NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

SSRIs and Pregnancy

Risk-Risk Conversation

Trainee Guide

Contributor
Sarah Nagle-Yang, M.D., Case Western Reserve University

Pre-reading (prior to session):

- Byatt, Nancy, Kristina M. Deligiannidis, and Marlene P. Freeman. "Antidepressant use in pregnancy: a critical review focused on risks and controversies." *Acta Psychiatrica Scandinavica* 127.2 (2013): 94-114.Warburton, W., C. Hertzman, and T. F.
- Yonkers, Kimberly A., et al. "The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists." *General hospital psychiatry* 31.5 (2009): 403-413.

Additional Reading (optional)

- Moses-Kolko, Eydie L., et al. "Neonatal signs after late in utero exposure to serotonin reuptake inhibitors: literature review and implications for clinical applications." *Jama* 293.19 (2005): 2372-2383.

Link to Video: https://youtu.be/fwd5v1j7cZ4

Objectives

- The learner will describe risks associated with untreated depression in pregnancy and postpartum
- The learner will formulate a perinatal case with a focus on depression management
- The learner will practice risk-benefit discussions in pregnancy
- The learner will appreciate unique factors in the management of perinatal depression in the context of risks of both medications and untreated psychiatric illness

Case Scenario

Ms. D is a 25yo G1 female at 24 weeks gestation who presents for an initial evaluation with chief complaints of depression and anxiety. Ms. D has had difficulty finding a provider who is comfortable managing her psychiatric medications during her pregnancy and found your name on your institution's website.

Psychiatric History: Ms. D has been treated for depression since age 18. She reports that when depressed her symptoms include low mood, hypersomnia, anhedonia, avolition, and feeling "overwhelming frustration and hopelessness." She states that when she has been at her worst, she was "completely not functional, in bed 23.5 hours a day." Anxiety symptoms seem to occur in conjunction with depressive episodes and are characterized by constant worry, feeling easily

overwhelmed, restless, "edgy," and tense.

Ms. D has periodically struggled with suicidal thoughts but has never had an attempt. She was hospitalized in 2015 for acute suicidality with plan to overdose on "pills and liquor." At other points, she has struggled with thoughts that it would be easier to die than to live with her depression.

Ms. D has had several medication trials in the past, including sertraline (ineffective at 200mg daily for 10 weeks), venlafaxine (ineffective at 225mg daily for 8 weeks), paroxetine (worked well but caused weight gain), and bupropion (exacerbated anxiety and was discontinued). Her current medication regimen includes:

- Escitalopram 20mg daily
- Lorazepam 1mg as needed (which she takes approximately twice weekly)

During the interview today, Ms. D tells you that her family doctor has been managing her medications since her inpatient admission in 2015. At her last appointment, she told him about her pregnancy, and he referred her to a psychiatrist, Dr. T. When she met with Dr. T. he told her that she would likely not need medications during pregnancy as the "pregnancy hormones" would suffice, but that if she insisted that she needed medication, he could prescribe her only sertraline or burpropion. She was disappointed at this advice as neither of these medications have been helpful to her in the past.

Through her own online research, she concluded the advice of Dr. T "just simply is not true" and decided to seek another opinion. She would like to discuss her medication options during pregnancy, but states that she also plans to discontinue all medications 1 month prior to birth in order to "not make my baby have to go through medication withdrawal."

DISCUSSION QUESTION

Q: How would you characterize the severity of Ms. D's illness? Why?

Psychiatric History, continued

Patient reports mild depressive symptoms currently, which she attributes to financial stress.

Denies any current suicidal ideation.

No history of panic attacks, obsessions/compulsions, hallucinations, delusions or manic episodes.

Family Psychiatric History:

Mother: Depression

Father: Bipolar Disorder and Alcohol Use Disorder

Brother: Bipolar Disorder, anxiety, and substance abuse (specifics unknown)

Paternal Grandmother with history of completed suicide

Medical History:

Asthma, severe

Allergies: penicillin

No other pregnancies

Substance Use:

History of tobacco use; quit 2 years ago

Occasional alcohol use prior to pregnancy

No illicit drugs

Social History:

Patient lives with her mother and 2 siblings.

Patient was born and raised in a Cleveland suburb by both parents.

She was previously working in a "vape store" in New Mexico, "it was the first time I had a job that I loved," but has been unemployed since moving back to Cleveland 3 months ago (when she learned of the pregnancy).

Boyfriend is the father of the baby, is still in New Mexico, but planning to move to Cleveland in the near future.

History of verbal and physical abuse per her father throughout her childhood; reports that her mother worked long hours while her father was disabled and was in the home "watching porn" and drinking most of the time.

MSE:

General: Patient appears well dressed and groomed, no abnormal movements

Speech: Normal rate and volume

Mood: Mildly anxious

Affect: Appropriate, bright, reactive Thought Process: Linear, goal-directed

Thought Content: No delusions, no hallucinations, no suicidality, no homicidality, no ruminations or obsessions

Behavior: Friendly, polite, interactive

Cognitive: alert and oriented x 3, language fluent

Insight/Judgement: good/good

DISCUSSION QUESTIONS CONTINUED

Q: What feedback would you give to Ms. D about the following?

- Her risk of recurrence during pregnancy
- If she does have a recurrence, the risks associated with an acute depressive episode during pregnancy

Q: What would be your advice for Ms. D right now? What factors would you consider when selecting a medication for her to take during pregnancy?

Q: Suppose you kept her on Lexapro. What would you tell her about the risks associated with taking Lexapro in the 3rd trimester? What would you advise her about her plan to discontinue the medication in the last month of pregnancy and her risks postpartum?

Q: What non-medications recommendations would you have for Ms. D?

RISK-RISK MODULE Instructions:

- Work with your partner to fill out the table on the next page to detail Ms. D's individual risk profile for untreated psychiatric illness.
- Use the table to practice with your partner how to talk to Ms. D about her individual risk profile.

Reproductive Domains	Risks Associated with Psychiatric Disorder	Risks Associated with SSRI Treatment
Congenital Malformations		Early studies: cardiac defects; PPHN (low absolute risk) More recent studies: no or very low association after corrections
Spontaneous Abortion		Equivocal studies; low odds ratios and same for women for stop SSRI prior to pregnancy
Length of Pregnancy		Preterm delivery
Size Effects		Small for gestational age baby
Withdrawal (Short-Term Risks)		Serotonergic withdrawal in newborn: - Gastrointestinal - Neuromuscular - Pulmonary - Psychiatric/behavioral Transient (24-48 hours); no treatment needed
Long-Terms Risks (Development)		Developmental studies show promise: - Prospective trials show catching up of any initial delays - Behavioral problems also occur in children of mothers with depression Autism studies are poorly constructed; no associations when sibling analyses and paternal factors are included
Other (e.g., Obstetrical Risks)		None known