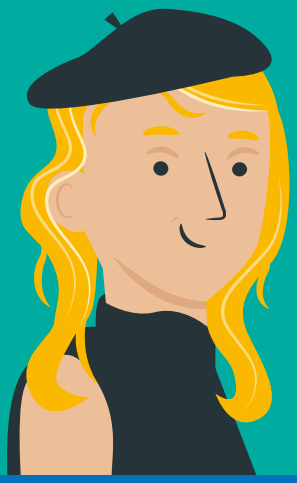


NHS
South East London

# Antidepressant in pregnancy and breastfeeding
## Guidance for GPs

This guide is intended to provide some initial information for prescribers in primary care considering antidepressant treatment for women who are either pregnant or planning a pregnancy. This guide does not provide detailed information about individual antidepressants. Prescribers should refer to the reference sources contained within this guide for information about individual antidepressants.

This guide is not intended for women with a serious mental illness (SMI) diagnosis. Women with an SMI diagnosis or women currently taking an antipsychotic or mood stabiliser should be referred to perinatal services. Women prescribed an antipsychotic or mood stabiliser who do not have an SMI diagnosis should be referred to the specialist team that initiated the antipsychotic or mood stabiliser.

## Background

Approximately 10% of pregnant women develop or have a pre-existing depressive illness[1]. Women who have had a previous episode of depressive illness are at higher risk of further episodes during pregnancy and postpartum. Relapse rates are higher in those with a history of depression who discontinue medication compared with those who continue. One study found that 68% of women who were well on antidepressant treatment and stopped during pregnancy relapsed, compared with 26% who continued antidepressants[2]. Risk is likely to be highest for women with a history of severe and/or recurrent depression[3]. The mental health of the mother influences foetal well-being, obstetric outcome and child development. The risks of not treating depression include harm to the mother through poor self-care, lack of obstetric care or self-harm and harm to the foetus or neonate.

Some data suggest that antidepressants may increase the risk of spontaneous abortion, pre-term delivery, low birth weight, respiratory distress in the neonate, a low APGAR (appearance, pulse, grimace, activity, and respiration) score at birth and admission to a special care baby unit. However, most studies are observational and did not control for maternal depression. Untreated maternal depression has itself been associated with an increased risk of spontaneous abortion, both low birth weight, small for gestational age and pre-term birth[4]. Selective serotonin reuptake inhibitors (SSRIs) do not appear to increase the risk of stillbirth or neonatal mortality[5,6].

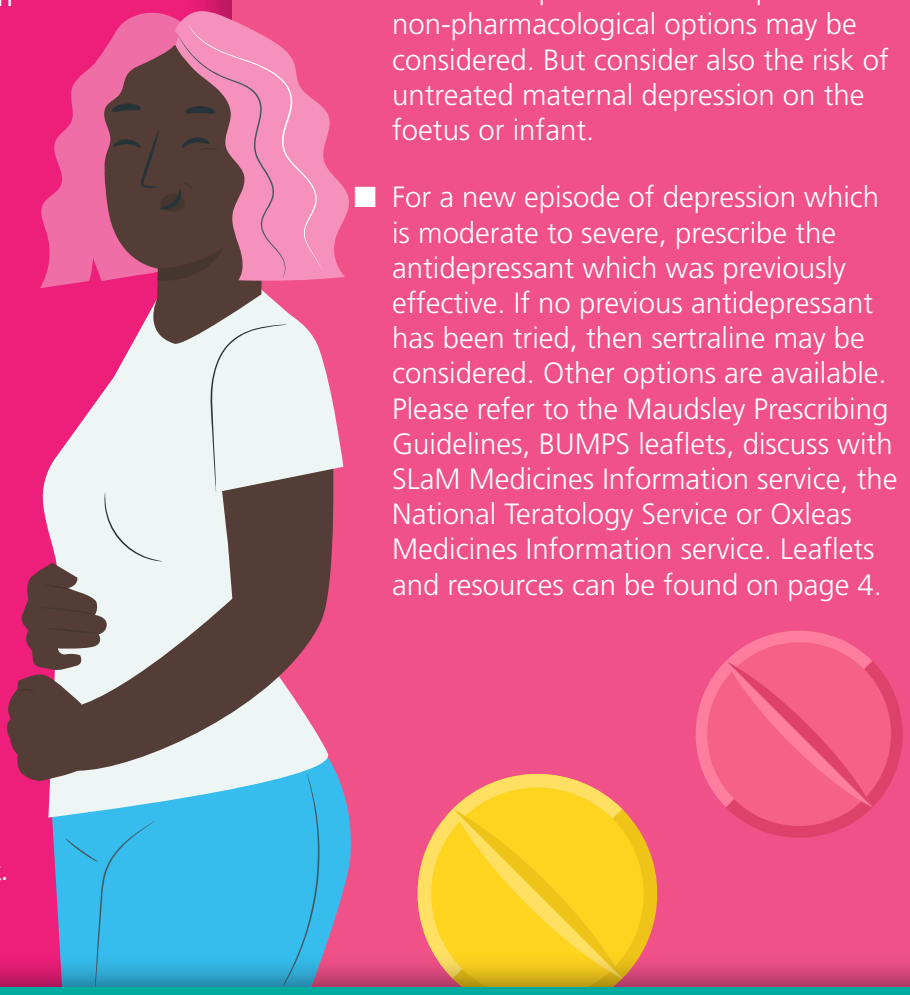
Some antidepressants have been associated with specific congenital malformations, many of which are rare and most of these potential associations remain unreplicated in further studies. SSRIs are not thought to be major teratogens.

Longer-term developmental outcomes with antidepressants are poorly studied. Maternal SSRI use has been associated with autism spectrum disorders[7-9]. However, large studies have failed to show this association after accounting for maternal illness[10-12] or have found it to be no longer significant[13,14].

# Recommendations for antidepressant use in women who are pregnant or are planning a pregnancy

## Women **currently** prescribed an antidepressant

- If the woman is currently prescribed an antidepressant and it is effective and well- tolerated continue it unless it is either contraindicated in pregnancy or the woman wishes to stop the antidepressant. Before stopping the antidepressant consider the risk of relapse of maternal mental illness and the risk of untreated maternal depression on the foetus or infant.
- It is not usually advisable to abruptly stop antidepressants. Contact South London and Maudsley (SLaM) Medicines Information service or Oxleas Medicines Information service for advice on how to stop antidepressants.
- If the woman is currently prescribed an antidepressant and it is not effective or not well-tolerated they can contact perinatal services, SLaM Medicines Information service or the Oxleas Medicines Information service, for advice on choice of antidepressant. If an antidepressant is not effective it should not be continued.



## Women **not currently** prescribed an antidepressant

- For a new episode of mild depression non-pharmacological options may be considered. But consider also the risk of untreated maternal depression on the foetus or infant.
- For a new episode of depression which is moderate to severe, prescribe the antidepressant which was previously effective. If no previous antidepressant has been tried, then sertraline may be considered. Other options are available. Please refer to the Maudsley Prescribing Guidelines, BUMPS leaflets, discuss with SLaM Medicines Information service, the National Teratology Service or Oxleas Medicines Information service. Leaflets and resources can be found on page 4.

# Some basic principles of antidepressant use in pregnancy

- For women at high risk of relapse it is usually best to maintain on the same antidepressant during and after pregnancy
- For new antidepressant prescriptions use the lowest dose that is effective.
- Remember to screen for smoking, alcohol, substance misuse and inform the woman of the known risks associated with these.
- Consider whether a referral to a specialist mental health midwife or caseload team may be appropriate during pregnancy, birth and postnatally.
- Liaise with the relevant Health Visiting team so that an antenatal contact can be offered and enhanced Health Visiting services be considered both antenatally and postnatally.
- Individualised birth planning can be made through the consultant obstetrician, consultant midwife and/or perinatal mental health team.

# Some basic principles of antidepressant use in breastfeeding

- It is usually advisable to continue the antidepressant which has been used during pregnancy.
- Switching for purpose of breastfeeding not usually sensible.
- When initiating a drug postpartum it is important to consider the mother's previous response to treatment.
- For new prescriptions postpartum sertraline or mirtazapine may be considered.
- Monitor infant for adverse effects, including abnormalities in feeding patterns and growth and development.
- If adverse effects or toxicity in the neonate are suspected refer to neonates or paediatric team, depending on age of baby and Trust guidelines, and advise the woman to stop breastfeeding and to switch to formula.
- Women receiving sedating medication should be strongly advised to not co-sleep in bed/sofa, as they may fall asleep and roll onto the baby, with a potential risk of hypoxia to the baby. Here is link to Lullaby Trust for sleep advice. Sedation may affect a woman's ability to interact with their children.

# Some further information

- Monoamine oxidase inhibitors (MAOIs) should be avoided in pregnancy because of a suspected increased risk of congenital malformations and because of the risk of hypertensive crisis. For women currently prescribed an MAOI, they can discuss this with perinatal services, SLaM Medicines Information or the Oxleas Medicines Information service.
- Women taking antidepressants should be monitored for gestational hypertension.
- An association between SSRIs and an increased the risk of postpartum haemorrhage has been reported. Obstetricians and midwives need to be aware of this possible increase in risk and monitor for blood loss after labour.
- Exposure to selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors during pregnancy is associated with an increased risk for persistent pulmonary hypertension of the newborn. The absolute risk appears to be small and may exist only in late pregnancy exposure and may be lower with sertraline than with other SSRIs.
- Poor neonatal adaptation syndrome and neonatal withdrawal symptoms has been reported with antidepressants. Continuing to breast feed and then 'weaning' by switching to mixed (breast/bottle) feeding may help reduce the severity of withdrawal reactions.

## Links to information

Bumps leaflets

Royal College of GP - Perinatal Mental Health Toolkit

NICE Guidance CG 192 Antenatal and postnatal mental health

Maudsley Prescribing Guidelines 14th edition

UKTIS.org

Breastfeeding Network

## Useful contact numbers

SLAM perinatal service and referral form

Oxleas perinatal service and referral form

SLAM Medicines information service 020 3228 2317

Oxleas Medicines information service 01322 625 002

National teratology service 0334 892 0909

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*Please note that women depicted in this document are for illustrative purposes only.
This tool is designed for use by all pregnant women, birthing people and those who breast or chest feed.


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*The guideline will be reviewed every 2 years in line with the review of the Maudsley Prescribing guideline.