Drug Tx May Be Appropriate for Depression During Pregnancy

BY NORRA MACREADY
Los Angeles Bureau

LOS ANGELES — Caring for a pregnant woman with a history of depression means weighing the risks of fetal exposure to psychotropic medication against the consequences of the untreated illness, Vivien Burt, M.D., said at a psychopharmacology update sponsored by the University of California, Los Angeles.

Abruptly discontinuing antidepressants during pregnancy is not necessarily best for the woman or her baby, said Dr. Burt, professor of psychiatry and biobehavioral sciences at the university.

In a review of 1,861 pregnancies among inner-city women, preterm delivery was significantly higher in women whose scores on the Center for Epidemiologic Studies Depression Scale were in the 91st to 100th percentile, than in patients with lower scores (Epidemiol. Rev. 1995;17:165-71).

In an earlier study by different investigators, the risk of a negative pregnancy outcome among inner-city adults rose 5%-7% for every point they scored on the Beck Depression Inventory (J. Clin. Epidemiol. 1992;45:1093-9).

Other research has linked maternal depression to neurobehavioral sequelae in the neonate, including decreased motor and vagal tone, lower activity levels, and fewer orienting skills, compared with infants born to women who were not depressed.

There may be dangers to the mother as well. The risks of untreated depression during pregnancy include poor self-care, including sleep disruption and poor judgment regarding nutrition and use of alcohol, tobacco, and illicit drugs. Depression and anxiety are associated with a higher risk of preeclampsia and postpartum depression. Dr. Burt recommended this approach to treatment:

For mild to moderate depression. Consider nonpharmacologic interventions such as psychotherapy, stress-reduction techniques, and a reliable support system.

For serious depression marked by suicidality, psychosis, poor weight gain, impaired self-care, or impaired bonding with the fetus. Consider medication.

When a change of medication is indicated. If the patient is not yet pregnant, make sure she is stable and put her on the safest possible agent. If the patient is pregnant, consider her prior history of response before switching her medication. Many antidepressants have been widely studied during pregnancy, so doctors and patients can make an informed decision about which ones are safest to take, Dr. Burt said.

In general, pregnant women should avoid mirtazapine, bupropion, and MAO inhibitors. Mirtazapine and bupropion haven’t been studied sufficiently in this patient population, and limited evidence associates bupropion with fetal cardiovascular defects. MAO inhibitors may produce a hypertensive crisis when used with tyloclipic agents and have been associated with congenital anomalies in animal studies.

Dr. Burt said she feels “fairly comfortable” prescribing tricyclic antidepressants and selective serotonin reuptake inhibitors; many studies have shown they do not cause major congenital anomalies even when taken in the first trimester. These agents have been associated with negative obstetric outcomes in a few studies, including a slight decrease in mean 5-minute Apgar score and transient tachypnea in newborns, but these effects don’t seem to produce any long-term damage.

As delivery approaches, Dr. Burt schedules additional appointments so she can monitor the patient closely. If the dose is lowered during the final month of pregnancy, then restore it to its usual level immediately thereafter.

Whatever drug is prescribed, make sure peer-reviewed studies support the choice, should it become necessary to justify the decision in court. These will carry more weight than the letter grades assigned by the Food and Drug Administration, Dr. Burt warned.

Therefore, the researchers used propensity scores, a statistical technique, to approximate a trial by controlling for confounders resulting from the nonrandomized assignment of women to the VBAC or repeat C-section cohorts.

The patients came from a year database of births at 17 university and community hospitals. All had a single gestation and one prior history of cesarean delivery. None had previously given birth vaginally. Dr. Lipkind said the success rate was 68% for the women who attempted VBAC.

Rupture was the most common major complication, occurring in 106 (2%) VBAC patients, compared with 19 (less than 1%) patients who elected C-sections (adjusted odds ratio 4.8).

Although the other major complications occurred in less than 1% of both groups, bladder injury more than tripled in the VBAC cohort; it occurred in 27 VBACs and 7 repeat C-sections (adjusted odds ratio 3.5). Other major complications were hemorrhage (29 VBACs vs. 17 repeat cesareans; adjusted odds ratio 1.5) and abortion (65 VBACs vs. 39 cesareans: adjusted odds ratio 1.4).

Minor complications were similar. Cesarean deliveries accounted for 27.3% of all births in 2003, while the VBAC rate plunged to a low of 10.6%, according to Dr. Lipkind, a fellow in maternal-fetal medicine at the University of California, College of Physicians and Surgeons in New York City, and her colleagues.

Dr. Lipkind and her associates reported that numerous studies have looked at VBAC complication rates, but none has been randomized, controlled trial.