Rapid Rounds: Clinical Essentials for Perinatal Mental Health Webinar Series

Medications and More: Comprehensive Approaches for Treating Perinatal Mental Health Conditions

Tuesday, January 20, 12:15 – 1:00 PM

Speakers: Erin Bider, MD and Tara Chettiar, MD, PMH-C, FACOG

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Funding and Partnerships

Kansas Connecting Communities is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $3,750,000 with 10% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

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Mental Health Consultation & Resource Network

Empowering clinicians. Elevating patient care.

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KCC Program Components

Training

- Didactic and case-based learning led by a collaborative and multi-disciplinary training team
- Monthly virtual training on treatment, medication management, and special topics in perinatal behavioral health
- On-demand modules, webinars, and additional custom training options available
- Training scholarship opportunities and up to 6 free CME/CEs offered annually

Consultation Line

- Psychiatric consultations with perinatal behavioral health team
- Resources and referral support
- Connection to training and technical assistance services
- Information about best practices, recommendations and research, and Medicaid billing and reimbursement

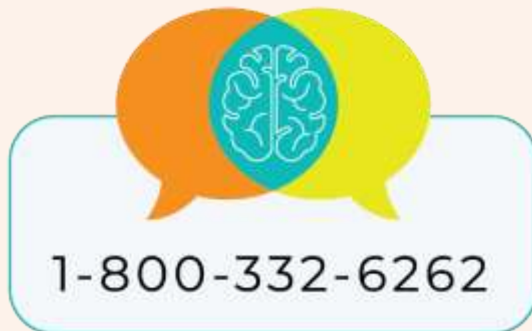
Technical Assistance

- Support to implement substance use and mental health screening in clinic, hospital, public health, and community settings
- Coaching to build a referral network and improve care coordination between referral partners.
- Assistance developing custom policies, workflows, and administrative support tools for screening and referrals

Access services to support your work with perinatal clients

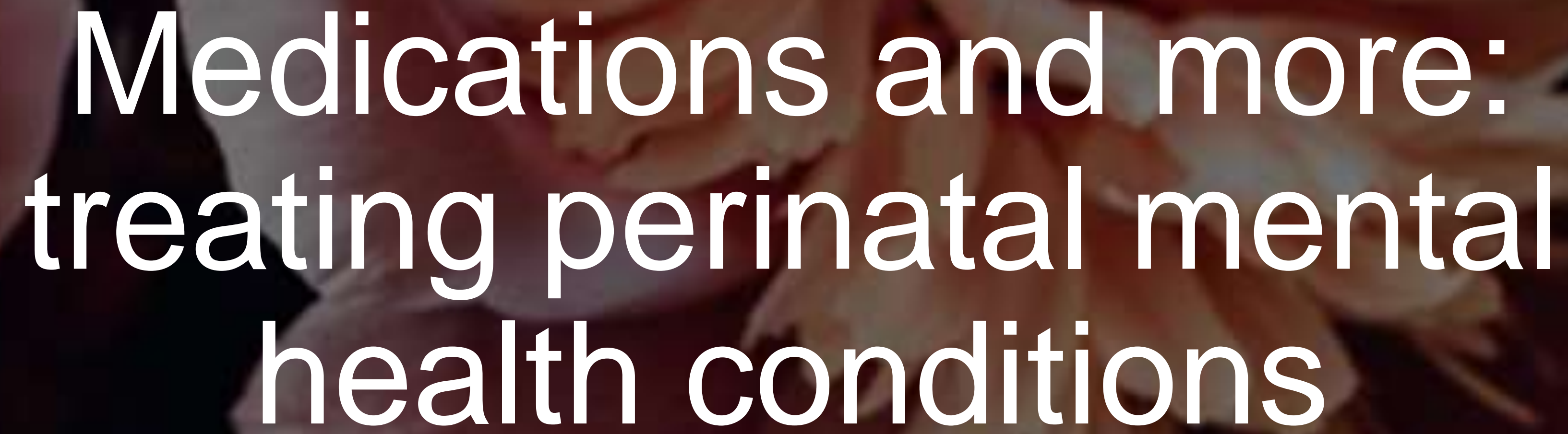
Registered KCC Providers Receive

- **Early registration** access to trainings and PSI scholarships
- Up to six hours of **free CEs** (continuing education credits)
- Access to a **consolidated hub** of KCC and KSKidsMAP (pediatric program) services



- Streamline use of the Mental Health Consultation & Resource Network

Sign up today!



Erin N. Bider, MD

Tara N. Chettiar, MD, PMH-C, FACOG

1. Discuss clinical approaches to managing psychiatric disorders in the perinatal period, including psychopharmacology, therapeutic interventions, and non-clinical support

2. Understand overarching principles for managing psychotropic medications in the perinatal period.

3. Review first-line medications for depression, anxiety, bipolar disorder, and psychotic disorders

Background

- Mental health conditions affect about 20% of pregnancies in the US, making them far and away the most common pregnancy complication
  - We estimate that up to 50% of women do not report their symptoms, so this is probably an underestimate
- Mental health conditions are the number one underlying cause of pregnancy-related deaths in the United States and in Kansas
- Estimated cost of untreated PMH disorders in the US is $14.2 billion annually

Martin, et al. (2016) *BMJ Open*

- Less adherence to prenatal care
- Poor nutrition
- Weight gain/loss
- More likely to abuse substances
- Low birth weight
- Preterm delivery
- Suicide

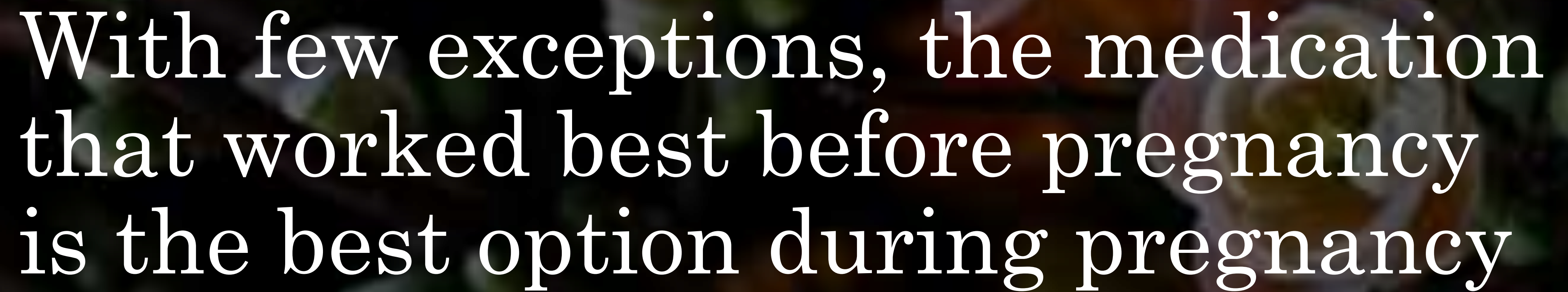
- Impaired mother-infant attachment
- Difficulty breastfeeding
- Developmental delay at 18 months
- Children exhibit poor emotional regulation
- Increased risk of mental illness in adolescence
- Suicide

Meltzer-Brody S, et al. (2018) *The Lancet*
Muzik M and Borovska S (2010) *Ment Health Fam Med*

Clinical Approach

Optimize non-pharmacological options

- Therapy
- Behavioral activation
- Exercise
- Mindfulness
- Adequate sleep
- Bright light therapy
- Ensure appropriate treatment for anemia, restless legs/periodic limb movement, thyroid disease, vitamin D and B12 deficiencies


With few exceptions, the medication
that worked best before pregnancy
is the best option during pregnancy

General "rules"

- Always strive to minimize the NUMBER of exposures to a pregnancy
- Untreated mental health symptoms are ALSO an exposure
- Changing meds unnecessarily often leads to multiple med exposures AND exposure to untreated symptoms
- It is lower risk to optimize/maximize the dose of one medication if possible before adding a second med

Depression and anxiety

<u>SSRIs</u>

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
- *Paroxetine (Paxil)*

<u>SNRIs</u>

- Venlafaxine (Effexor)
- Duloxetine (Cymbalta)
- Desvenlafaxine (Pristiq)

Pregnancy considerations for SSRIs/SNRIs

Generally, SSRI/SNRI safety data is comparable between meds. There is NO NEED to switch people to Zoloft if they are stable on a different SSRI

There is no dose-dependent increase in risk

- Neonatal discontinuation syndrome
- Persistent Pulmonary Hypertension (PPH)
- Paroxetine - small risk of cardiac defects with first trimester exposure
- SNRIs - hypertension and tachycardia

Bipolar Disorder

- Pregnancy is a very high-risk time
  - 85% risk of mood episode if meds are stopped during pregnancy
  - 33% risk even if maintained on meds
- Lamotrigine has good safety data but does NOT prevent mania and requires very close monitoring, frequent dose adjustment due to changes in glucuronidation in pregnancy
  - Not associated with NTD. No evidence for high folic acid supplementation
- Lithium is often the best choice
  - Risk of Ebstein's anomaly is 0.6/100 births with lithium and 0.18/100 births in the general population
  - Requires close monitoring and dose adjustments due to changes in TBW and GFR
- Avoid always:
  - Valproate
  - Oxcarbazepine

Psychotic Disorders

- Antipsychotics generally have good safety data, but double check some of the newer ones
- Placental passage varies between medications:
  - Highest olanzapine (72%)
  - Haloperidol (65%)
  - Risperidone (49%)
  - Quetiapine (24%)
- Pharmacokinetic considerations:
  - Metabolism is unpredictably affected by changes in hepatic metabolism
  - Monitor symptoms and may need to increase dose over course of pregnancy (> 26 weeks gestation)

Antipsychotic Classes

First Generation ("Typical")

- Chlorpromazine (Thorazine)
- Thioridazine (Mellaril)
- Trifluoperazine (brand name no longer available)
- Perphenazine (Trilafon)
- Haloperidol (Haldol)
- Fluphenazine (Prolixin)

Second Generation ("Atypical")

- Clozapine (Clozaril)
- Quetiapine (Seroquel)
- Olanzapine (Zyprexa)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)

  *partial D2 agonist – inhibits prolactin

Antipsychotic Pregnancy Considerations

- First generation: potential risk of neonatal EPS
- Second generation:
  - Increased risk of gestational diabetes
  - Increased risk of gestational hypertension
  - Excess weight gain/obesity
  - Small and large for GA infants
- Aripiprazole: dramatic impact on prolactin levels due to partial dopamine agonism
  - Almost always prevents exclusive breastfeeding

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Attention-Deficit Hyperactivity Disorder

Non-stimulants

- Atomoxetine (Strattera)
- Clonidine (Catapres or Kapvay)
- Guanfacine (Intuniv)

Stimulants

- Methylphenidate derivatives
  - Ritalin
  - Focalin
  - Concerta
- Amphetamine derivatives
  - Adderall
  - Dexadrine
  - (Vyvanse)

Pregnancy Considerations

- This is a risk vs risk conversation. ADHD can have very significant impact on ability to perform at work, at home, and can lead to safety and other consequences
- Non-stimulants have almost no safety data
- Methylphenidates have preferable safety data compared to amphetamine derivatives
- Monitor growth, placental blood flow, blood pressure
- Dopamine activity could decrease prolactin/milk supply and interfere with ability to nap during immediate postpartum phase. Often recommend holding during the first couple of weeks after delivery if they can function without it

Resources

MotherToBaby®

LactMed®

from National Library of Medicine

Learn how medications can impact nursing mothers and their babies.

Infant Risk

MGH CENTER *for* Women's Mental Health

Reproductive Psychiatry Resource & Information Center

Thank you

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