ANTIDEPRESSANTS IN PREGNANCY : NEONATAL WITHDRAWAL AND TOXICITY

1. OPTIMAL OUTCOMES
   • Neonatal withdrawal and toxicity is recognised and treated appropriately

2. PATIENT
   • Woman medicated with antidepressants in the third trimester of pregnancy
   • Neonate with medicated mother

3. STAFF
   • Obstetric and neonatal medical staff
   • Registered Midwives, Registered Nurses & Mothercraft nurses

4. EQUIPMENT

5. CLINICAL PRACTICE
   Antenatal Management
   • Question all women when booking into antenatal care if they are on any antidepressants or psychotropic medication
   • Discuss benefits for mother and baby of antidepressant use with (where possible) both parents.
   • Inform all women taking antidepressants in the third trimester of pregnancy about the risk of withdrawal/toxicity syndrome
   • Appropriate liaison with the woman’s prescribing physician (general practitioner, psychiatrist) regarding their antidepressant medication.
   • Refer to Mothersafe for more information where appropriate
   • Plan a multi-disciplinary perinatal management for mother and baby. This may include obstetrician, psychologist, neonatologist, midwife and social worker.

   Neonatal management
   • Observe all at risk babies in hospital for the first 3 days after birth. Complete the Neonatal Abstinence Score (NAS) Chart (Finnegan’s) 3-4 hourly.
     o Neonatal review of any baby scoring above 7 on the NAS.
     o Consider admission to Newborn Care Centre (NCC) for further observation if confirmed signs of withdrawal.
     o A NAS score of more than:
       ▪ 11 on one occasion
       ▪ 7 on three (3) consecutive occasions
       ▪ an average score of 8 on 3 occasions
       should be treated in accordance with the RHW withdrawal policy. This includes the use of phenobarbitone for withdrawal symptom
   • Admit to NCC if indicated, and perform formal blood glucose, calcium and magnesium levels.
     Investigations to exclude other conditions may be required.
   • Inform mothers going home on the Home Midwifery Service about need for prompt reporting of specific symptoms to their midwife.

6. HAZARDS/SUB-OPTIMAL OUTCOMES
   • Failure to recognise and treat neonatal withdrawal resulting in the deterioration of neonatal well-being.

7. DOCUMENTATION
   • Neonatal Abstinence Score Chart (NAS)

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8. EDUCATIONAL NOTES

- Women are able to breastfeed when on Selective Serotonin Re-uptake Inhibitors (SSRIs) except with a premature or ill baby. SSRI exposure through breastfeeding is very low (usually < 5% and often < 1%).
- Psychiatric causes of maternal mortality are greater than any other including cardiac cause, hence adequate treatment of depression in pregnancy is essential.
- SSRIs are the most common antidepressant prescribed in pregnancy.
- Late trimester exposure to antidepressants may be associated with withdrawal syndromes and subtle negative neonatal neurobehavioral outcomes at birth. The decision to continue antidepressants in pregnancy is thus a serious one and requires individual risk-benefit analysis.
- Neonatal SSRI withdrawal/toxicity symptoms include respiratory distress, temperature changes, feeding difficulty, jitteriness, irritability, fits, settling difficulties, floppiness, rigidity, hypoglycemia, jaundice and increased rate of admission NCC.
- Withdrawal symptoms may occur in up to 25% infants and are especially associated with Paroxetine (Aropax). Onset is usually within 4 days (& duration 2-3 days). Symptoms are usually mild.
- Serotonergic symptoms (myoclonus, restlessness, tremor, shivering, rigidity) are reported with Fluoxetine (Prozac), which abate over the next few days.
- Venlafaxine (Efexor) withdrawal symptoms: mostly neurological symptoms, in particular myoclonic jerks.
- Baby admitted to NCC for management is to have an established on-going management plan.
- There is recent concern that the use of SSRIs after the 20th week of pregnancy is associated with an increased risk of persistent pulmonary hypertension of the newborn (pphn), ref Chambers. Until further data is available, such SSRI-exposed infants should be offered a cardiology assessment if there is clinical suspicion of PPHN. This potential risk may be taken into account in the clinical decision of prescribing SSRIs in late pregnancy.

9. RELATED POLICIES/ PROCEDURES

10. REFERENCES