

INFORMATION FOR CLINICIANS ON ANTIDEPRESSANTS DURING PREGNANCY AND BREAST FEEDING - FEBRUARY 2009

This chart is produced by the University of Illinois at Chicago (UIC) Perinatal Mental Health Project as a summary of research on antidepressants in human pregnancy and breastfeeding.

Sources of data:

- Pregnancy data: Data presented here are based on controlled studies during human pregnancy. The Food and Drug Administration (FDA) Pregnancy Risk Categories, as found in the Physician's Desk Reference¹, are based on a combination of animal and human studies. FDA pregnancy risk categories have limitations. No medication is yet specifically FDA-approved for use during pregnancy. All psychotropic medications cross the placenta, so are never Category A ("no risk"). Medications that are non-teratogenic in animal studies but have never been studied in humans are classified as "Category B". Since teratogenicity does not generalize across species, it is misleading to think that "Category B" medications are "safer" for women than Category C or D medications. Several medications have been shifted from Category B to C or D as their risks become better studied and better understood.
- Breastfeeding data: Data about the side effects to breastfeeding babies is based on limited case reports and case studies. In cases where no side effects have been reported, that does not necessarily mean the medication does not cause side effects; often it means there are few case reports available. The estimated percents of maternal dose to breastfeeding babies are weight-adjusted estimates that include the agent and its active metabolite(s).

General guidelines:

- Treatment needs to be based on individual patient characteristics and clinical judgment.
- Risks of antidepressants during pregnancy and lactation must be weighed against the risks of untreated illness. Risks of untreated perinatal depression may include preterm birth and other obstetric complications, increased risk of infection and more difficult temperament in the infant, impaired parenting, and impaired cognitive development, emotional and behavioral problems and increased reactivity to stress in children.

All antidepressants may be associated with following risks:

- Gestational age decreased by an average of one week.
- Possible increased risk of miscarriage, but rates within norms of the general population.

All SSRI antidepressants (citalopram, escitalopram, fluoxetine, paroxetine, sertraline) may be associated with the following risks:

- Possible increased risk of persistent pulmonary hypertension in the newborn with exposure later in pregnancy.
- Risk of neonatal side effects such as respiratory distress, excessive crying, changes in sleep and behavioral state, difficulty sleeping, increased or decreased muscle tone, hyperreflexia, seizures or cardiac arrhythmias.
- Most studies have found no increased risk of birth defects from SSRI antidepressants as a group. One retrospective case control study² found a possible increased risk of anencephaly, craniosynostosis and omphalocele, and a retrospective prescription event monitoring study found an increased risk of anomalies in general: absolute risks were small³.
- For dosing strategies during pregnancy please refer to: [www.psych.uic.edu/research/perinatalmentalhealth/pdf/Miller et al Balancing Risks.pdf](http://www.psych.uic.edu/research/perinatalmentalhealth/pdf/Miller%20et%20al%20Balancing%20Risks.pdf)

For questions, references, or permission to reprint, call the UIC Perinatal Mental Health Project at 1-800-573-6121 or visit www.psych.uic.edu/research/perinatalmentalhealth/

1: Physician's Desk Reference, Thomson Reuters, Montvale, NJ. 2: Alwan S et al. Use of selective serotonin-reuptake inhibitors in pregnancy and the risk of birth defects. N Engl J Med. 2007 Jun 28;356(26):2684-92. 3: Wogelius et al. Maternal use of selective serotonin reuptake inhibitors and risk of congenital malformations. Epidemiology. 2006 Nov;17(6):701-4.