A Guide to Managing Depression in Pregnancy

ACOG and APA collaborate on recommendations for treatment depending on disease severity.

BY DIANA MAHONEY

Women taking antidepressants who are thinking about getting pregnant might consider tapering or discontinuing drug therapy if they have experienced only mild or no symptoms for at least 6 months, depending on their psychiatric history, according to a new report on the treatment of depression during pregnancy.

The report, issued jointly by the American Psychiatric Association and the American College of Obstetricians and Gynecologists, also said medication discontinuation might not be appropriate for women with a history of severe recurrent depression or those who have psychosis, bipolar disorder, other psychiatric illness requiring medication, or a history of suicide attempts.

The report was published in the September issue of Obstetrics and Gynecology, and produced by an APA/ACOG work group convened to evaluate and summarize information about the risks associated with depression and antidepressant therapy during pregnancy. Representatives from both professional associations, along with a consulting developmental pediatrician, conducted a critical review of published literature on fetal and neonatal outcomes associated with depression and antidepressant treatment during childbearing.

The authors concluded that the symptoms of depression and exposure to antidepressant therapy might be linked to certain fetal growth and development changes, "but the available research has not yet adequately controlled for other factors that may influence birth outcomes, including maternal illness or problematic health behaviors that can adversely affect pregnancy," wrote lead author Dr. Kimberly A. Yonkers of Yale University, New Haven, Conn., and her colleagues (Obstet. Gynecol. 2009;114:703-13). The report is being published concurrently in the September/October issue of General Hospital Psychiatry (doi:10.1016/j. genhosppsych.2009.04.003).

For preconceptional patients receiving pharmacologic treatment for depression, a determination of the severity of symptoms should guide management recommendations, the authors wrote. Patients with suicidal or acute psychotic symptoms should be referred to a psychiatrist for aggressive treatment and counseled to wait a period of time after achieving euthymia before conceiving.

Similarly, patients with moderate to severe symptoms should continue and optimize antidepressant therapy and wait for a period of time before conceiving.

"While it is difficult to specify an exact or optimal length of time for all patients, guidelines such as those from the [Agency for Healthcare Research and Quality] suggest antidepressant treatment for a first, acute episode of depression should endure at least 6-12 months," they wrote.

For women with mild or no symptoms for at least 6 months who are candidates for medication discontinuation, the decision to initiate a treatment hiatus should be made in consultation with her psychiatrist, and the subsequent taper should be slow—such as a 25% reduction in dose every 1-2 weeks with close monitoring for relapse, the authors said.

The obstetrical care of women with a history of severe, recurrent mood disorders who continue drug treatment should also be coordinated with the psychiatric provider to monitor for illness relapse, they wrote, noting also that some women may benefit from individual or group psychotherapy, alone or in combination with medication.

Women with untreated depression that is diagnosed during pregnancy and those with depression who have discontinued their medication should similarly be evaluated for symptom severity and, if necessary, referred for psychiatric consultation, according to the report.

For patients with severe depressive, suicidal, or psychotic symptoms, the use of antiepileptic agents, newer antipsychotic drugs, and antidepressants should be avoided in the first trimester, if possible, because of the teratogenic potential of the antiepileptics and relative lack of reproductive safety information for the newer antipsychotics and antidepressants, the authors stated.

Those women who are not "gravely disabled or at high risk of relapse" may benefit from psychotherapy, and those with bipolar affective disorder should be managed by a psychiatrist because of the risk that antidepressant monotherapy could trigger mania and psychosis, they wrote.

In all women who begin antidepressant treatment during pregnancy, the treatment choice should be guided by the drugs' safety profile and the stage of gestation, as well as the patient's symptoms, history, and preferences, the authors stressed.

For women who are taking antidepressant medication when they become pregnant, "if the patient is willing to consider discontinuation of medication and she is not currently having symptoms, then, depending upon the individual's psychiatric history, a trial of medication taper may be appropriate," the authors wrote. They noted, however, that "women with a history of severe, recurrent depression, even if currently asymptomatic or minimally symptomatic, are at a high risk of relapse if medication is discontinued." For those women who prefer to continue medication, "discuss risk/benefit issues and document this discussion and the patient's choice, in her medical record," they advised.

If a woman being treated for severe depression refuses to continue medication, alternative treatment, such as psychotherapy, and close monitoring are advised. Similarly, women with depressive symptoms or recurrent depression despite medication, might benefit from the addition of psychotherapy, the authors wrote.

In addition to the recommendations, the report addresses several frequently asked questions about antidepressant treatment during pregnancy. In evaluating the cumulative research related to antidepressant use in pregnancy, the authors noted several limitations. Specifically, few of the studies that assessed associations between antidepressant treatment and birth outcomes included information on maternal psychiatric illness and confounding factors that influence birth outcomes, such as poor prenatal care and drug, alcohol, and nicotine use, which occur at a higher rate among depressed vs. nondepressed women, were often not controlled.

Some of the report authors disclosed having received research support and consultants fees from various pharmaceutical companies, including Eli Lilly, Pfizer, Wyeth, Boehringer Ingelheim, Bayer Schering Pharma AG, Berlex, and GlaxoSmithKline. ■

Most U.S. Women Report Using Postpartum Contraceptives

BY HEIDI SPLETE

The majority (88%) of postpartum women reported current use of at least one form of contraception, based on an analysis of data from more than 43,000 women.

Reducing the percentage of births within a year of a previous birth among women in the United States is one of the Center's for Disease Control and Prevention's Healthy People 2010 goals. Use of effective contraceptive methods after a recent pregnancy can help prevent unintended pregnancies, ensure adequate birth spacing, and reduce adverse maternal and infant outcomes, according to Maura Whiteman, Ph.D., and colleagues at the CDC.

The researchers reviewed data from the CDC's Pregnancy Risk Assessment Monitoring System from 2004 to 2006 from New York City and 12 states. The postpartum period was defined as 2-9 months after giving birth. The report is the first population-based study to examine differences in postpartum contraceptive use based on maternal characteristics (MMWR 2009;58:821-6).

Overall, 62% of of 43,887 postpartum women reported using highly effective contraceptive methods (such as sterilization, IUD, pill, patch, or ring).

Another 20% reported using moderately effective methods (such as condoms) and 6% reported using less effective methods (such as the rhythm method, sponge, or diaphragm), while 12% reported no postpartum contraception, they reported.

Women who were least likely to use at least one method of contraception included those who had no prenatal care, women aged 35 years and older, women who said they wanted to get pregnant sooner, and women who identified themselves as Asian/Pacific Islander.

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When the data were broken down by race, highly effective postpartum contraception use ranged from a low of 35% among Asian/Pacific Islanders to a high of 71% among black women and American Indian/Alaska Native women.

In addition, women with Medicaid coverage prior to pregnancy were more likely to use highly effective contraception postpartum than women without Medicaid, while women with no prenatal care were less likely to use highly effective contraception postpartum than those who had any prenatal care.

The study was limited by several factors, including the use of self-reports, a lack of data from all parts of the United States, and a lack of data on several additional contraceptive methods such as spermicides, emergency contraception, and lactational amenorrhea.

But the results can help clinicians identify women who need more information about postpartum contraception, the researchers noted.

"Health care providers should consider encouraging postpartum women to use highly effective contraceptive methods to increase the proportion of pregnancies that are intended and promote healthy birth spacing," they said. ■