

## Recommended Steps before Beginning Antidepressant Medication Algorithm

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

### Counsel patient about antidepressant use:

- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- 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 or as an alternative when clinically appropriate

### Risks of antidepressant use during pregnancy

- Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine
- The preponderance of evidence does not suggest birth complications
- Studies do not suggest long-term neurobehavioral effects on children
- Possible transient neonatal symptoms

### Risks of under treatment or no treatment of depression during pregnancy

- Increases the risk of postpartum depression
- Birth complications
- Can make it harder for moms to take care of themselves and their babies
- Can make it harder for moms to bond with their babies

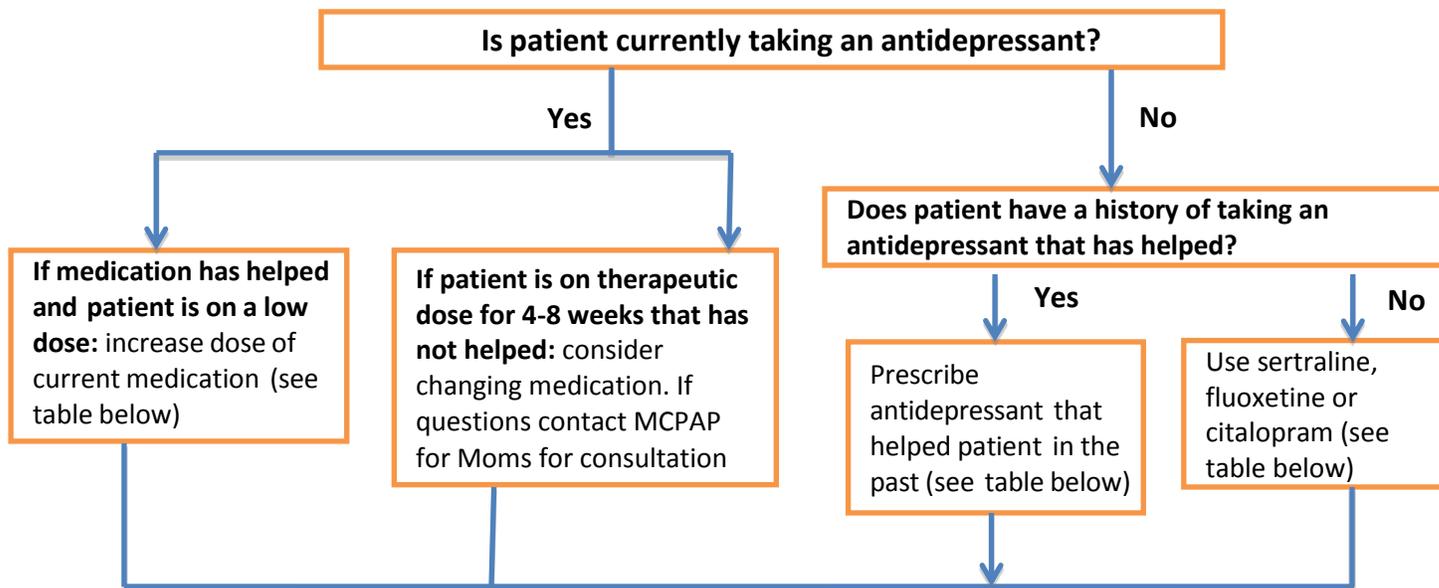
- *If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- *If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

**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**

## 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 <i>Increase in 50 mg increments</i>	fluoxetine (Prozac) 20-60 mg <i>Increase in 10 mg increments</i>	citalopram (Celexa) 20-40 mg <i>Increase in 10 mg increments</i>	escitalopram (Lexapro) 10-20mg <i>Increase in 10 mg increments</i>
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 <i>Increase in 10 mg increments</i>	venlafaxine (Effexor) 75-300mg <i>Increase in 75 mg increments</i>	bupropion (Wellbutrin) 300-450mg <i>Increase in 75 mg increments</i>	
*fluvoxamine (Luvox) 50-200mg <i>Increase in 50 mg increments</i>	duloxetine (Cymbalta) 30-60mg <i>Increase in 20 mg increments</i>	mirtazapine (Remeron) 15-45mg <i>Increase in 15 mg increments</i>	
*Considered a safer alternative in lactation because they have the lowest degree of transplacental passage and fewest reported adverse effects compared to other antidepressants. <b>In general, if an antidepressant has helped it is best to continue it during lactation.</b>			

### 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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