

From the editor



Depressed and pregnant: Now what?

What do you do when a patient with major depressive disorder who is being successfully maintained on medication wants to become pregnant or has just learned she is pregnant?

If you're like me, you worry—a lot. If you stop maintenance antidepressants, the chance of depressive relapse is substantial. If you continue the medication and the child has congenital anomalies, the chance of you being blamed is substantial. Either way, you can be sued for malpractice.

Two articles this month address this dilemma: an evidence-based review on use of SSRIs in pregnancy (*page 31*) by Caitlin Hasser, MD, Louann Brizendine, MD, and Anna Spielvogel, MD, PhD, from the University of California, San Francisco, and a commentary on the FDA's paroxetine advisory (*page 45*) by Lawson Wulsin, MD, of the University of Cincinnati.

FDA categorizes most drugs we prescribe as pregnancy risk category C, "Risk cannot be ruled out." Paroxetine has recently been moved to category D, "Evidence of risk to the fetus in human studies." About 3% of births involve anomalies; a recent study of women who took paroxetine during pregnancy showed a 4% rate. If you treat 30 or more pregnant, depressed patients during your career, odds are that at least one of them will have a child with birth defects, purely by chance.

If we continue antidepressant therapy during pregnancy, the best we can do is study the literature, document that we discussed risks and benefits with the patient, and avoid paroxetine if possible. If we discontinue the medication, the best we can do is document that we discussed risks and benefits with the patient and follow her closely for depressive relapse.

Nobody said this job would be easy.

James Randolph Hillard, MD