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Medication use during Perinatal Period

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Consultant Psychiatrist
Perinatal Psychiatry team

With **all of us** in mind.

Session overview

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- Statistics
- Survey
- Medications
- Case scenario
- Take home message

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What is “perinatal”?

- Preconception
- Mental health during pregnancy
- Mental health for the first 12 months after birth

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Question?

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- How common is perinatal mental health problem?

- Up to 1 in 5
- Up to 1 in 20
- Up to 1 in 100
- Up to 1 in 1000

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Perinatal Mental Health Matters

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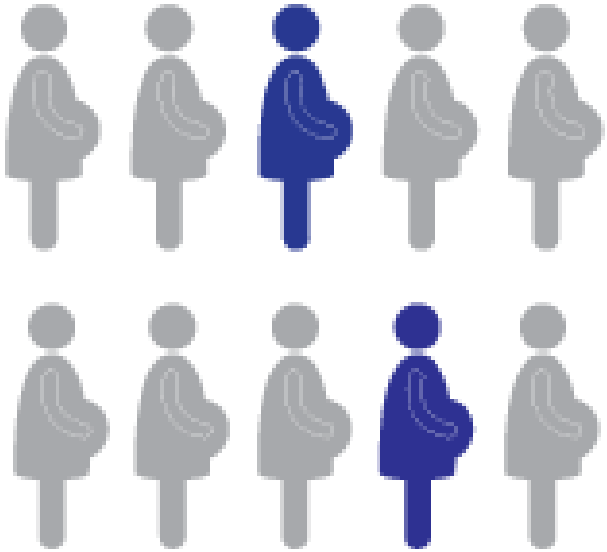

Up to 20%

of women develop a mental health problem during pregnancy or within a year of giving birth

The most likely time in a woman's life when she will develop a mental health problem

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

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Perinatal Mental Health Matters

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Costs v improvement

The cost to the public sector of perinatal mental health problems is **5 times** the cost of improving services.

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

mind.

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Of these costs

28%

relate to the mother

72%

relate to the child

Babies do best with well mums

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

Epigenetics

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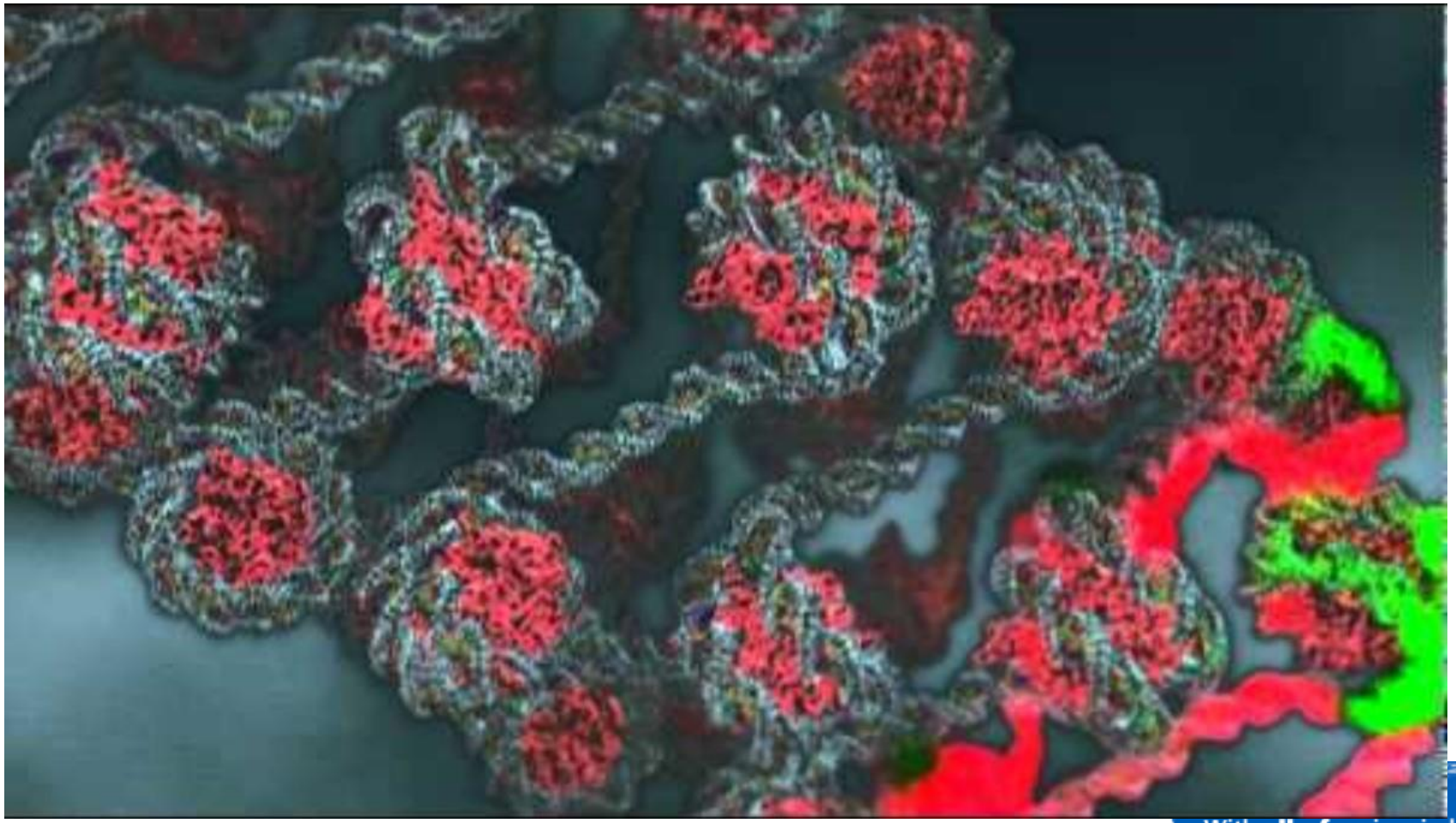

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Statistics

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Pregnant

- Depression – 12%
- Anxiety – 13%

Postnatal

- Depression & Anxiety – 15-20%
- Psychosis – 1-2/1000

Only half - Diagnosed.
Fewer – receive adequate treatment

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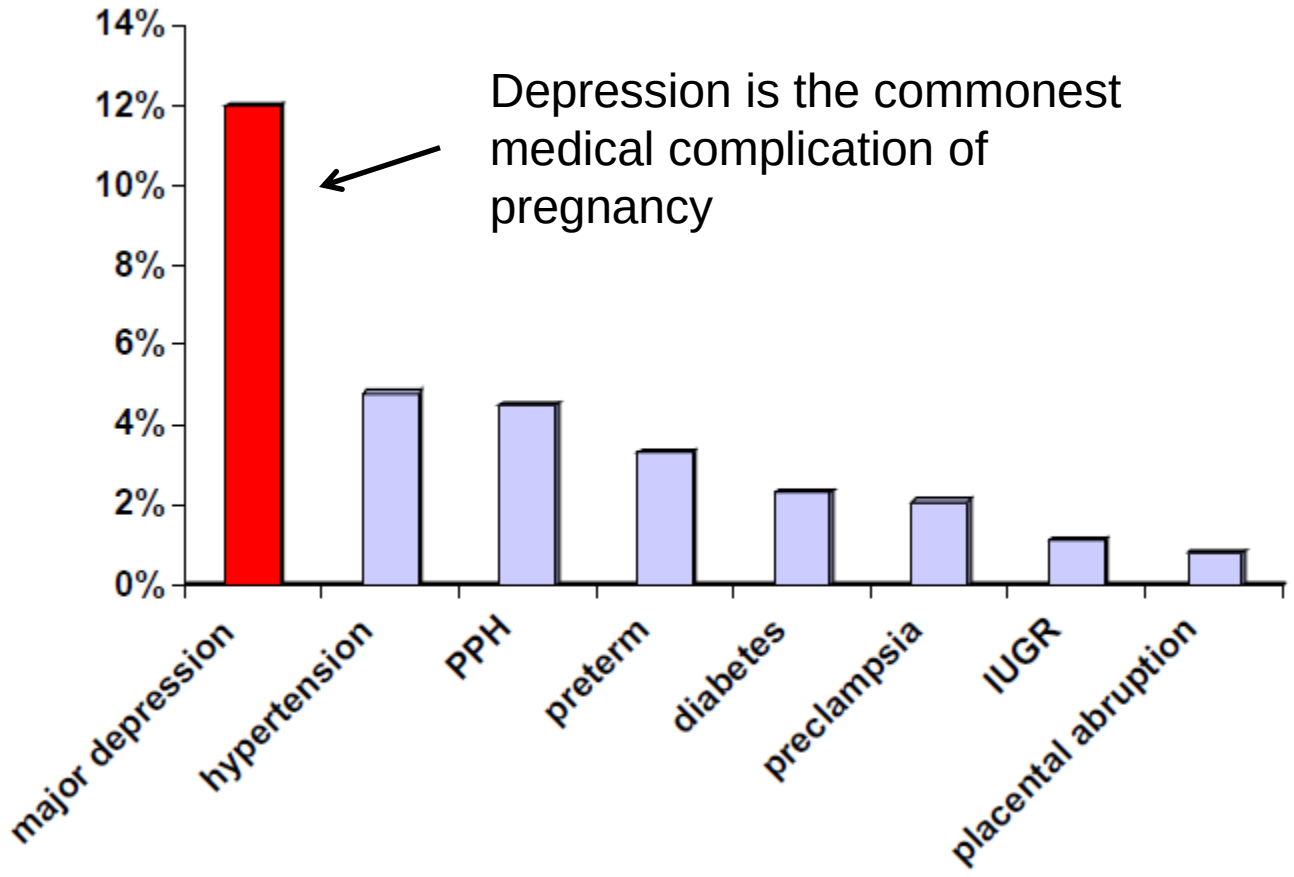
Incidence of Perinatal Mental Disorder



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Questions:

Q: If you had just had a baby and were referred to mental health services, what would your first thought be?

A: “They want to take my baby away from me” - Fear

A: “They think that I’m an unfit mother” - Guilt

Q: What % of mums hide or downplay their symptoms?

A: 70%

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Falling through the gaps - 2015 report - Barriers to detection for women:

- Women put significant effort into **hiding** their distress:
  - Stigma
  - Wanting to be a good mother
  - Fear the child might be taken away
  - Don't recognise that they are ill

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Barriers

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- Women were **put off disclosing** to health practitioners due to:
  - Feeling dismissed or told that what they were feeling was ‘normal’.
  - Feeling rushed, judged or processed
  - Lack of continuity/fragmentation of care: different GPs, midwives, health visitors
  - Experiencing inconsistent responses

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What women want from their HCPs

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- Wanted them to be more **proactive** in asking about mental health

- Give **time** and **compassion**

- Needed to feel **hopeful** that something could be done

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What do you do when your patient tells you that she is pregnant and wants advice on her psychotropic medication?

- STOP
- Reduce the dose
- Continue same dose/meds

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Quiz

- Q: What is the relapse rate of depression in mums who stop taking antidepressants in pregnancy?
- A: 70%
    - more severe depression = higher likelihood relapse

- Q: What happens when people get stressed/depressed?
- A: Increased use of alcohol, nicotine, drugs; worse diet; reduced/delayed engagement in antenatal care; 4-fold increase in reduced birthweight in depressed vs non-depressed mums; increased rate of ADHD, conduct disorder & ?autism

Learning point

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- Automatically stopping antidepressants if a woman becomes pregnant is not necessarily the safest option for baby (and mother).
- Risks of treating vs. risks of not treating
- Support mum to make the best choice for her and her family (?effects of depressed mum on other children)

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Mental illness

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- Pregnancy – not protective against mental illness
- Late pregnancy and early postpartum – increased risk of relapse
- May increase risk of relapse - if medications discontinued

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Mental Health - Red Flags

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

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Other warning signs

- Mum presenting in the first 6 weeks post-delivery
- Mum having thoughts of running away
- Previous history of psychosis/SMI or attempted suicide
- Any thoughts of harm to child or psychotic thoughts relating to the child

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Postnatal (or post partum/ puerperal) psychosis

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Quiz

- Having which of the following conditions makes a woman most likely to experience a postpartum psychosis?
- A- Paranoid Schizophrenia
- B- Severe Depressive Illness
- C- Bipolar 1 Disorder
- D- Alcohol Dependence Syndrome

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Relapse rates of various conditions

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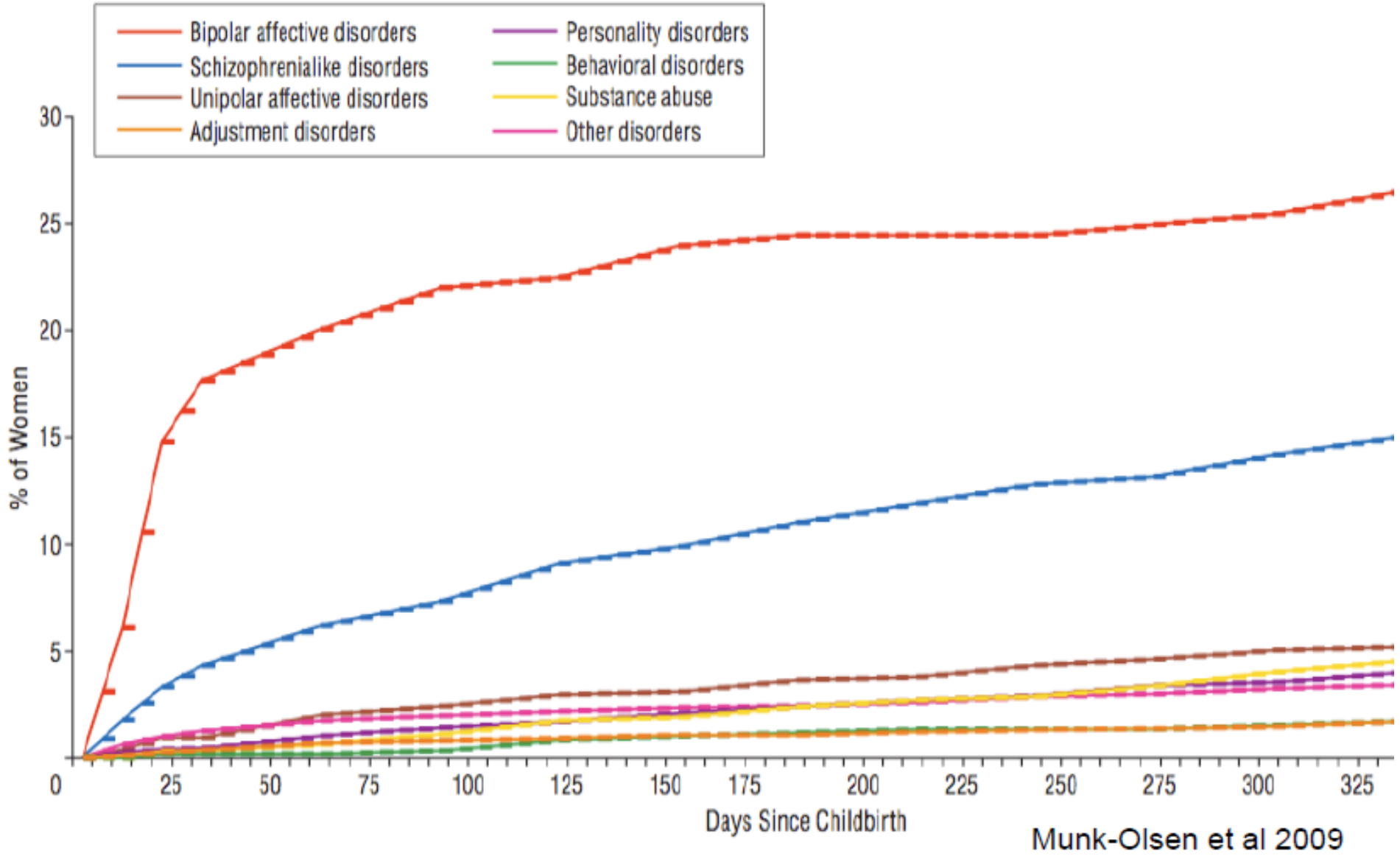

Highest risk of incidence of Psychosis

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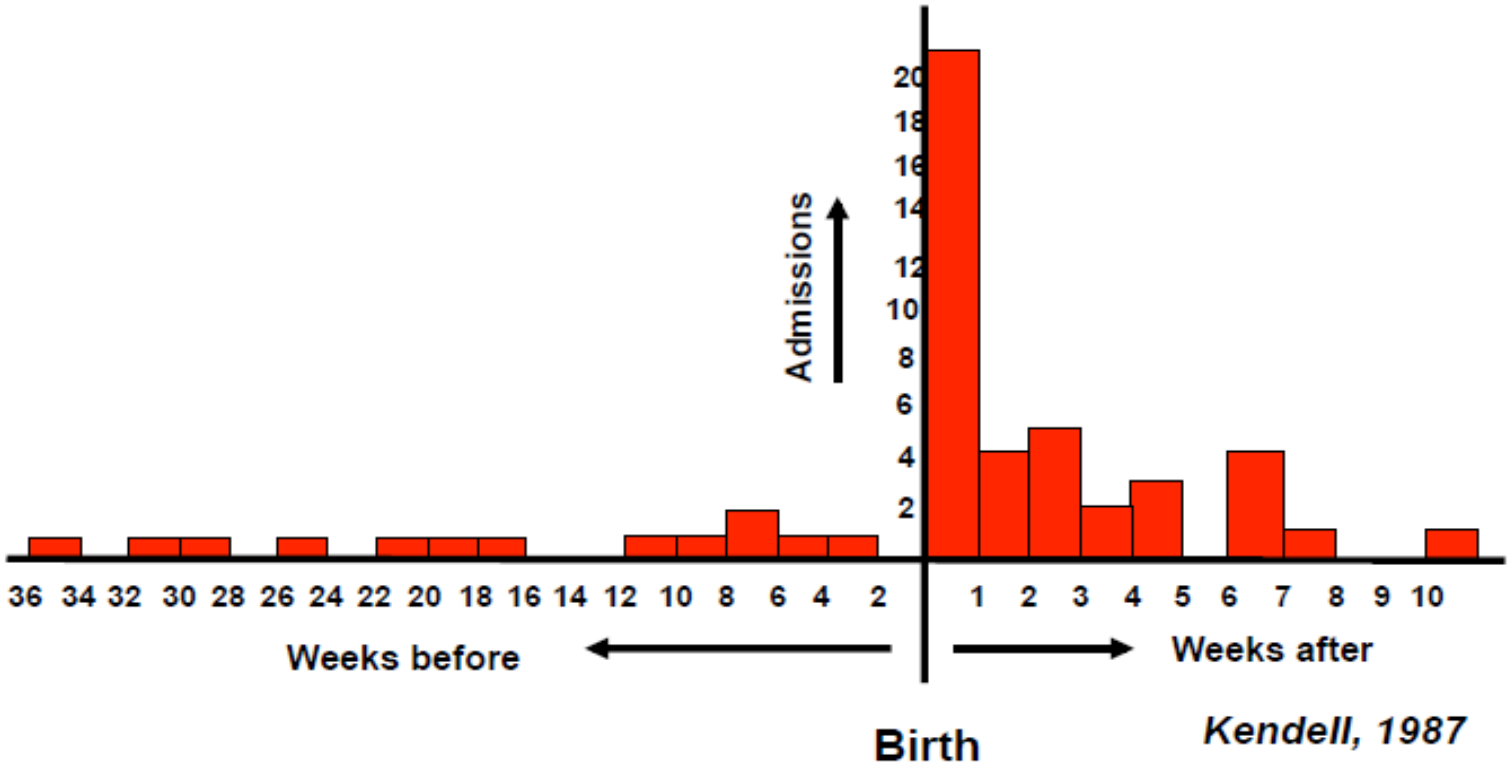

Puerperal psychosis: more rapid onset, more severe, and higher risk than at any other time (Oates, 1996; Appleby et al 1998)

Post Natal Psychosis

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- Severe illness, rapid onset, progressively worsening
- Early signs can be non-specific with insomnia, agitation, perplexity or odd behaviour
- There may be rapidly changing symptoms – with “windows” of normality in-between more obvious symptoms
- Usually a combination of rapidly changing mood symptoms (depression and/or mania) with psychotic symptoms

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Post Natal Psychosis

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- Florid psychosis may be rapidly progressive and develop within a few hours, commonly with manic features, lability of mood, rambling speech, distractibility, confusion or delusions of control.
- **Psychiatric emergency (see within 4 hours)**
- Significant risks to mother (suicide) and child (infanticide)
- Consider Mother & Baby Unit (MBU) admission rather than IHBT

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Post Natal Depression: Symptoms 1

- Symptoms similar to depression in non-pregnancy settings:
- Low mood, hopelessness, despair, pessimism about the future, reduced self-esteem, thoughts of suicide, poor sleep, poor appetite, tearfulness, anxiety, etc.
- Onset any time in first 6 months, but most severe cases developing within 6-8 weeks

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Post Natal Depression: Symptoms 2

- Plus more specific parenting worries: Feeling like “a bad mother”, inability to cope, poor bond, preoccupied about baby’s health, frequent presentations to GP / HV etc.

- Failure to respond to appropriate reassurance with severe increasing anxiety can be a warning sign that serious illness may be developing

- Careful enquiry regarding suicidality and thoughts of harm to child, which must be acted on promptly with **reduced threshold for admission than non-postnatal depression**

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Post Natal Anxiety & OCD

- Large overlap of symptoms with postnatal depression. Perhaps best viewed in the early stages as one broader disorder.
- Obsessions can be extremely distressing and often take the form of “I might hurt the baby”, which escalates to such an extent that mum feels the baby is at risk from herself, even though hurting the baby is the last thing she wants to do
- Such “ego-dystonic” ideas are so horrifying that mums often fear that their child will be taken away from them. Therefore they don’t tell us and struggle with their thoughts alone

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Post Natal Anxiety & OCD 2

- Mum then becomes increasingly depressed because she believes she is a horrible mother and the child doesn't deserve her - estrangement
- Obsessional thoughts can respond very well to SSRI antidepressants alongside CBT, plus explanation that such thoughts are surprisingly common in mums and are not a sign of severe illness
- Severe OCD can easily be misdiagnosed as psychosis because of perceived risks in professionals' minds.
- Understanding that a distressing thought is not the same as a safeguarding concern

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Medication - Challenges

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- medications are not licensed to prescribe
- ethical issues - robust research is difficult
- Safety – cannot be clearly established
- Decisions on medication – based on database studies (many limitations)
- Long term outcomes – not much data

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MEDICATION USE DURING PREGNANCY - SSRI

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- No major teratogenicity
- No major neurodevelopmental problems
- Generally safe to use during pregnancy

- decreased gestational age, spontaneous abortion, decreased birth weight, Persistent Pulmonary Hypertension (PPH).

- Neonates – exposure to antidepressants in late pregnancy - discontinuation symptoms – irritable, crying, shivering, or problem with feeding and sleeping. These are mild and self limiting within 2-3days.

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Antipsychotics

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- Current evidence does not suggest that antipsychotics are major teratogens
- Possible exception of risperidone – more data needed
- Association with a small increase in babies small for gestational age, and pre-term birth. Whether true effects or due to confounding factors is not clear.
- Association with gestational diabetes
- There is no indication for any significant long-term neurodevelopmental effects

PRN medications

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- Benzos – not teratogenic but preferable to avoid its use. 3rd trimester use – floppy baby S.
- Avoid longer acting drugs.
- Breast-feeding – short-acting agent eg lorazepam should be prescribed in divided doses
- Promethazine – sedative

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Breast feeding

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- Most medications – safe
- Relative infant dose (RID) ≤ 10

- Avoid - lithium, Clozapine, Carbamazapine

- To Consider – mixed feeding, change time of the dose, expressed breast milk

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Medication – not effective

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- Compliance
- Pregnancy – trimester
- Comorbidity – alcohol/physical health
- Social stressors
- Dose – titrate to higher doses
- Consider PRN – sleep
- Change Medication

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Case scenario

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- 40 year old lady with long history of anxiety and depression, currently stable taking venlafaxine 150mg mane dose, informs that she came to know that she is pregnant recently (suspects she could be 8 weeks pregnant).

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Medications - Learning points

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- Antidepressants – avoid abrupt discontinuation
- Risk vs benefit – likely benefits outweigh risk
- Give patient information leaflets
- Consider PRN medications

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SWYFT Perinatal Psychiatry team

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- Cover Barnsley, Wakefield, Kirklees, Calderdale
- Base – Fox View Hub, Dewsbury.
- 9-5pm
- Phone no – 01924316009

- Referral form – email.
- Accept Self referral.
- Admission – Leeds MBU – online form

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Who is this?

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- Daksha Emson had a glittering undergraduate medical career
- Won a research grant
- Was diagnosed with bipolar disorder as a student
- Was well on lithium, but stopped it when she became pregnant
- Unfortunately she became psychotic after giving birth
- Stabbed both herself and her baby Freya, then set themselves both alight
- Freya died, and Daksha was re-united with her 3 weeks later

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Resources

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- Medication leaflet –
- https://www.choiceandmedication.org/swyp/printable-leaflets/drugs-in-pregnancy
- Teratogenicity – BUMPS

http://www.medicinesinpregnancy.org/

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Resources

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- Royal College of Psychiatry – Perinatal Faculty page
- https://www.rcpsych.ac.uk/members/your-faculties/perinatal-psychiatry/news-and-resources

- https://www.nice.org.uk/guidance/cg192
- (Antenatal and postnatal mental health: clinical management and service guidance)

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Take Home Messages

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Be more proactive in asking about mental health

No need to stop medications if helpful and doing well

Give hope that something could be done

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