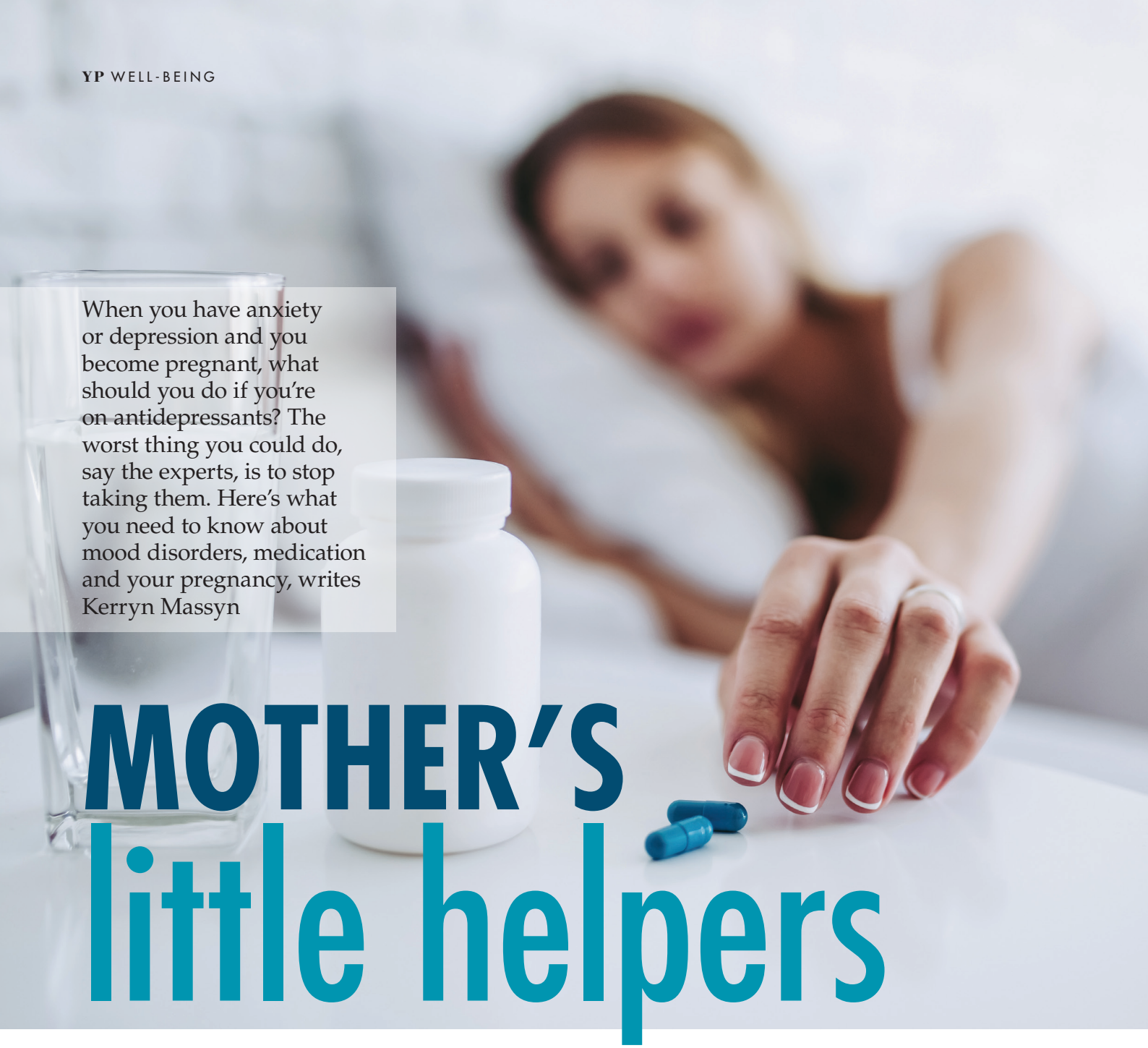

When you have anxiety or depression and you become pregnant, what should you do if you're on antidepressants? The worst thing you could do, say the experts, is to stop taking them. Here's what you need to know about mood disorders, medication and your pregnancy, writes Kerryn Massyn

MOTHER'S little helpers

DURING PREGNANCY, we're looking after the health and wellbeing of two people – that of ourselves, and of our growing babies. So, what do we do to ensure we're giving that baby-to-be everything it needs to grow healthy and strong? We eat healthily, we take prenatal vitamins, and we see our midwives and doctors for scans and regular checks. In short, we do everything within our power to create a healthy environment for the foetus to grow in. But this health doesn't begin and end with our physical bodies – mental health is just as important in a pregnant woman, and especially if you have experienced anxiety, depression or another mental illness.

WHEN YOU'RE DEPRESSED AND ANXIOUS

We don't like talking about mental-health issues because they're still covered by a dark and threatening cloud in South African society, but pretending that we aren't affected by these issues does not make them go away. "More than 20 percent of women develop a mental health problem (when referring to depression or anxiety) during pregnancy or within the first year of their baby's life. The whole range of psychiatric illnesses can occur in the so-called perinatal period, which covers before and after pregnancy," say Associate Professor Simone Honikman and Dr Annamarie Schmidt. That's one in every five pregnant women. Both Prof. Honikman and Dr Schmidt are at the University of Cape Town's Perinatal Mental Health Project (pmhp.za.org), the former as its director, and the latter while on sabbatical from her full-time position as a consultant in perinatal psychiatry in the UK.

Pregnancy is an emotional time for any woman, but for a woman with an untreated mental illness, it can be even more turbulent. And, a mother's mental state may have an effect on her developing baby. "New research shows that if left untreated, depression and anxiety results in an excess production of a stress hormone called cortisol, in the mother," says Dr Lavinia Lumu,

a specialist psychiatrist at the Crescent Clinic (crescentclinic.com), a private psychiatric facility in Randburg near Johannesburg. "The excess cortisol crosses the placenta and can affect the foetus by slowing down brain development and overall growth of the foetus during pregnancy.

"Foetuses exposed to high levels of cortisol are more likely to have difficulties after birth."

Untreated mental illness can also affect the physical health, of both mom and baby, explains Cape Town psychiatrist and maternal mental-health care expert Dr Elsa du Toit. "Women with untreated mental illness often experience more physical symptoms such as nausea, headaches and back pain during pregnancy," she explains. "For this they may use more prescribed and over-the-counter medication, which then cross the placenta and reach the developing baby too.

"Various symptoms of the mental illness may also cause other health risks, such as not eating well, neglecting to look after yourself, smoking or drinking alcohol, or even avoiding antenatal care and pregnancy supplements. These illnesses have also been associated with numerous adverse outcomes for mother and baby, such as high blood pressure, miscarriages, premature births and increased caesarean deliveries."

WHEN YOU'RE MEDICATED

When you're pregnant, you're advised to avoid taking medication, as some medication that's usually quite safe to take can have effects on your developing baby.

But when it comes to the medication you're taking to treat your depression or anxiety (or other mental condition), the rules are a bit different.

"In the past, it was believed that psychiatric medication was harmful to the baby, but more recent studies have demonstrated that psychiatric medication can often be continued in pregnancy with relative safety. Stopping psychiatric medication during pregnancy can actually result in more harm, not only to the mother but also to the baby," Dr Lumu says.

Prof. Honikman and Dr Schmidt further explain that the research is showing that benefits of treatment seem to outweigh the potential side effects of the medication. "Babies born to mothers with depression who were treated with antidepressants during pregnancy may have better longer-term emotional and behavioural development compared to babies born to mothers with depression or anxiety that was untreated. What is a lot less certain is whether antidepressants are associated with an increased risk of congenital malformations, postpartum haemorrhage, effects on gestational age, birth weight and Apgar scores and autistic spectrum and attention deficit and hyperactivity disorders later in childhood. However, larger studies are not finding significantly increased risks for these complications."

> "Babies born to mothers with depression and treated with antidepressants during pregnancy may have better longer-term emotional and behavioural development compared to babies born to mothers with depression or anxiety that was untreated"

There has also been at least one study showing that children whose moms were not treated for antenatal depression had an increased risk of developing problem behaviour (hyperactivity, inattention and peer problems) later in life. This same study showed that this increased risk was not seen in the children whose mothers took antidepressants during pregnancy.

"Most antidepressants are considered safe during pregnancy.

"Remember that no pregnancy is without risks – even if you are young, healthy and not using any medication, certain baseline risks will always be present," explains Dr du Toit.

"Therefore, when we examine risks of medication during pregnancy, they need to be measured against the baseline risks that are always present. Medication can also only be seen as 'risky' if it causes more than the expected risk for the general population. Antidepressants do not cause more than the expected three to five percent abnormalities in babies. Often, we are so afraid of the possible risks of medication that we completely ignore or minimise the risks of untreated maternal illness."

But, this does not mean that there are no risks when taking medication to treat depression and anxiety during pregnancy. There are medications that present increased risks – but, assure the experts, the overall risk remains relatively low. According to Dr du Toit, some studies suggest that the use of the class of antidepressants called selective serotonin uptake inhibitors (SSRIs) – which contain sertraline, fluoxetine, paroxetine, citalopram, escitalopram, fluvoxamine – during pregnancy can contribute to complications such as persistent pulmonary hypertension (PPHN) in newborns.

"However, it is difficult to know whether these findings are due to the medication, the underlying disorder or other factors. The background risk [meaning, in babies who are not exposed to SSRIs during pregnancy] for PPHN is one to two babies in 1 000. If there is an increased chance of PPHN from SSRIs, it may increase to three babies in 1 000. The absolute risk, if any, is thus small."

Besides PPHN, your baby could also experience neonatal adaption syndrome. "After birth there is a sudden drop in the SSRI in the baby's blood. This sudden drop results in discontinuation or 'withdrawal' symptoms," explains Dr Lumu. "These symptoms include jitteriness, rapid breathing, increased muscle tone and poor feeding, and may require a longer hospital stay and observation by a paediatrician. The symptoms are self-remitting within days to two weeks without medical treatment and do not result in any long-term harmful effects to the baby."

But, remind Prof. Honikman and Dr Schmidt, the increased risk is also small, as neonatal adaption syndrome occurs in 30 percent of babies exposed to SSRIs and in 10 percent of babies who weren't exposed at all.

WHAT YOU'RE TAKING

Overall, few of the antidepressants that are widely used today are to be absolutely avoided during pregnancy,

say Prof. Honikman and Dr Schmidt. But some are better than others. And, just like all medication, some are used to treat some very specific symptoms, and so your doctor may prescribe a specific medication. This is where things get a bit technical.

"For antidepressants, which imply drugs that are effective in treating both depression and anxiety, the largest evidence base around reproductive safety is for the SSRIs," they explain.

"As a result, most guidelines recommend SSRIs as first-line pharmacological treatments for depression both preconception and in pregnancy for women who have never taken antidepressants before. Sertraline appears to have the least placental exposure and is least likely to cross into breastmilk, so it's usually recommended for new episodes of depression. For women who have taken antidepressants before, your doctor should make a decision based on which antidepressant has been most effective in the past and a discussion of its risks and benefits."

Dr du Toit adds that, "Other mood stabilisers – such as lithium, lamotrigine and second-generation anti-psychotics – may be used in women with bipolar affective disorder.

"But, if you have this condition, it must be treated by a psychiatrist during pregnancy as both these medications and the illness are more complex to manage."

WHAT YOU SHOULDN'T BE TAKING

Our experts name benzodiazepines (a class of tranquillisers), valproate (or valproic acid) and carbamazepine as ingredients that have all been shown to have adverse side effects on either women or developing foetuses.

And here comes a bit of a surprise… Eglonyl is not really an antidepressant!

"Sulpiride [sold under the name Eglonyl here] is an older antipsychotic drug commonly prescribed by obstetricians, gynaecologists or doctors for the treatment of postnatal depression and also for the stimulation of lactation.

Despite its frequent use, it is not an antidepressant and therefore has poor

> The risks of not taking medication must be weighed with the benefits of taking medication

efficacy in the treatment of depressive symptoms. It's for this reason that an antidepressant would be preferred," adds Dr Lumu.

What happens if you've been taking a medication that you shouldn't? Don't be too worried. Chat with your psychiatrist and/or gynaecologist. "It often happens that women only realise that they are pregnant at around week eight – by this time the baby was already exposed, and if they stop medication at that point, all that happens is that they will be much more vulnerable to a relapse of their illness," Dr du Toit explains. "However, if you realise you're pregnant while on an antidepressant that may not be considered a first-line treatment, ask yourself – and your doctor – a few questions before changing your treatment: why did we choose that particular agent?

"Often it's because you have been on SSRIs without response, and in this case it will not make sense to change to a so-called first-line drug that you most likely won't respond to.

"And how far pregnant are you? Sometimes the critical period is already past, and it makes little sense to change at such a point."

YOU'RE NOT ALONE IN THIS

While this is good news, it's never a good idea to take any medication (whether you're pregnant or not) without your doctor's advice.

What's more, by their very nature, conditions such as depression and anxiety should be treated by a medical professional.

So, if possible, chat to the doctor who is managing your illness before you become pregnant.

"Ideally a woman of reproductive age should discuss the risks and benefits of antidepressants in pregnancy with the prescriber when the antidepressant is first prescribed. This will enable her to consider her choice of antidepressant, to have a plan regarding what she would like to do in the event of pregnancy, and to consider the use of contraception," say Prof. Honikman and Dr Schmidt.

"When planning a pregnancy or pregnant, you should discuss the use of antidepressants with the prescribing doctor, usually your general practitioner or a psychiatrist, as soon as possible. These doctors will know your history and should be able to advise you appropriately. Then, make sure you share the decision you've made from this discussion with the healthcare professional supporting the pregnancy: your midwife, general doctor or gynaecologist. This needs to be in your maternity notes, together with information including your risk of relapse, whether you plan to breastfeed and the plan for medication post-delivery."

What about therapy – instead of medication – to treat depression and anxiety? Again, your doctor should be in on the decision. "In some instances, mild to moderate depression can be managed without medication through therapy with a psychologist or counsellor," Dr Lumu says. "But it is always best to consult a psychiatrist. The severity of the depression needs to be determined, and the risks of not taking medication must be weighed with the benefits of taking medication. Illnesses such as bipolar are best controlled with medication, and therapy alone will not suffice."

If you decide to stop your medication during pregnancy, know the risks and be smart about it. "If you do decide to stop taking your antidepressants, even if this is without discussing with a doctor, do not do so abruptly," advise Prof. Honikman and Dr Schmidt. "Rather slowly decrease your dosage over about four weeks until you aren't taking it anymore. This will decrease your risk of relapse and also withdrawal symptoms."

It's important to remember, agree all the experts interviewed here, that the data available in terms of the safety of medication during pregnancy is limited, and there are very few absolutes. **YP**

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