Massachusetts Child Psychiatry Access Project
MCPAP For Moms

Recommended Steps before Beginning Antidepressant Medication During Pregnancy and Lactation

(Discussion should include yet not be limited to the below)

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

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

Funding provided by the Massachusetts Department of Mental Health

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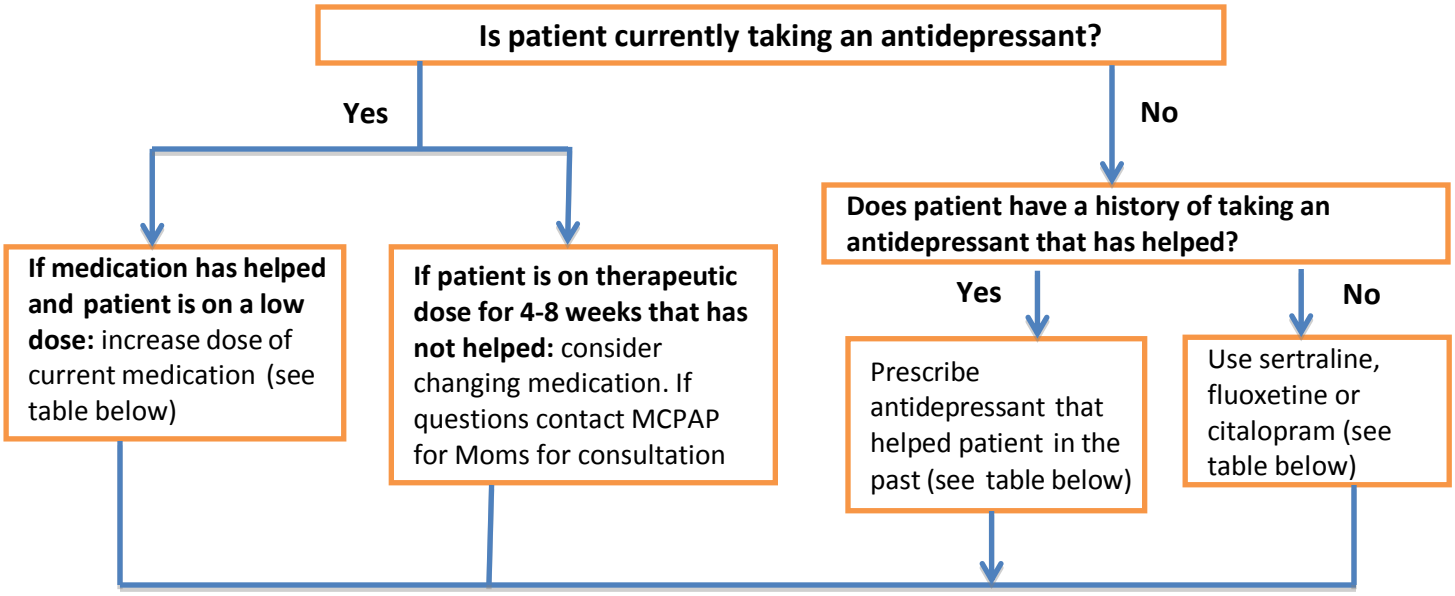
Antidepressant Treatment Algorithm

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



To minimize side effects, half the recommended dose is used initially for 2 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			
SSRIs	**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**
*paroxetine (Paxil) 20-60mg *Increase in 10 mg increments*	venlafaxine (Effexor) 75-300mg *Increase in 75 mg increments*	bupropion (Wellbutrin) 300-450mg *Increase in 75 mg increments*	
*fluvoxamine (Luvox) 50-200mg *Increase in 50 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 MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

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. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

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