Recommended Steps before Beginning Antidepressant Medication During Pregnancy and Lactation

Counsel patient about antidepressant use:

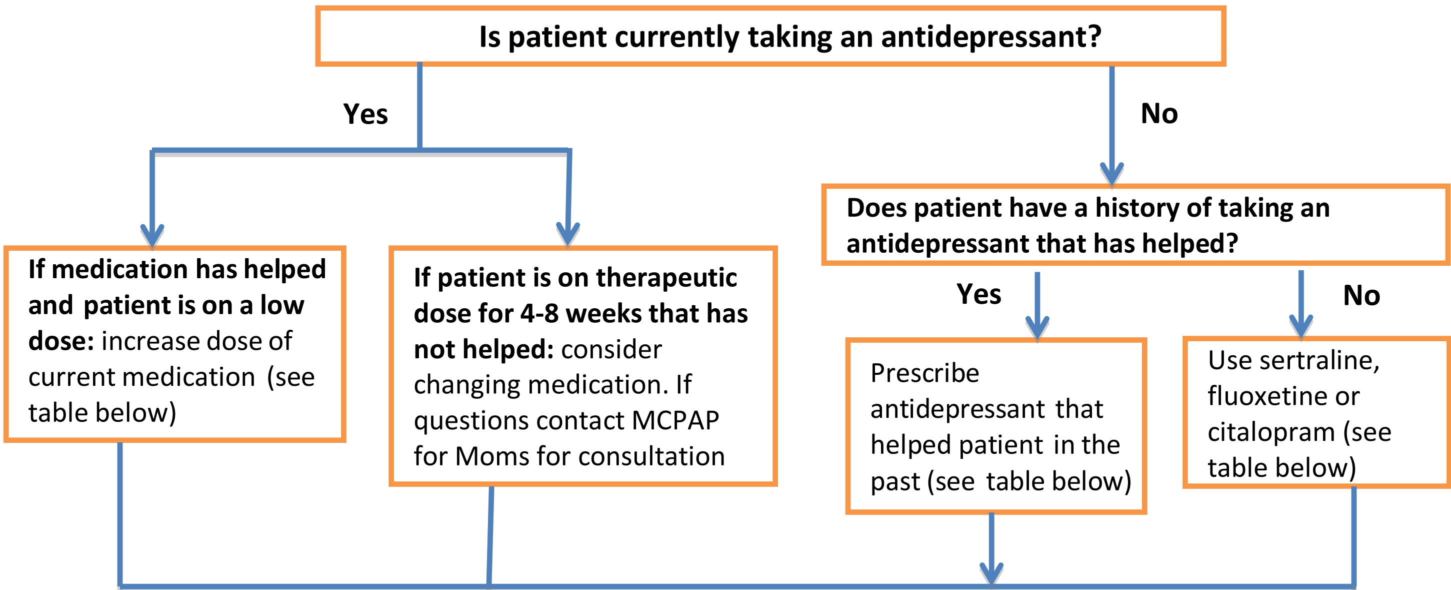
- No decision during pregnancy is risk free.
- Most studies on antidepressant use during pregnancy have examined SSRIs.
- SSRIs are among the best studied class of medications during pregnancy.
- Both medication and non-medication options should be considered.
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment and/or as an alternative when clinically appropriate.

Antidepressant use during pregnancy may increase risk of:	**Risks of under treatment or no treatment of depression during pregnancy:**
➢ Persistent pulmonary hypertension of the newborn (PPHN), but low absolute risk ➢ Pre-term labor ➢ Transient neonatal symptoms ➢ Long-term developmental effects, data are mostly reassuring	➢ Postpartum depression ➢ Pre-eclampsia ➢ Pre-term labor ➢ Substance abuse ➢ Suicide ➢ Poor self-care ➢ Impaired bonding with baby
• The preponderance of evidence does not suggest associations with birth defects (with possible exception of paroxetine).	• Postpartum depression is associated with negative outcomes for mother, baby, and family.

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

Antidepressant Treatment Algorithm

(use in conjunction with **Depression Screening Algorithm for Obstetric Providers**)



To minimize side effects, half the recommended dose is used initially for 7 days, then increase in small increments as tolerated.

First line treatment (SSRIs)			
sertraline (Zoloft) 50-200 mg** ***Increase in 50 mg increments	**fluoxetine (Prozac) 20-60 mg** ***Increase in 10 mg increments***	**citalopram (Celexa) 20-40 mg** ***Increase in 10 mg increments***	**escitalopram (Lexapro) 10-20mg** ***Increase in 10 mg increments***

Second line treatment		
SNRIs	**Other**	**If a first or second line medicine is currently helping, continue it** **Strongly consider using first or second line medicine that has worked in past**
venlafaxine (Effexor) 75-300mg *Increase in 75 mg increments*	bupropion (Wellbutrin) 300-450mg *Increase in 75 mg increments*	
duloxetine (Cymbalta) 30-60mg *Increase in 20 mg increments*	mirtazapine (Remeron) 15-45mg *Increase in 15 mg increments*	

*Considered a safer alternative in lactation as it has the lowest degree of translactal passage and fewest reported adverse effects compared to other antidepressants. **In general, if an antidepressant has helped it is best to continue it during lactation.**

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

If no/minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose
2. If patient has side effects, switch to a different med

If you have any questions or need consultation, contact or place a referral for Journey's Clinic

If clinical improvement and no/minimal side effects

Reevaluate every month and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.