Perinatal Psychiatry

- Who should be referred to a psychiatrist during pregnancy?

- Women with a history of serious mental illness:

  - Schizophrenia
  - Bipolar Disorder
  - Schizoaffective Disorder
  - Severe Depression

- What questions should be asked?

1) Do you have a history of mental health problems?

2) Have you seen a psychiatrist or been in hospital because of a mental health problem?

3) Does anyone in your family have a history of Bipolar Disorder, or Postnatal Psychosis?

Treatment in Pregnancy

Guidelines are useful

NICE guidelines

Management of depression during pregnancy: a report from the American College of Obstetricians and Gynaecologists.

Yonkers K.A. et al

Medication during pregnancy

- Risk/benefit discussion and informed consent
- Don’t just stop a medication because of the pregnancy
- Risk of deterioration
  - Severity of condition
  - Current mental state
  - Recurrent condition
  - Psychosocial support

What do we know about depression in pregnancy?

- Miscarriage ?
- Growth Effects ?
- Preterm Delivery ?
- Neonatal Effects Elevated Cortisol
  ↑ ® Frontal EEG activation
  ↓ vagal tone

Long time effects unclear.

What do we know about SSRIs in pregnancy

- Miscarriage ?
- Growth Effects Low birth weight
  Small gestational age
  shown by some studies
- Preterm birth PTD < 37/40
  shown by some studies

  Longer exposure more likely to decrease gestational age.

- Teratogenic effects — No consistent information to suggest morphological teratogenic risks apart from paroxetine and heart defects
- Foetal Effects — Neonatal Adaptation Syndrome

  PPHN risk elevates from 1.2/1000 to 3/1000

  Limited information re long term effects

What about Lactation?

- Low levels in breast milk
- Fluoxetine has long half-life and may accumulate in baby
- Paroxetine and venlafaxine shortest half-life but have more side effects in mum
- Chose antidepressant according to desired effects (eg anxiolysis) and previous experience

What do we know about other antidepressants?

- Tricyclics
  - Early concerns about limb reduction malformations not born out by subsequent meta-analyses
  - Serum-level monitoring
  - Better option than benzos for sleep/anxiety
  - Reasonable safety in lactation
- Others
  - Venlafaxine, bupropion, mirtazapine - caution
  - Hypericum (St John's Wort) – no evidence of safety

What do we know about other psychotropic medications?

- Mood stabilisers
  - Lithium
    - Increased risk of Ebsteins anomaly
    - Taper and stop then resume
    - Monitor serum levels
    - Problems with breast feeding
  - Anticonvulsants
    - Dose related
    - Alternative if possible

What do we know about other psychotropic medications?

- Antipsychotics
  - Typical (usually injectable and high potency)
  - Atypical – more commonly used, relatively new, paucity of evidence
  - Minimal excretion into breast milk
  - Clozapine

- Benzodiazepines
  - Increased risk of midline clefts in first trimester
  - Soft neurological signs in second and third
  - Increased risk of apnoea and “floppy baby” in third trimester
  - Prefer not to use in lactation but can “pump and dump” with short-acting hypnotics

Management

- 50% of all pregnancies not planned
- Avoid anti epileptic drugs in 1st trimester if possible
- Avoid polypharmacy if possible
- Counsel re alcohol, tobacco and other drugs
- Aim for women being well at time of delivery

Commonly asked questions re SSRIs

- Should SSRI be changed if woman taking Paroxetine?
- Counselling after postnatal treatment with SSRI
- Should SSRIs be decreased prior to delivery?
- Contraindications to stopping SSRI in pregnancy

Any Questions?