General advice when prescribing SSRIs/SNRIs in pregnancy and lactation.

It is important that mums/ parents are supported to stay healthy in the perinatal period to reduce the risk of more serious illness. The benefits of a well parent/ baby dyad who are supported and happy will maximise bonding of the child and their parent(s) at a critical time. We must first consider the risks associated with untreated depression and anxiety during pregnancy including deterioration in mental state, preterm delivery, low birthweight, postnatal depression, and poor bonding with baby as well as the effects this may have on baby's future development and long-term health.

While it is common to see limited data in typical resources such as the BNF or Summary of Product Characteristics, specialist resources such as SPS- Specialist Pharmacy service, UKTIS, and so on should be used to guide decisions with patients. Clinical data, specialist resources and experience can help us to assess the benefits and risks of treatment. The risks of no treatment must be considered as well as the benefits of supporting parents to reach their breastfeeding goals as this will impact both the parents and baby's health in the short and long term.

All SSRIs are considered 'relatively safe' during the perinatal period and evidence suggests there are no significant long-term behavioural or developmental effects associated with babies exposed to SSRIs. **Sertraline** is considered the antidepressant of choice during pregnancy and lactation however using an alternative antidepressant that is known to have been effective in the past may be preferable. Experience suggests that antidepressants are unlikely to harm an infant and may improve the breastfeeding relationship.

The potential risks to baby when taking an SSRI during pregnancy include:

- Transient discontinuation symptoms (irritability, shivering, difficulty settling and difficulty feeding). These effects are associated with use of SSRIs during pregnancy however there is no definitive causal link. Not all babies experience discontinuation effects (up to 1 in 3), they are temporary (often subsiding within 48 hours), usually mild and do not require treatment. Breastfeeding may help to reduce the risk of baby experiencing discontinuation effects as they will receive small amounts of medication in breastmilk.
- Recent data suggests SSRIs do not significantly increase the risk of cardiac malformation or persistent pulmonary hypertension of the newborn (PPHN) once confounding factors such as smoking are taken into account.
- Data suggests taking an SSRI in the final month before delivery may increase the risk of postpartum haemorrhage in certain people. Individual risk factors for bleeding or thrombotic events may need to be considered when initiating or reviewing a SSRI during pregnancy; it is important that benefits associated with antidepressant treatment are weighed against the potential risks.

It is crucial that the *lowest **effective** dose* is prescribed as exposing baby to a drug whilst **undertreating** the parent's symptoms may prove counterproductive. Mental state can be monitored every 2-4 weeks and increasing the dose of the SSRI if responding well, tolerating and feels a higher dose would be helpful.

Sedating medication affects the safety of bedsharing; share appropriate sleep resources for parents to read. Sedating medication may also impact establishing feeding if night-time feeds are missed during the first 6-8 weeks; seek trained support so the parent is empowered to establish feeding and maintain supply.

Switching medication during the perinatal period carries a risk of relapse but also exposes the foetus / baby to more drugs. Careful consideration of risks should be undertaken before a change in treatment is commenced.

All infants should be monitored for drowsiness, poor feeding, irritability/restlessness.

Patient resources

Pregnancy:

- » Printable leaflets (choiceandmedication.org)
- bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)

Lactation:

- Anxiety and Breastfeeding - The Breastfeeding Network
- Antidepressants and Breastfeeding - The Breastfeeding Network
- Breastfeeding: the first few days - NHS (www.nhs.uk)
- National Breastfeeding Helpline – Helpline (Trained support available 365 days a year)

Safe Sleep - BASIS – Baby Sleep Information Source (basisonline.org.uk)

IAPT/ Talking therapies - Talking Therapies - Somerset IAPT Service

Safer medicines Poster - NHS Somerset: Safe-Prescribing-in-Pregnancy-Poster-December-2022.pdf

Medication	Drug-specific advice	RID
Sertraline	Sertraline is considered the antidepressant of choice for use in pregnancy and lactation. It may be continued throughout pregnancy and whilst breastfeeding if benefits out-weigh potential risks.	0.4%-2.2%
Citalopram	Citalopram may be continued throughout pregnancy and whilst breastfeeding if benefits out-weigh potential risks.	3.5%-5.4%
Duloxetine	Duloxetine may be continued throughout pregnancy and whilst breastfeeding if benefits out-weigh potential risks.	0.12%-1.12%
Fluoxetine	Fluoxetine should not be routinely initiated in pregnancy, or if planning to become pregnant or breastfeeding. However, if a mother is already well and stable whilst taking fluoxetine it may be advisable to continue treatment due to the risks associated with switching medication, or previous treatment success may indicate suitability to use. The average amount of fluoxetine found in breastmilk (RID) is higher than with other SSRIs and is long acting which may increase the risk of accumulation or side effects in an infant, the likelihood of side-effects reduces after 2-4 months postpartum. If fluoxetine is required by the mother/ parent, it is not a reason to discontinue breastfeeding.	1.6%-14.6%
Paroxetine	Paroxetine should not be routinely initiated in pregnancy or if planning to become pregnant due to the increased risk of discontinuation symptoms. However, if a mother is already well and stable whilst taking paroxetine it may be advisable to continue treatment due to the risks associated with switching medication. If paroxetine is required by the mother/ parent, it is an SSRI of choice in lactation and not a reason to discontinue breastfeeding.	1.2%-2.8%
Mirtazapine	Mirtazapine may be continued throughout pregnancy where clinically indicated with caution and whilst breastfeeding if benefits out-weigh potential risks. An alternative drug may be preferred, however, if a mother is already well and stable whilst taking mirtazapine it may be advisable to continue treatment due to the risks associated with switching medication. Low levels in milk are not anticipated to cause side-effects in an infant, especially if they are over 2 months of age. If mirtazapine is required by the mother/ parent, it is not a reason to discontinue breastfeeding. Mirtazapine is likely to cause drowsiness in the parent which can make bed-sharing unsafe, share safe sleep information (link in parent resources), discuss night feeding and possibility of needing help to breast/ chestfeed/ hold the baby if drowsy.	1.6%-6.5%
Venlafaxine	Venlafaxine should not be routinely initiated for women who are pregnant or planning to become pregnant due to the increased risk of discontinuation symptoms. However, if a mother is already well and stable whilst taking venlafaxine it may be advisable to continue treatment due to the risks associated with switching medication. If venlafaxine is required by the mother/ parent, it is not a reason to discontinue breastfeeding. Venlafaxine is likely to cause drowsiness in the parent which can make bed-sharing unsafe, share safe sleep information (link in parent resources), discuss night feeding and possibility of needing help to breast/ chestfeed/ hold the baby if drowsy.	6.8%-8.1%

RID= Relative infant Dose in lactation

References

- Medicines in pregnancy, children and lactation - NHS Somerset
- USE OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS IN PREGNANCY – UKTIS
- USE OF VENLAFAXINE IN PREGNANCY – UKTIS / Monographs – UKTIS
- Depression: treatment during pregnancy – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- Safety in Lactation: Antidepressants – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- Management | Depression - antenatal and postnatal | CKS | NICE
- CG192 NICE: Antenatal and postnatal mental health: clinical management and service guidance
- Drugs and Lactation Database (LactMed) - NCBI Bookshelf (nih.gov)
- *Hale's Medications and Mothers' Milk* Dr. Thomas W. Hale, Springer Publishing, 2019