TREATMENT OF DEPRESSION IN PREGNANCY:CURRENT TREND

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ABSTRACT

Pregnancy has traditionally been considered a time of emotional well-being for women conferring protection against psychiatric disorders. But depression during pregnancy affects nearly 20% of women. Depression experienced by obstetric patients frequently remains unrecognized and untreated. Lack of adequate management of depression during pregnancy may result in a potentially devastating consequences that impact upon both mother and baby. So clinicians and patients need up-to-date information to assist with decisions about depression treatment during pregnancy.

Key words- ***Treatment, Depression, Pregnancy.***

INTRODUCTION

Major depressive disorder (MDD), a chronic and recurrent illness, **[1]** is a leading cause of disease burden for women aged 15–44 years in both developed and developing regions of the world**[2].** Each year, a substantial number of women, i.e. between 7 and 13% of the global female population, experience MDD**[3, 4,5 6,7].** Its onset coincides with the reproductive yearsand according to the American congress of obstetricians and gynecologists (ACOG), between (14-23)% of women will experience a depressive disorder while pregnant **[8, 9].** For women of low socioeconomic status (SES), rates as high as 50% have been reported **[10]**. Depression experienced by obstetric patients frequently remains unrecognized and untreated**[11]** .This lack of recognition, coupled with a general unwillingness to use medication throughout gestation **[12]** has resulted in the likelihood that depressed pregnant women will not be treated with antidepressant medication**.** In the absence of adequate treatment the depression can accelerate and episodes may become more frequent and severe, resulting in substantial maternal and infant morbidity **[13, 14].**

Major depression during pregnancy

Pregnancy has traditionally been considered a time of emotional well-being for women conferring protection againstpsychiatric disorders. About one third of depressed pregnant women, represents the first episode of major depression.Clinically significant depressive symptoms during pregnancy, particularly observed in the setting of antidepressant discontinuation or with past history of mood disorder. Women with recurrent major depression who have been maintained on an antidepressant medication before conception appear to be at an especially high risk for relapse during pregnancy.In women who have been diagnosed as recurrent depression prior to conception and in whom antidepressant medications have been discontinued, rates of relapse can approximate 75% and can be seen frequently during the first trimester. Pregnant women may have many clinical signs and symptoms overlapping with those seen in major depression (e.g. sleep and appetite disturbance, diminished libido, and low energy). Some medical disorders commonly seen during pregnancy, such as anemia, gestational diabetes, and thyroid dysfunction, may be associated with depressive symptoms and may complicate the diagnosis of depression during pregnancy. Other risk factors for antenatal depression include marital discord or dissatisfaction, inadequate psychosocial supports, recent adverse life events, lower socio-economic status, and unwanted pregnancy.

Functional impairment, inadequate prenatal care, pre-eclampsia, substance abuse **[15]**, increased risk of postnatal depression and ultimately poor pregnancy outcomes have all been associated with depression during the obstetric period.Their babies borne from depressed mothers are often irritable and lethargic, with irregular sleep habits. Lack of adequate management of depression during pregnancy may result in a potentially devastating consequences that impact upon both mother and baby.On the other hand the use of antidepressant medications during pregnancy have been associated with negative

consequences for the newborn.While weighing the risks and benefitsof treating depression during pregnancy following facts should be taken into consideration: risk of untreated depressive disorder, effects of depressive disorder on the fetus, teratogenicity of antidepressant medications,long term behavioral effects on child and incomplete reproductive safety data for medications.So clinicians and patients need up-to-date information to assist with decisions about depression treatment during pregnancy.

Treating a pregnant woman who is depressed

The therapeutic goal of the treatment of depression during pregnancy is to achieve mental stability of the mother, without causing harm to the fetus **[16]**. Thus, it is necessary to weigh the expected benefits to both the mother and fetus against the potential risks of treatment. Treatment options for the management of depression during pregnancy include pharmacotherapy and psychotherapy. Management should be based upon the physician's clinical judgement, the patient's preference, and the availability of professional and support services.

Recommendations

The American Psychiatric Association and the American College of Obstetricians and Gynecologists **[17]** recommend the following:

1. Women who plan to start a family and have mild depressive symptoms for six months or longer may be able to taper off medication. This may not be appropriate for women with a history of severe anxiety or depression, or who have bipolar disorder or a history of suicide attempts.
2. Women who are pregnant, psychiatrically stable, and prefer to continue taking their medication may be able to do so after consulting with their psychiatrist and Obstetricians and Gynecologists.
3. Women who are pregnant and have severe depression or anxiety should remain on medication, as they are at high risk for relapse.

Antidepressant treatment during pregnancy

There are no antidepressant drug efficacy trials in depressed pregnant women. However, there is little reason to think that response would differ between pregnant and non-pregnant women. It is ideal, but not always possible, to evaluate a woman with a past or current depressive illness prior to conception.

Pre-conceptional patients

For women on medication with mild or no symptoms for six months or longer, it may be appropriate to taper and discontinue medication before becoming pregnant. Medication discontinuation may not be appropriate in women with a history of severe, recurrent depression (or who have psychosis, bipolar disorder, other psychiatric illness requiring medication, or a history of suicide attempts). Women with suicidal or acute psychotic symptoms should be treated aggressively. Some women may also benefit from referral to a therapist who can provide psychotherapy. While CBT or IPT are preferable, other types of counseling may be helpful if empiric-based therapies are not available.

Pregnant patient who is not receiving pharmacotherapy

It is common to diagnose untreated depression during pregnancy and to encounter patients who have discontinued their medications but are symptomatic. Psychotherapy may be beneficial in women who prefer to avoid antidepressant medication and is not gravely disabled or at high risk of relapse . For women who prefer taking medication, risks and benefits of treatment choices should be evaluated and discussed, including factors such as stage of gestation, symptoms, history of depression, and other conditions and circumstances (eg, a smoker, difficulty gaining weight). The dose of agents metabolized primarily by cytochrome P450 2D6 or P450 3A4 may require an increase in the second half of pregnancy **[18].**

Patient with current or recent MDD who is taking antidepressants in pregnancy

Psychiatrically stable women who prefer to stay on medication may be able to do so after consultation between their psychiatrist and obstetrical clinician to discuss risks and benefits. Women who would like to discontinue medication may attempt medication tapering and discontinuation if they are not experiencing symptoms, depending on their psychiatric history. Women with a history of recurrent depression are at a high risk of relapse if medication is discontinued. Women with recurrent depression or who have symptoms despite their medication may benefit from psychotherapy to replace or augment medication. Women with severe depression (with suicide attempts, functional incapacitation, or weight loss) should remain on medication. If a patient refuses medication, alternative treatment and monitoring should be in place, preferably before discontinuation.

The impact of antidepressants on birth outcomes

The use of multiple medications during pregnancy makes it difficult to assess the impact of a single compound, such as an antidepressant, on maternal and fetal outcomes. Increased risk for spontaneous abortion is associated with the use of various antidepressants in early pregnancy**[19].** No differences were observed among the various classes of antidepressants.Reductions in birth weightis associated with SSRI use in pregnancy **[20].**Butnot all studies show this association**[21, 22],** although only a few had adequate power to find a difference. Some studies found that preterm delivery is significantly higher among women who used antidepressants, including SSRIs and TCAs**[23,24].** Other studies do not support this association**[25].**The majority of studies have not shown an association between TCA use in pregnancy and structural malformations**[26].**The current data on SSRI exposure show no consistent information to support specific morphological teratogenic risks.**[27]**

While some linked database reports find that compared to unexposed offspring, those exposed to paroxetine during the first trimester are at higher risk of cardiac malformations **[27]**, these results are disputed by other reports including several large case cohort studies**[28].**Infants exposed in utero to an SSRI in combination with a benzodiazepine but not an SSRI alone, may have a higher a incidence of congenital heart defects compared to no exposure**[29]**. Such results raise the possibility that presumed associations between antidepressants and malformations may be complicated by poly-drug interactions. Other antidepressants including bupropion, venlafaxine, duloxetine ,nefazodone, and mirtazapine known not to be teratogenic. **[22,30,31].**

Neonatal neurobehavioral outcomesof antidepressants

In utero exposure to TCAs are associated with increased perinatal complications including jitteriness, irritability and, rarely, convulsions in neonates**.[16,23].** A cluster of symptoms termed “poor neonatal adaptation” has been reported during the immediate neonatal days among infants exposed to SSRIs which include tachypnea, hypoglycemia, temperature instability, irritability, a weak or absent cry, and seizures**[19].** These symptoms occurred in 15–30% of women who took SSRIs in late pregnancy . Symptoms in neonates were transient and typically resolved by 2 weeks or sooner after delivery. An increased risk of persistent pulmonary hypertension (PPHN) was found among newborns whose mothers were treated SSRIs with a greater risk for infants who were exposed later in pregnancy**[32, 33].**

Electroconvulsive therapy during pregnancy

Electroconvulsive therapy (ECT) is considered safe & effective for depression during pregnancy. It is an option for moderate to severe depression in pregnant patients who are unsuitable for or unresponsive to antidepressants, have psychotic features, &/or are suicidal.There is little evidence that it is harmful to the woman or fetus when both are carefully monitored**[34].**

Non-drug treatments for depression in pregnant

There are a number of non-drug treatments that are effective for even major depression in pregnancy . Non-drug treatments include psychotherapy, Omega-3 fatty acids , exercise, bright light therapy and St. John's wort. Many of these can be combined with each other, and are sometimes used in addition to antidepressants (only St. John's wort cannot be combined with medications)

Behavioral treatments for mood disorders

Many patients with mild-to-moderate depression can be treated by psychosocial approaches including individual and group psychotherapy without use of medication. Patients with residual symptoms, those at high risk of relapse, those with comorbid conditions such as panic disorder and those who prefer to avoid medication may benefit from psychotherapy. This is an especially critical option for women preparing for conception or currently pregnant since a large percentage of women may plan to avoid medication. Cognitive behavioral therapy (CBT) or interpersonal psychotherapy (IPT) have been shown to be effective for depression in pregnant women **[35]**.While evidence for supportive and psychodynamic psychotherapy is limited, these approaches are also reasonable if IPT and CBT are unavailable.

SCREENING OFDEPRESSION DURING PREGNANCY

Females shouldbe screened for peri-pregnancy depression during :

1. Pre-conception: should be ask about personal and family history of mental health disorders and treatment.
2. Pregnancy: during the first routine antenatal visit.
3. Postpartum: during routine postnatal visits at 4-6 weeks and 3-4 months postpartum.

Depression screening tools used in pregnancy & postpartum are :

1. Edinburgh Postnatal Depression Scale – validated for use during both pregnancy and postpartum**[36].**

2. Patient Health Questionnaire 9(PHQ-9)
3. National Institute for Health and Clinical Excellence: Screening for Depression During Pregnancy**[37].**

Screening tools do not confirm a diagnosis of depression, but rather identify patients who require further assessment. Using screening tools which focus on somatic symptoms (e.g. Beck Depression Inventory) should be avoided as it can be difficult to distinguish between symptoms of depression versus pregnancy should be avoided.

CONCLUSION

The treatment of depression during pregnancy can be challenging for patients and providers alike. An increasing attention to perinatal mood disorders has led to an expanding literature that is often difficult for providers to navigate. Women who are depressed during pregnancy have been found to have an elevated risk of poor obstetrical outcomes, although studies of the relationship between depression and outcomes are limited. Women who are treated with antidepressants during pregnancy are also at risk for a host of poor obstetrical and fetal outcomes. Understanding the current data and their limitations will allow providers to guide their patients in choosing treatment options. Consistent and simple strategies should be used when discussing the risk-benefit analysis with the patient.

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