# DO'S AND DONT'S in Pregnancy and Postpartum

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# Disclosures

- No conflicts of interest
- May be discussing off label use of some medications

# Do's

- Regular exercise
- Healthy and balanced diet
- Always assess for substance use especially marijuana
- Rule out medical causes of the presentation- thyroid imbalance, anemia, side effects of some medications

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( Physical Activity and Exercise During Pregnancy and the Postpartum Period | ACOG )
( Pregnant & Postpartum Activity: An Overview | Physical Activity Basics | CDC )

# Do's

- Psycho-education and support
- Support partners as well- postpartum depression (PPD) occurs in the partners as well
- Mandated rest
- Screening for risk
- Treat maternal mental health
- Resources, referrals and follow-up

# Don’t

- Underestimate the negative impact of untreated mental illness in pregnancy
  - ✓ Placental abnormalities
  - ✓ Small-for-gestational-age fetuses
  - ✓ Fetal distress
  - ✓ Preterm delivery
  - ✓ Adverse neurodevelopmental outcomes
  - ✓ Disordered attachment

(Atif et al., 2015)
(Balbierz et al., 2015)
(Grigoriadis et al., 2013)
(Grote et al., 2010)
(Paulson et al., 2006)

# Don’t

- Follow the FDA pregnancy category system- ABCDX

✓ New PLLR system followed now

✓ Provides comprehensive information  of drug use during pregnancy, lactation and on reproductive system

Pregnancy and Lactation Labeling (Drugs) Final Rule | FDA

# Don’t

- Stop all psychotropic medications (most can be continued in pregnancy and breastfeeding)
- Stop cold turkey (taper whenever possible)

✓ May gradually work on adjusting the dosages and if possible number of agents after discussing risk and benefits

**Results** Among the 201 women in the sample, 86 (43%) experienced a relapse of major depression during pregnancy. Among the 82 women who maintained their medication throughout their pregnancy, 21 (26%) relapsed compared with 44 (68%) of the 65 women who discontinued medication. Women who discontinued medication relapsed significantly more frequently over the course of their pregnancy compared with women who maintained their medication (hazard ratio, 5.0; 95% confidence interval, 2.8-9.1; $P<.001$).

(Cohen et al, 2006)
(Viguera et al., 2007)
(Payne,2021)

# Don’t

- Switch to older and/or to a more studied agent

  - ✓ Selective Serotonin Reuptake Inhibitors (SSRI’s) having most data with Sertraline being prescribed most commonly
  - ✓ Switching increases the risk of exposure to new agent, untreated mental health if no response to new agent

(McAllister-Williams et al, 2017)

# Don’t

- Give antidepressant to women with previous diagnosis of bipolar disorder even though they may be depressed at present
  - ✓ Antidepressant alone might induce cycling into hypomania/mania
  - ✓ 50 % of women with bipolar are 1st diagnosed in the postpartum period
  - ✓ ¼ of women who screened positive on Edinburgh Postnatal Depression Scale were later diagnosed with bipolar disorder

(Munk-Olsen et al., 2012)
(Wisner et al., 2013)

# Don’t

- Prescribe Valproic Acid (Depakote) in women of reproductive age

  - ✓ The absolute risk of major malformations with valproate was 10.93%
  - ✓ Fivefold increase in risk of congenital malformations
  - ✓ Significantly higher risk of neural tube, cardiac, orofacial/craniofacial, and skeletal and limb malformations, cognitive delay, language delay, psychomotor delay and autism/dyspraxia
  - ✓ The risk of major malformations with valproate is dose-dependent

(Andrade et al., 2021)
(Andrade, 2018)
(Watkins et al., 2019)
(Veroniki et al., 2017)

# Don’t

- Avoid use of lithium in pregnancy and breastfeeding where and if needed
  - ✓ Not contraindicated
  - ✓ Not associated with preterm labor, Small for Gestational Age, miscarriage, LBW, adverse neonatal outcomes
  - ✓ Small but significant increased risk of cardiovascular malformation- Ebstein anomaly but very small absolute risk
  - ✓ Risk is dose related, tripled risk beyond dose of 900 mg daily

(Fornaro et al., 2020)

# Don’t

- Stop antipsychotics
  - ✓ No association with spontaneous abortion
  - ✓ No association with malformation except Risperidone
  - ✓ Associated with
    - ❖ Preterm birth but difficult to rule out due to confounding factors
    - ❖ Gestational diabetes- olanzapine and quetiapine (high risk)- low dose preferred if possible but optimum dose is  equally important

(Anderson et al., 2020)
(Coughlin et al., 2015)
(Huybrechts et al., 2016)
(Reis & Källén, 2008)

# Don’t

- Refuse to give stimulants due to concerns of malformations
- Women who discontinued psychostimulant treatment during pregnancy
  - ✓ Had a clinically significant increase in depression despite not changing their antidepressant medication
  - ✓ Had impairment in functioning

(Baker et al, 2022)
(Huybrechts et al., 2018)
(Kolding et al., 2021)

# Don’t

- Refuse to prescribe BZD’s or discontinue when individuals find about their pregnancy
  - ✓ Concerns of withdrawals which can be dangerous for people taking high dosages and for long time
  - ✓ Gradual taper preferred (some individuals may require even more slower taper)
  - ✓ More efficacious than antihistaminic agents for anxiety

(Gopalan et al., 2014)

# Don’t

- Change to a different agent in breastfeeding because of concerns of more passage into breast milk

  ✓Exposure to drug through breast milk is lesser than through placental transfer
  ✓Especially if the neonate was exposed during pregnancy

(Payne, 2021)

# Take aways

- No one size shoe fits all
- This is not the comprehensive list
- All the Do’s and Don'ts need to be followed on individual case by case basis
- Risk and Benefit discussion is the most important

# Resources

- Massachusetts General Hospital (www.womensmentalhealth.org)
- Postpartum Support International (www.postpartum.net 1-800-944-4PPD)
- The Periscope Project (Perinatal Specialty Consult Psychiatry Extension)
- Mother to baby (www.mothertobaby.org)
- MCPAP for moms
- National Curriculum on Reproductive Psychiatry

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