Psychopharmacology for the Clinician
Psychopharmacologie pratique

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.

Treating depression during pregnancy

Ms. A. is a pleasant 29-year-old woman, 17 weeks pregnant, in a stable and supportive marital relationship. She was referred to our clinic for treatment of depression. She has 2 healthy daughters at home, aged 2 and 4 years. She has a history of 5 episodes of depression, with 2 perinatal episodes associated with her previous pregnancies. She had been maintained successfully on antidepressants before and between pregnancies but, on the advice of her family physician, discontinued medications abruptly when she discovered she was pregnant. Over the past several weeks, symptoms of depression, anxiety, insomnia, loss of appetite, irritability and anhedonia gradually increased to the point that she felt overwhelmed and was barely able to look after herself and her 2 daughters. At the time of her first visit to our clinic, her Edinburgh Depression Scale score for antenatal depression was 25 out of a maximum of 30, indicating severe depression and anxiety. She did not express any thoughts or intent of harming herself or others. When presented with different treatment options including supportive, interpersonal or cognitive-behavioural psychotherapy, as well as antidepressant medication, she expressed her wish to be seen at our clinic on a regular basis for support. Given her past experience, she was also willing to contemplate antidepressant treatment and was eager to be educated about their potential hazards and safety for her unborn child. In consultation with her husband and with the Motherisk Program at the Hospital for Sick Children in Toronto (www.motherisk.org, a service providing counselling on reproductive risk or safety of drugs in pregnancy), she agreed to start treatment with the specific serotonin reuptake inhibitor escitalopram. Ms. A. and her husband were informed of the Health Canada advisory prompted by recent reports of minor adverse effects on newborns after treatment of pregnant women with antidepressants during the third trimester. They were also informed that the information regarding her use of antidepressants would be highlighted on her baby's initial record to alert the team on the labour and delivery unit in case of any observed neonatal distress. She was started on a dosage of escitalopram 10 mg that was increased after 2 weeks to 20 mg every morning. Ms. A. was maintained on this dosage throughout the pregnancy and was also seen biweekly for supportive counselling. By week 24 of her pregnancy, her depression lifted, and her Edinburgh score was down to 4 out of the maximum of 30. She delivered at term a healthy baby boy with no adverse effects or complications. She continued the same dosage of escitalopram throughout the entire pregnancy and into the postpartum period.

Although this case portrays a picture-perfect scenario and outcome, decisions regarding the use of antidepressants in pregnancy should not be taken lightly. The attending healthcare provider must establish from the patient's current mental status and history that there is an absolute indication to use medication. This decision should not be made solely on the basis of a solid diagnosis; it should also take into account the stress and burden of illness that the pregnant woman is under. Her own and her partner's choice should have a role in the final decision unless she suffers from acute psychosis or is suicidal, in which case she will need hospitalization. To help a couple to make the right choice, it is imperative to provide them with as much information and education as possible. They need to understand the potential risks to the fetus of not treating stress, anxiety and depression during pregnancy as well as the risks and benefits of antidepressant use.

This is particularly important in view of recent media attention to published reports of negative outcomes in babies born to mothers taking antidepressants at different phases of their pregnancy. Again, the risk–benefit ratio must be explored on a case-by-case basis. Recent accumulating evidence that abrupt discontinuation of antidepressants is associated not only with physical withdrawal symptoms but also with a high incidence of relapse into depression must also be taken into account. Last but not least, the notion that the use of antidepressants in pregnancy is relatively safe is very recent. The prudent clinician must be vigilant and up-to-date with published evidence based in this new and exciting field of psychiatry.

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Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography that will be available only at the journal website and that can be accessed through a link at the bottom of the column. Please submit appropriate columns online at http://mc.manuscriptcentral.com/jpn; inquiries may be directed to jpn@cma.ca.