

HELPING PATIENTS STOP PSYCHIATRIC MEDICATIONS DURING PREGNANCY

DEB COWLEY MD UNIVERSITY OF WASHINGTON







GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

Director, Perinatal Psychiatry Consultation Line



OBJECTIVES

- 1. Describe general approach to prescribing during pregnancy
- 2. Apply understanding of risks of medications versus underlying psychiatric disorder to a specific case example
- 3. Discuss approach to discontinuing medications for or during pregnancy



CASE EXAMPLE

 Danielle is a 28 yo woman with a history of depression who would like to become pregnant. She is taking sertraline 200 mg daily, clonazepam 0.5 mg bid, and trazodone 100 mg qhs. What would you advise her about taking these medications during pregnancy?





GENERAL APPROACH

Weighing risks and benefits



GENERAL APPROACH TO PRESCRIBING IN PREGNANCY

Be supportive if the patient goes against your recommendations

There are many reasons why a woman might choose to go against her psychiatric treatment provider's advice, particularly regarding drug use during pregnancy.

It is important that the treatment provider continues to support the patient despite such disagreements.

Again, a team approach will often help avoid disagreements, and providing as much information as possible on the risks of untreated psychiatric disorders during pregnancy can also be helpful

RULE 5

Use a team approach

This includes family and other doctors involved in the patient's care.

To provide good care for mother and child it is essential to educate the family about the risks and benefits of treatment and no treatment, as well as signs and symptoms of relapse.

Similarly, communicating directly with the obstetrician and the pediatrician will minimize miscommunication and differences of opinion, and maximize the patient's treatment outcomes

RULE 4

Minimize the number of exposures for the baby

Try to minimize the number of drugs used but consider exposure to psychiatric illness an exposure.

Changing drugs once a woman is pregnant increases the number of exposures. One common scenario is for a woman on a newer psychotropic drug to become pregnant and be switched to an older drug that has more evidence for safety. This plan increases the exposures for the baby—first to the newer drug and secondly to the older drug.

In addition, it is highly likely that the mother would relapse after switching, and exposure to the psychiatric disorder would constitute a third exposure for the child

RULE 1

All changes to drugs should be carried out before pregnancy if possible

This minimizes the number of exposures to the baby and promotes mood stability for the mother

RULE 2

Ideally the patient should be stable psychiatrically for at least 3 months before trying to get pregnant

This is not always practical but should provide some evidence and reassurance that the patient's mood is stable before pregnancy begins

RULE 3

Use drugs that we know something about: fewer data are available for recently approved drugs

If a drug has been available for several years there is at least some evidence that it is unlikely to be associated with major organ malformations, for example

(Chisolm & Payne 2016)



RISKS OF STOPPING MEDICATION

- Withdrawal symptoms with sudden discontinuation
- Relapse of psychiatric disorder/symptoms
- Risks of untreated depression during pregnancy
 - Maternal distress, functional impairment, hospitalization, suicide
 - Increased rates of cigarette, alcohol, and other substance misuse
 - Increased ambivalence about the pregnancy
 - Low maternal weight gain, preterm birth, low birth weight
 - Higher rates of pre-eclampsia and gestational diabetes
 - Increased risk of postpartum depression and poor attachment
 - Prenatal exposure to maternal stress affects infant temperament
 - Children exposed to perinatal depression have higher cortisol levels and this finding continues through adolescence. Treatment of depression during pregnancy seems to normalize infant cortisol levels
 - Higher rates of internalizing and externalizing disorders in children



HOW LIKELY IS SHE TO RELAPSE IF SHE STOPS HER ANTIDEPRESSANT?

201 women, recurrent MDD, euthymic at conception Relapse in 68% of those stopping antidepressants, 26% of those continuing

50% of relapses in first trimester

Relapse risk higher with >4 episodes or >5 years of illness

Cohen et al., JAMA 2006



WHAT ARE THE RISKS OF HER MEDICATIONS?

- Sertraline (SSRIs)
 - PPHN (persistent pulmonary hypertension of the newborn): RR= 1.28 (2.6 vs. 2.0/1,000 births)
 - Neonatal adaptation syndrome: RR= 1.58 (9.5 vs. 6/1,000)
 - Postpartum hemorrhage: RR= 1.47 (42.6 vs. 29/ 1,000)
 - ? Whether preterm birth, spontaneous abortion, longterm neurodevelopmental outcomes different with SSRIs compared with depression
 - » Huybrechts K, 2018



WHAT ARE THE RISKS OF HER MEDICATIONS?

Clonazepam

- No increase in malformations (data re increase in oral clefts with diazepam inconsistent)
- Increased risk of respiratory depression, hypotonia in neonate ("floppy infant")
- No difference in language development at age 3
- ? Preterm birth, other neurodevelopmental outcomes
- Clonazepam and lorazepam preferred to diazepam due to lower placental passage, fetus better able to clear medication



WHAT ARE THE RISKS OF HER MEDICATIONS?

- Trazodone
 - Very limited data show no increase in malformations or adverse pregnancy outcomes





APPROACH TO STOPPING MEDICATIONS

- Don't stop all medications suddenly
 - Increased risk of relapse and withdrawal
- Taper medications slowly if possible
- Minimize number of exposures doses
 - But dose requirements often increase during pregnancy
- Consider alternative treatments



ALTERNATIVE TREATMENTS

- Psychotherapy
 - Cognitive-behavioral therapy (CBT)
 - Interpersonal therapy (IPT)
- Exercise
- ECT, rTMS
- Light
- Omega-3-fatty acids
- Folate, L-methyl-folate
- Massage
- Acupuncture









SOME OTHER MEDICATIONS IN BRIEF

Lithium

 Relapse rate higher if discontinue over 14 days or less (63%) versus 15 days or more (37%)

Depakote

 Major teratogen – 24% malformation rate with 1500 mg/day or more

Stimulants

- No increase in rate of malformations
- Risks of IUGR, hypertension in pregnancy



RESOURCES

- https://womensmentalhealth.org/
- https://reprotox.org/
 - Need to register free via UW Health Sciences Library through Micromedex
- https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
 - Via UW Health Sciences Library under databases or access directly
- If you only read one article:
 - Chisolm MS, Payne JL. Management of psychotropic drugs during pregnancy. BMJ 2016 Jan 20;352:h5918.



PERINATAL PSYCHIATRY CONSULTATION

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DEPARTMENT OF PSYCHIATRY
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Perinatal Psychiatry Consultation Line

Providing telephone consultation to healthcare providers caring for women with mental health needs during pregnancy and postpartum

(206) 685 - 2924

Weekdays from 3-5 PM

 Consultation for providers throughout Washington State who are caring for pregnant or postpartum women with mental health problems

