Antenatal depression

Unrecognised or untreated depression during pregnancy poses considerable risk to both the mother and the developing foetus.

Depression in the antenatal period can have significant negative effects on early mother-infant interactions and can compromise the cognitive, emotional and behavioural development of the child. These childhood developmental disturbances can be prolonged and appear to be most evident in boys and socially disadvantaged children.[5]

There is little information on the prevalence of depression that occurs during pregnancy and how this compares to the prevalence of depression outside the antenatal period. One meta-analysis estimated a prevalence of depression in the antenatal period to be between 4.5 and 11%.[20]

The occurrence of depression during pregnancy is associated with a previous episode of postnatal depression, and is also a risk factor for recurrence of depression during subsequent pregnancy, and at other times.

Management principles are similar to depression that occurs in non-pregnant women, but a key challenge is deciding when to use antidepressants, and assessing their risks and benefits in this patient population.

Assessment and diagnosis of antenatal depression

Assessment and diagnosis follows the same principles as in depression outside the antenatal period. Simple screening questions can be used at regular intervals during pregnancy and followed up with the EPDS and PHQ-9.

It is beneficial, but not always possible, to assess a woman with a history of mental health disorders before she conceives. This allows any anticipated treatment to be planned with respect to using the safest and most effective options. A woman who is currently taking an antidepressant may wish to trial supervised withdrawal if appropriate, prior to conception, or switch to a medicine that is recognised as being safer. If medicine withdrawal is not possible for the stage of the illness, it may be appropriate to delay pregnancy until treatment is no longer required.

Treatment of antenatal depression

There are few well designed clinical trials that demonstrate the effectiveness of psychological or antidepressant treatment in pregnant women. Recommendations are largely extrapolated from the general population on the assumption that treatment effects should be similar.

Consequently, the treatment of depression in pregnancy follows a similar stepwise approach to the treatment of depression in adults.

Non-pharmacological interventions, such as enhanced social support and/or a psychological intervention should be considered before antidepressant treatment, especially if symptoms are mild or in early pregnancy (first trimester).[1]

The major considerations are when to use antidepressants and the safety of these medicines during pregnancy. Due to concerns about the safety of antidepressants in pregnancy, many mothers may prefer to trial psychological therapies before an antidepressant. Pregnant women who are prescribed an antidepressant may be poorly compliant or stop taking their medicine due to safety concerns. This can lead to poor control of depressive symptoms and increased risk of harm to mother and infant. The provision of clear and accurate information about the effectiveness and risks and benefits of treatment is extremely important.

Antidepressants in pregnancy

Which SSRI in pregnancy ?

Fluoxetine is considered to be the first choice antidepressant for use in pregnancy. However, there is little evidence that paroxetine or citalopram pose greater risks and treatment choice should be based on history of previous response rather than safety concerns.

The risks and benefits of any switch in treatment should be considered. For example, a woman who is responding well to paroxetine and becomes pregnant may be put at risk if an attempt is made to switch to another SSRI where clinical response is uncertain.

Both depressive symptoms and exposure to antidepressants during pregnancy are associated with foetal growth changes and shorter gestation time. The relative effects are difficult to determine as the majority of studies that have evaluated the risk of antidepressant use have been unable to control for the possible effects of a depressive disorder. Short term neonatal behavioural changes and irritability are also linked to both maternal depression and antidepressant treatment.[21]

Several studies have reported foetal malformations in association with first trimester exposure to antidepressants, but there is no specific pattern of defects associated with individual drugs or drug classes. SSRIs are widely used in pregnancy and a recent study estimated that 2.3% of pregnant women are exposed to SSRIs.[22]

There has been recent concern about an increased risk of cardiac malformations with first trimester exposure to paroxetine. This led to warnings and recommendations against the use of paroxetine for the treatment of depression in pregnancy, especially during the first trimester. Fluoxetine then emerged as the SSRI of choice for the treatment of depression in pregnancy. However, a recent review conducted in the UK has concluded that the risks of cardiac malformations associated with paroxetine and fluoxetine are similar.[23] This report further stated that the risk of a foetal cardiac abnormality is increased from 1% to 2% with antenatal exposure to fluoxetine – an absolute risk increase of about 1%, similar to that reported with paroxetine. These figures are still debated due to study design problems and the influence of confounding factors. Although fluoxetine remains the preferred SSRI for use in pregnancy there is no strong evidence that it is any safer than paroxetine or the other SSRIs.

All SSRIs are associated with a small increased risk of persistent pulmonary hypertension in new-born infants. The background rate of this condition is 0.5 – 2 per 1000 and it has been estimated that SSRI exposure in pregnancy increases this to 3 – 6 per 1000.[21]

All antidepressants taken during late pregnancy can give rise to neonatal withdrawal symptoms. Symptoms with SSRIs include irritability and feeding problems but they are usually mild and short-lived. These symptoms are probably less likely with fluoxetine due to its longer half-life. Venlafaxine can cause similar withdrawal symptoms.

TCAs, e.g. amitriptyline, imipramine and nortriptyline, have been used for many years in pregnancy and are considered relatively safe. However, in practice, an SSRI is considered preferable as they are better tolerated and are less toxic in overdose.

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