

Pregnant and mentally ill: Protecting mother and child

In reproductive psychiatry, we can find ourselves taking 1 step forward and 2 steps back. In the February 2008 article "Treating anxiety during pregnancy: Just how safe are SSRIs?" the authors propose an algorithm for treating anxiety disorders in pregnancy. The dangers of extrapolating from small studies with limited distinction between true mental illness and sub-optimally treated mental illness are evidenced in references to the Suri et al paper.¹ Of greater concern is limited consideration of the risk of relapsing to disabling mental illness in the postpartum period.

Discontinuing a selective serotonin reuptake inhibitor (SSRI) may prevent or protect against developing a self-limited syndrome without evidence of long-term or significant sequelae, but it also puts a psychiatrically vulnerable woman at risk of developing postpartum illness and its myriad acute, interim, and long-term consequences. As is alluded to in the article, but not clinically applied in the authors' recommendations, the teratogenicity of benzodiazepines has not been supported by recent cohort studies.²

In addition, Dr. Nasrallah's editorial ("Pregnant and mentally ill: A labor-intensive clinical challenge") might mislead clinicians about the FDA's drug classification system's utility, which rewards limited data and encourages clinicians to choose medications that have been less exhaustively studied over those with a richer data set.

The most telling example of the need to look beyond the FDA system



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lies in the recently amended classification of bupropion as a Category B medication. The use of bupropion in pregnant patients has limited anecdotal data and very small animal samples to support its safety, whereas SSRIs such as fluoxetine and citalopram are category C despite >2,000 cases of first-trimester exposure as evidence of their safety.

In our efforts to protect our patients and their future children, we must carefully consider the potential paradoxical impact of our efforts to "do no harm."

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References

1. Suri R, Altshuler L, Helleman G, et al. Effects of antenatal depression and antidepressant treatment on gestational age at birth and risk of preterm birth. *Am J Psychiatry* 2007;164(8):1206-13.
2. Wikner BN, Stiller CO, Bergman U, et al. Use of benzodiazepines and benzodiazepine receptor agonists during pregnancy: neonatal outcome and congenital malformations. *Pharmacoepidemiol Drug Saf* 2007;16(11):1203-10.

Dr. Nasrallah responds

Thanks to Drs. Freeman and Brogan for their thoughtful comments. I agree that traditionally sound clinical principles do not apply in the absence of evidence-

based data, as is the case with treating mental illness in pregnant women. For ethical and legal reasons, we never will be able to establish with prospective controlled clinical trials which psychotropic drugs qualify as Category A during pregnancy. I also agree that animal studies used to classify a drug (such as with clozapine) as Category B may not be practical in humans and extensive clinical databases such those supporting the safety of SSRIs in pregnancy should be considered useful clinical evidence.

I implied in my editorial that physicians must exercise judgment when treating mentally ill pregnant women by weighing the risks and benefits of using a psychotropic because no drug is indicated for these patients. Psychiatrists face a similar dilemma when treating dementia-related psychosis; most geriatric psychiatrists still select an atypical antipsychotic based on clinical usefulness and safety, despite a "black box" warning and lack of an approved indication.

Managing mentally ill pregnant women is a prime example of how clinicians exercise good judgment in the absence of definitive scientific evidence or guidelines.

Dr. Brizendine & colleagues respond

We agree with concerns raised by Drs. Freeman and Brogan about the risk of relapse of disabling mental illness in the postpartum period if not aggressively treated in women with a history of postpartum depression. The topic of treating postpartum depression is well covered in the literature and was not the focus of this article on treating anxiety disorders in pregnant women.

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