Treatment of GDM Reduces Perinatal Morbidity, Study Suggests

BY MIRIAM E. TUCKER
Senior Writer

T
reatment of gestational diabetes reduces serious perinatal morbidity, Caroline A. Crowther, M.D., of the University of Adelaide (Australia) and her associates reported.

Although the risks associated with gestational diabetes mellitus (GDM) are well recognized, it has been uncertain whether screening and treatment to reduce maternal glucose levels reduces these risks. Given this uncertainty, professional groups disagree on which patients should be screened and when they should be screened, the investigators said (N. Engl. J. Med. 2003;349:77-80).

Now, new investigation findings in favor of screening come from the 18-center Australian Carbohydrate Intolerance Study in Pregnant Women (ACOS), in which serious perinatal complications occurred in just 1% of the infants of 490 women with GDM who were randomized to intensive glucose management, compared with a 3.9% risk in 510 women who received routine care.

A prevalence of probable bipolar disorder at some time during their lives.

In the second trimester, the prevalence of depression was about 32% among women with a history of bipolar disorder, about 24% among those with a history of unipolar depression, and about 8% among women with no history of a mood disorder. The differences between the bipolar and unipolar groups and the women with no mood disorders were statistically significant, Dr. Viguera reported.

At the sixth week post partum, the prevalence of depression was about 50% among women with a history of bipolar disorder, about 32% among women with a history of unipolar depression, and about 16% among women with no history of mood disorders. Again, the prevalence of depression was significantly greater among women with a history of bipolar disorder or unipolar depression, compared with those who did not have this history.

During and after pregnancy, depression should be closely monitored, especially in women with a history of depression or bipolar disorder. These women can be treated like any other patients with these disorders, Dr. Viguera said. Patients with bipolar disorder should receive a mood stabilizer, while those with unipolar depression get an antidepressant.

The passage of lithium from mother to child via breast milk was examined in a separate study that involved 10 mother-infant pairs. Serum and breast milk samples were obtained from both the mothers and infants at 4-12 weeks' post partum, both before and after a dose of lithium was administered and within 12 hours after a dose. Repeat samples were collected from five subjects.

The average maternal dose of lithium was 850 mg/day, which led to an average serum concentration of 0.76 mg/L. The average lithium concentration in milk was 0.35 mg/L, and the average serum level in the infants was 0.16 mg/L.

The findings suggest a "rule of halves" for lithium. Breast milk contains about half the lithium concentration as maternal serum, and infant serum contains about half of the concentration in breast milk, Dr. Viguera said. (This means that infant serum contains about one-fourth the concentration in breast milk.)

Nine of the 10 infants in the study showed no adverse effects from lithium exposure. One infant had an elevated level of TSH, but the drug was terminated within 2 weeks after lithium was stopped. All of the other nine infants had TSH levels that were within the normal range. Renal function was normal for all 10 infants, and there were no other acute effects seen. Follow-up observations and reports also showed no late developmental abnormalities.

In routine practice, infants who are nourished by mothers treated with lithium should be monitored by serum assays of TSH, blood urea nitrogen, and serum creatinine every 6-8 weeks during breastfeeding, Dr. Viguera said.

Bipolar History Linked to Depression in Pregnancy

BY MITCHEL L. ZOLER
Philadelphia Bureau

PITTSBURGH — Women with a history of unipolar or bipolar disorder at risk for peripartum, postpartum depression.

Serious perinatal outcomes, including death, shoulder dystocia, bone fracture, and nerve palsy, occurred in 1% of the intervention group vs. 4% of the routine care group after adjustment for maternal age, race, ethnicity, and parity. Thus, 14 mothers would need to be treated to prevent one serious outcome in an infant, they said.

Women in the intervention group were significantly more likely to have induction of labor (34% vs. 22%), but the rates of cesarean delivery were similar (31% vs. 32%), as were the reasons for it. Infants in the intervention group also had fewer admissions to the neonatal nursery (71% vs. 61%). At 3 months' post partum, fewer women in the intervention group had a score on the Edinburgh Postnatal Depression Scale suggestive of depression (8% vs. 17%); anxiety scores were similar.

In the second trimester, the prevalence of depression was about 32% among women with a history of bipolar disorder, about 24% among those with a history of unipolar depression, and about 8% among women with no history of a mood disorder. The differences between the bipolar and unipolar groups and the women with no mood disorders were statistically significant, Dr. Viguera reported.

At the sixth week post partum, the prevalence of depression was about 50% among women with a history of bipolar disorder, about 32% among women with a history of unipolar depression, and about 16% among women with no history of mood disorders. Again, the prevalence of depression was significantly greater among women with a history of bipolar disorder or unipolar depression, compared with those who did not have this history.

During and after pregnancy, depression should be closely monitored, especially in women with a history of depression or bipolar disorder. These women can be treated like any other patients with these disorders, Dr. Viguera said. Patients with bipolar disorder should receive a mood stabilizer, while those with unipolar depression get an antidepressant.

The passage of lithium from mother to infant pairs, Dr. Viguera reported in a second poster at the conference, which was sponsored by the University of Pittsburgh. The prevalence of bipolar depression in pregnancy increased between the first and second trimesters and in postpartum women who sought prenatal care at the Massachusetts General Hospital during 1996-1999.

A mood disorder questionnaire was completed by 1,814 of the study participants during their second trimester, and 526 women completed a second questionnaire when they were seen at the clinic 6 weeks after delivery.

Bipolar disorder was diagnosed in women with a self-reported history of mania with or without a history of depression. Depression during pregnancy or the postpartum period was diagnosed when women scored at least 16 on the Center for Epidemiologic Studies Depression Scale.

The average age of the entire group of 2,340 women was 32.5 years, and 61% did not have children before the index pregnancy.

The women who finished their pregnancy questionnaires had a 3.2% overall prevalence of probable bipolar disorder at some time during their lives.

In the second trimester, the prevalence of depression was about 52% among women with a history of bipolar disorder, about 34% among those with a history of unipolar depression, and about 8% among women with no history of a mood disorder. The differences between the bipolar and unipolar groups and the women with no mood disorders were statistically significant, Dr. Viguera reported.

At the sixth week post partum, the prevalence of depression was about 50% among women with a history of bipolar disorder, about 32% among women with a history of unipolar depression, and about 16% among women with no history of mood disorders. Again, the prevalence of depression was significantly greater among women with a history of bipolar disorder or unipolar depression, compared with those who did not have this history.

During and after pregnancy, depression should be closely monitored, especially in women with a history of depression or bipolar disorder. These women can be treated like any other patients with these disorders, Dr. Viguera said. Patients with bipolar disorder should receive a mood stabilizer, while those with unipolar depression get an antidepressant.

The passage of lithium from mother to child via breast milk was examined in a separate study that involved 10 mother-infant pairs. Serum and breast milk samples were obtained from both the mothers and infants at 4-12 weeks post partum, both before and after a dose of lithium was administered and within 12 hours after a dose. Repeat samples were collected from five subjects.

The average maternal dose of lithium was 850 mg/day, which led to an average serum concentration of 0.76 mg/L. The average lithium concentration in milk was 0.35 mg/L, and the average serum level in the infants was 0.16 mg/L.

The findings suggest a “rule of halves” for lithium. Breast milk contains about half the lithium concentration as maternal serum, and infant serum contains about half of the concentration in breast milk, Dr. Viguera said. (This means that infant serum contains about one-fourth the concentration in breast milk.)

Nine of the 10 infants in the study showed no adverse effects from lithium exposure. One infant had an elevated level of TSH, but the drug was terminated within 2 weeks after lithium was stopped. All of the other nine infants had TSH levels that were within the normal range. Renal function was normal for all 10 infants, and there were no other acute effects seen. Follow-up observations and reports also showed no late developmental abnormalities.

In routine practice, infants who are nourished by mothers treated with lithium should be monitored by serum assays of TSH, blood urea nitrogen, and serum creatinine every 6-8 weeks during breastfeeding, Dr. Viguera said.

Women with a history of unipolar or bipolar disorder at risk for peripartum, postpartum depression.

BY MITCHEL L. ZOLER
Philadelphia Bureau

PITTSBURGH — Women with a history of unipolar or bipolar disorder at risk for peripartum, postpartum depression.

Serious perinatal outcomes, including death, shoulder dystocia, bone fracture, and nerve palsy, occurred in 1% of the intervention group vs. 4% of the routine care group after adjustment for maternal age, race, ethnicity, and parity. Thus, 14 mothers would need to be treated to prevent one serious outcome in an infant, they said.

Women in the intervention group were significantly more likely to have induction of labor (34% vs. 22%), but the rates of cesarean delivery were similar (31% vs. 32%), as were the reasons for it. Infants in the intervention group also had fewer admissions to the neonatal nursery (71% vs. 61%). At 3 months' post partum, fewer women in the intervention group had a score on the Edinburgh Postnatal Depression Scale suggestive of depression (8% vs. 17%); anxiety scores were similar.

In the second trimester, the prevalence of depression was about 52% among women with a history of bipolar disorder, about 34% among those with a history of unipolar depression, and about 8% among women with no history of a mood disorder. The differences between the bipolar and unipolar groups and the women with no mood disorders were statistically significant, Dr. Viguera reported.

At the sixth week post partum, the prevalence of depression was about 50% among women with a history of bipolar disorder, about 32% among women with a history of unipolar depression, and about 16% among women with no history of mood disorders. Again, the prevalence of depression was significantly greater among women with a history of bipolar disorder or unipolar depression, compared with those who did not have this history.

During and after pregnancy, depression should be closely monitored, especially in women with a history of depression or bipolar disorder. These women can be treated like any other patients with these disorders, Dr. Viguera said. Patients with bipolar disorder should receive a mood stabilizer, while those with unipolar depression get an antidepressant.

The passage of lithium from mother to