

Antidepressants during Pregnancy

Why take antidepressant medication in pregnancy?

As the name suggests, antidepressants are usually prescribed for depression although they are also sometimes prescribed for other conditions such as anxiety, obsessive compulsive disorder, bipolar affective disorder (aka manic depression) and pain.

Depression and anxiety in pregnancy are common, particularly in those who have a past history of these difficulties. There is evidence to show that mothers who suffer with untreated depression can struggle to interact warmly with their babies, and this can have long term implications for bonding and infant development. There is also evidence that women with recurrent depression who stop their antidepressant because they are pregnant are at much greater risk (about 3 times more likely) of having a relapse of depression than those who continue on their medication. Hence during pregnancy and after birth, the possible risk to the baby of using medication must be balanced against the possible benefits.

Which antidepressant medication is best in pregnancy?

All antidepressants will pass through from the mother's bloodstream to the baby's during pregnancy so it is important that we understand as much as possible about any effect they may have on the baby.

We cannot carry out randomised treatment studies in pregnant women (where some women are given the medication and some are given a placebo) so most of our information comes from finding out all we can about babies born over the years to women who have taken antidepressants. This information takes time to gather, so we usually have more evidence about antidepressants that have been in use for many years (decades for many of these medications).

In situations where an antidepressant is being started for the first time in pregnancy, the current recommended SSRI antidepressant in pregnancy is Sertraline and the most commonly recommended Tricyclic antidepressant in pregnancy is Amitriptyline.

However, if you are already taking an alternative antidepressant (apart from certain types as described below) it is often advised to carry on with the same antidepressant rather than change to a different one. Changing medications may lead to relapse as the new one may not be effective, and the unborn baby will be exposed to two different medications rather than only one.

How do I make the best decision for my baby and me?

There is no perfect answer, as everyone feels differently about the risk of becoming ill and the risk to the unborn baby. Even in a pregnancy without any

medication, the risk of having a baby with a birth defect is about 2 or 3 in 100 pregnancies, so there is never a way of ensuring that everything will go ideally. The important thing is to consider the different risks and benefits and make a decision that is informed and is right for you. This handout is intended to give you some helpful information for this decision.

If you have taken antidepressants during pregnancy, make sure your Obstetrician knows, as they may wish to pass this information on to the Paediatrician when your baby is born.

Risks of medication in pregnancy:

There are several different risks to consider:

- Teratogenicity (risk of malformation)
- Withdrawal in the newborn baby
- Long term effects on the child

1) Teratogenicity

SSRIs (such as Fluoxetine, Citalopram or Sertraline) have a lot of evidence showing that they are safe in pregnancy, but some studies have suggested a small risk of some problems. Many of these studies contradict each other, so any risks present are likely to be extremely low

One large study has shown a slightly increased risk of septal heart defects (usually 5 in 1000) if Fluoxetine (6 in 1000), Sertraline (15 in 1000) or Citalopram (11 in 1000) are taken in the first trimester, and this risk is increased if more than one of these medications is taken at this time (21 in 1000), (as would happen if someone finds out they are pregnant and switches from their usual antidepressant to one that is perceived as safer in pregnancy). Septal heart defects sometimes require surgery, but sometimes resolve without intervention. Paroxetine has also been implicated more strongly in causing cardiac defects, and so other antidepressants are preferred for use in pregnancy.

SSRIs taken after 20 weeks of pregnancy have been linked to some babies having raised blood pressure in their lungs immediately after birth (a condition known as “pulmonary hypertension”). The early indication is that this risk goes up from about 1-2 in 1000 (in those taking no medication) to 3 in 1000 (in those on SSRIs). Pulmonary hypertension can affect the baby’s breathing, and can be a serious concern, so some pregnant women choose to stop their SSRI a few weeks before they’re due to deliver. There is not yet enough evidence to know whether this helps reduce the risk of pulmonary hypertension and it may increase the mother’s risk of depression at the time of birth.

There is also some suggestion that SSRIs can be linked to low birth weight, early miscarriage and preterm birth – but maternal depression is also known to cause this.

Remember these risks with SSRIs are **suspected** (not definite) and **small**.

Tricyclic antidepressants have been in use for at least 40 years, and until recently no studies have shown any association with malformation, developmental delay or any adverse outcomes, other than possibly some mild withdrawal effects. However one recent large study has suggested there may be similar small suspected risks to those found with SSRIs.

It can be difficult to be sure whether the small risks associated with these medications are truly caused by the antidepressants, or are because of the depressive illness itself, or perhaps even some third factor.

There is some evidence that suggests that switching antidepressants in the first trimester (eg from a medication perceived to be higher risk in pregnancy to one thought to be safer) may in fact increase the risk of teratogenicity.

2) Poor neonatal adaptation

There have been various reports of symptoms seen in babies who have been exposed to Tricyclics, SSRIs and SNRIs during late pregnancy. Venlafaxine and Paroxetine seem to be slightly more likely to cause these symptoms after birth, but all antidepressants carry this risk to some extent. Symptoms can include agitation, irritability and in very rare cases, seizures. However this occurs in a minority of cases and lasts only a short period of time. It is not clear whether these symptoms might be due to a withdrawal from the medication the babies were exposed to in utero, or whether it is a reaction to the medication.

Some women choose to stop their antidepressant a few weeks before they're due to deliver to reduce the likelihood of this happening, but in fact the risk of developing depression may be a greater concern than the small possibility of a minor and brief symptoms in the baby.

3) Long term effects on the child

Studies on Fluoxetine and Tricyclics during pregnancy show no detectable effects on the child's IQ or behaviour. Other antidepressants have not been studied in as much detail, but we have no reason to believe they have any negative long-term effects.

One large recent study has shown that babies born after their mums have taken SSRI antidepressants in pregnancy may be slightly more likely to be on the autistic spectrum, although without learning difficulties. This apparent connection may be due to other factors and is not necessarily caused by the medication, but even if the antidepressants were found to be the cause they would account for only 0.6% of children diagnosed with autistic spectrum disorders. Once again these risks are **suspected** (not definite) and **small**.

(Venlafaxine can cause increased blood pressure in anyone who takes it, and in pregnancy it may be particularly important that medical staff monitor this regularly.)

More specific information about particular antidepressants in pregnancy can be found at www.medicinesinpregnancy.org which is part of the UK Teratology Information Service website (www.uktis.org).

Risks of untreated depression in pregnancy:

Maternal depression can affect the baby both before and after birth. Some studies have shown an association between depression and low birth weight or preterm birth. There is also some early evidence to suggest that being depressed or anxious during pregnancy can affect the baby later in life, though more work is being done in this area and the data is not yet clear. After birth, depression can affect the mother's ability to bond with her baby and respond to its needs, and this is associated with behavioural problems, insecure attachment and a slight decrease in IQ.

Risks of medication in breastfeeding:

All antidepressants pass into breast milk from the mother's bloodstream to some extent, but the amount that the baby absorbs will always be less than during pregnancy if the mother was taking the same antidepressants while pregnant.

No serious side effects have been reported in children whose mothers took SSRIs during breastfeeding. Citalopram and Fluoxetine are present in breast milk in relatively higher concentrations, and Sertraline and Paroxetine in lower concentrations. But if the mother is already on an SSRI that is working for her, it may not be helpful to change this to one that is present in smaller amounts in breast milk.

No serious side effects have been reported in children whose mothers took Tricyclics during breastfeeding, except for Doxepin. Relatively low concentrations of Imipramine, Nortriptyline and Amitriptyline are present in breast milk.

Breastfeeding does not automatically have to stop because an antidepressant has been commenced – this decision needs to be made individually. There are benefits to a baby in breastfeeding, and in having a healthy mother, all of which needs to be considered. However the risks of breastfeeding on medication may be greater if the baby is premature, or has any problems with its heart, kidneys, liver or brain. In all cases the baby should be watched for signs such as drowsiness or colic.

Detailed information about safety of individual medications can be found at <https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

Alternatives to medication:

It may be possible for psychological therapy to be arranged to treat your illness instead of medication. For mild to moderate depression psychological therapy has been shown to be as effective as medication, and it may even be preferable with anxiety disorders.

It is also reasonable in some cases for a decision about medication to be delayed, and the patient's mood monitored over a period of time to assess for any improvement or deterioration. Sometimes this is combined with self-help strategies, which can guide an individual in taking the steps they need towards improving their state of mind on their own.

The decision about medication is different for each person, and it is important that you discuss with your doctor the specific factors affecting what choice you make for yourself and your baby. It is also important to remember that the earlier you discuss this issue with your doctor, the easier it will be to make wise decisions about how to proceed. Thinking about medication before you are even pregnant can often be the best way forward.

For more information, please see the NICE guideline:

www.nice.org.uk/nicemedia/pdf/CG045NICEGuidelineCorrected.pdf

Dr Fiona Murray, May 2009

Updated Oct 2009

Updated June 2010

Updated August 2011

Updated October 2011

Updated June 2013

Updated July 2014

Dr Robert Stewart, Updated April 2017

Please be aware that this handout requires regular updates for accuracy, and ensure that your healthcare professional has given you the most recent version available from the Perinatal Mental Health Service. It is intended to aid discussion with your doctor, not as a substitute for this discussion.