MANAGEMENT OF PERIPARTUM DEPRESSION

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Disclosures

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

Perinatal Depression affects 1 in 7 women

American College of Obstetricians and Gynecologist recommends all pregnant women be screen at least once during the perinatal period.

(ACOG Committee Opinion No. 757, 2018)
(ACOG Committee Opinion No. 630, 2015)
(Liu et al., 2022)

Baby blues vs Postpartum depression

Postpartum Blues (Baby Blues)	Postpartum depression (PPD)
More Common (70 - 80%)	15 - 20%
Within 2-3 days of delivery with peak on 4-5th day. May last for few hours to few days – up to maximum of 2 weeks	If symptoms beyond 2 weeks: need further evaluation to rule out PPD, especially in high-risk females
No functional impairment	Functional impairment
No specific treatment	Mild-psychotherapy Pharmacological interventions – moderate to severe
Supportive Reassurance with regular monitoring for development of PPD and follow up	Supportive reassurance with regular monitoring for further worsening and follow up

(Postpartum Depression | ACOG); (Is this Baby Blues or Postpartum Depression? | American Pregnancy Asc)

No decision is risk free and no medication is completely safe in pregnancy

Impact of Untreated Maternal Mental Health

Mother	Offspring
No proper prenatal and well baby visits	Low birth weight
Substance abuse	Preterm delivery
Maternal suicide	Cognitive delays
Infanticide	Behavioral problems

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

Treatment

- Mild symptoms-Psychotherapy
- Moderate –Severe symptoms- pharmacotherapy
- First line – SSRI (Selective Serotonin Reuptake Inhibitors)
- Start low and go slow
- Lowest possible dose
- Change as clinically indicated
- Preferably resume what has worked for patient in the past
- Continue what is working for the patient with proper risk and benefit discussion as changing to new agent will increase the risk of exposures with no guarantee of response with newer agent

(Payne, 2021)

Treatment

- Don’t hesitate to increase dose if needed (do not undertreat)
  - Requirements of dosages may ⇧ as pregnancy progresses due to pharmacokinetic changes
- Decrease the dosages gradually after delivery to a lower dose as tolerated
- Watch for emergence of hypomania and mania as about 22% women who were diagnosed with PPD for first time got diagnosed with Bipolar disorder later
- Monotherapy preferred
- Augmentation--severe depression--not responding to monotherapy

(Wisner et al., 2013)
(Payne, 2021)

SSRI Safety

- Reproductive safety data on most SSRIs actually exceeds most other medications
- Absolute risk of overall **congenital malformations or cardiovascular** malformations in children of pregnant women exposed to SSRI is **small**
- Preterm labor and lower birth weight—difficult to assess as depression itself is a risk factor for same outcome

(Cantarutti et al., 2016)
(Gao et al, 2018)
(Huybrechts et al., 2014)

Common Concerns With SSRIs

- Late trimester exposure to SSRIs – poor neonatal adaptation syndrome -- transient irritability, jitteriness, tachypnea and gets better mostly without any additional intervention
- Majority of studies do not suggest major long term adverse effects in terms of neurobehavioral/neurodevelopmental effects whereas postpartum depression itself is associated with poor outcome in terms of neurobehavioral effects

(Ewing et al., 2015)
(Suarez et al., 2022)

Common Concerns With SSRIs

- Autism/ADHD—we do not see consistent findings of Autism or ADHD with SSRI exposure in pregnancy

- Persistent Pulmonary Hypertension (PPHN)—risk in newborn exposed to SSRI appears small

(Andrade, 2020)
(Brown et al., 2017)
(Figueroa, 2010)
(Källén & Olausson, 2008)
(Leshem et al., 2021)

New Labeling System

- FDA pregnancy categories A, B, C, D and X have phased out

- PLLR – Pregnancy and Lactation Labeling Rule- new system- provides comprehensive information discussing potential risks and benefits to mother and fetus.

(Pregnancy and Lactation Labeling (Drugs) Final Rule | FDA)

When is it Time to Refer?

- Referral to Psychiatrist
  - Moderate- Severe depression
  - Not responding to medication adjustments
  - Unable to take care of themselves or their baby
- Referral to higher level of care: inpatient or partial program
  - Danger to themselves or others as there is high risk of suicide (20%) associated with perinatal mood disorder
  - Psychotic (disorganized)—there is about 4% risk of infanticide in Postpartum psychosis (PPP)

(Friedman et al., 2023)
(Lindahl et al., 2005)

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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