed to pregnant women, including, as examples, various anti-infectives, antiemetics, and medicines used to treat gastroesophageal reflux.

The ACOG opinion does refer to the recent unpublished reports from a Swedish registry and a U.S. claims database associating first-trimester exposure to paroxetine with a greater risk of atrial and ventricular septal defects. (This prompted the Food and Drug Administration to change paroxetine's pregnancy category label from C to D in late 2005.) Interestingly, the committee does not suggest that paroxetine absolutely is contraindicated during pregnancy, but wisely states that paroxetine should be avoided when planning pregnancy and during pregnancy.

Also referenced in the opinion are reports of syndromes of perinatal toxicity or poor neonatal adaptation associated with SSRI exposure in late pregnancy—transient neonatal symptoms that include jitteriness, mild respiratory distress, weak cry, and neonatal ICU admissions—findings that I have addressed in previous columns. With respect to persistent pulmonary hypertension of the newborn (PPHN), the more serious outcome, the opinion summarizes the case control study that found a sixfold greater risk in PPHN associated with SSRI use after 20 weeks' gestation.

The PPHN finding was the topic of another FDA public health advisory in 2006, which, as the ACOG opinion points out, also addressed the risk of depression relapse. That advisory cites our study, which found relapse was fivefold higher among women who stopped antidepressants during pregnancy than it was among those who continued with treatment.

The opinion then states that "the potential risk of SSRI use throughout pregnancy must be considered in the context of the risk of relapse of depression if maintenance treatment is discontinued" and refers to the increased risks of low weight gain and alcohol and substance abuse that are associated with untreated depression.

The ACOG opinion advises that treatment decisions need to be carefully tailored, and "optimally, shared decision making among obstetric and mental health clinicians and women should occur before pregnancy." But, it concludes, 50% of pregnancies are unplanned; hence, preconception planning will not always be possible "and decisions regarding treatment with SSRIs will undoubtedly occur during gestation."

In our experience, we see directly what prompts women to make decisions about SSRI use during pregnancy. These decisions are not necessarily driven by severity or duration of illness, or number of past episodes, but more from their perception of risk and the willingness to accept the risk of depression relapse vs. fetal exposure to medication. Every patient applies her own calculus with respect to the amount of risk she and her partner may be willing to accept.

When it comes to prescribing SSRIs, we need to collaborate with patients on a decision in circumstances in which we have imperfect estimates of risk on both sides of the risk-benefit equation. As in any other clinical situation, we tailor treatment based on the clinical scenarios and patients' wishes.

Dr. Cohen *directs the perinatal psychiatry program at Massachusetts General Hospital, Boston, which provides information about pregnancy and mental health at www.womensmentalhealth.org. He is a consultant to manufacturers of several antidepressants, including SSRIs.*