HealthPathways Melbourne

Putting knowledge into practice

CASE STUDY 18:

Medications for depression and anxiety (pregnancy and breastfeeding)

Ella, a 34-year-old human resources manager, has presented to her usual GP after completing a positive home pregnancy test.

After her mother passed away from terminal cancer 12 months ago, she has been on escitalopram 20mg daily. Since being on antidepressant therapy, she has noticed a marked improvement in her ability to focus on complex tasks at work, has rediscovered joy in her life, and reports being able to respond to the grief appropriately, without feeling the need to cry and ruminate on most days.

Despite this pregnancy being unplanned, she is excited about the prospect of becoming a mother, and states that this is something she and her partner of six years had hoped would bless their lives.

Ella is, however, a little anxious about entering this chapter, particularly because she will not have the guidance of her mother, and she is quite concerned about experiencing another depressive relapse during the perinatal period. Part of her is motivated to remain on treatment throughout her pregnancy, and possibly for some time postpartum. But another part of her is concerned about the potential impact the medication may have on her unborn child.

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Ella is Australian-born, and, except for one maternal aunt with a history of bipolar affective disorder type 2, there is no family history of mental illness. She has never experienced psychotic symptoms, there has been no evidence of hypomania since being on escitalopram, and she has never needed mental health support up until her mother's passing.

There was a very brief period where she noticed some fleeting suicidal ideation, with the desire to "not go on living". However, there was never any intent, plan or attempt. Suicidal thoughts have remained non-existent since being on treatment. Similarly, there is no current drug or alcohol misuse.

Despite being well supported by her partner, the couple are largely socially isolated. Ella moved to Sydney eight years ago for work, leaving behind her parents and brother, who remained in Fremantle, in WA. Her partner, Stuart, is originally from the UK. He migrated to Australia four years ago, after two years of being in a long-distance relationship with Ella. The couple met online. Stuart has no family in Australia.

The GP assesses Ella as low risk at the present time, and acknowledges that her depression is well controlled. There are some concerns around the lack of social support to help raise the child, and Ella is likely to be at mild-to-moderate risk of worsening depression during the latter stages of her pregnancy, and potentially postpartum, as she navigates motherhood largely on her own.

Using the Medications for Depression and Anxiety (Pregnancy and Breastfeeding) pathway, the GP discusses the risks and benefits of SSRI continuation in pregnancy and considers it appropriate for Ella to remain on escitalopram throughout her pregnancy.

- risks of untreated depression or anxiety

Risks of untreated depression or anxiety

- Poor maternal nutrition
- Poor antenatal attendance
- Increased smoking
- Increased alcohol and substance abuse
- Increased risk of maternal suicide
- Obstetric complications:
  - Gestational hypertension

- potential adverse effects of medication

Potential adverse effects of medication

- Pregnancy:
  - Most safety data exists for selective serotonin reuptake inhibitors (SSRIs).
  - Less safety data for tricyclic antidepressants and serotonin noradrenalin reuptake inhibitors (SNRIs).
  - The absolute risk of a negative outcome such as a congenital anomaly is low but is not zero. Studies suggesting there is an increased risk of birth defects associated with antidepressant use in pregnancy have been mostly observational and clouded by confounding variables.
- Neonatal:
  - Risk of withdrawal or toxicity in neonates (poor neonatal adaptation syndrome).

Moving forward, Ella has an uncomplicated pregnancy and delivery. At two weeks postpartum, she is brought into the practice again, by her partner, with concerns that she is becoming increasingly paranoid that something detrimental will happen to the baby.

Stuart has observed her staying awake all night sitting right beside the bassinet, watching the baby. In the past 24-48 hours, Ella has advised him to lock all the doors and keep the curtains drawn to prevent the neighbours and anyone passing by from looking in.

Astutely, the GP is concerned about an emerging postpartum psychosis, and uses the Perinatal Mental Health (Pregnancy and Postnatal) pathway to urgently liaise with the local perinatal psychiatry service and expedite an inpatient admission. She is appropriately managed with antipsychotic medication under the direction of her inpatient psychiatry team and remains in remission, as outlined in the Medications for Depression and Anxiety (Pregnancy and Breastfeeding).

CASE STUDY 18:

- Postpartum psychosis

Postpartum psychosis

- A psychotic episode that arises following childbirth, usually in the first few weeks postpartum.
- Higher incidence with previous history of bipolar disorder and schizophrenia but can also occur without history of these.
- Onset of symptoms is sudden and can include:
  - delusional beliefs
  - disorganised thinking and confusion
  - mood lability and/or irritability
  - perceptual disturbance such as hallucinations excessive anxiety
  - fixation on a specific concern e.g., baby's health
  - severe inability to cope

For patients

- 1300 MEDICINE
- Alfred Health – Psychotropic Drug Advisory | Service (PDAS)
- MotherSafe – Depression and Anxiety During Pregnancy and While Breastfeeding
- The Royal Women's Hospital – Medicines Information Service

Management

1. Seek perinatal psychiatry advice if there is risk or complexity.

Risk or complexity

- There is a concern about risk, such as suicidal or infanticidal thinking.
- There is a severe or complex mental health history.
- There is a high risk of relapse.
- Patient has bipolar disorder and/or psychotic illness.
- Patient is using mood stabilisers, antipsychotics, or benzodiazepines.
- There are concerns about impaired mother-baby attachment.

About three years later, Ella returns to see her GP again in relation to pre-pregnancy planning. She is keen to have another child, and is very aware that her risk of a subsequent postnatal psychosis is high.

Ella is referred back to her perinatal psychiatrist for medication guidance. After consulting the Medications for Depression and Anxiety (Pregnancy and Breastfeeding) pathway, the GP also provides her with a list of patient resources regarding psychotropic medication in pregnancy.

She is also strongly encouraged to remain regularly engaged with her GP once she is pregnant again, to monitor mental health and review whether any medication is required, and collaborate with Ella's psychiatrist if needed.