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Major Depressive Disorder during Pregnancy

English summary

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Québec

SUMMARY

Major Depressive Disorder during Pregnancy

Introduction

Approximately 10-15% of women experience an episode of major depressive disorder during pregnancy. The risks associated with untreated depression during pregnancy are significant, and can affect both mother and child, increasing the risk of post-partum depression, danger to the pregnant person or others, substance use by the mother, obstetrical complications, and difficulty in forming an attachment bond with the infant. Several effective treatment options are available, including antidepressants. However, the use of antidepressants during pregnancy can lead to certain neonatal complications, including Neonatal Adaptation Syndrome (NAS), a set of signs and symptoms that appear to be serotonergic, but are mild and transient in the majority of infants. More severe cases, in the presence of risk factors, may require admission to neonatal intensive care, and rare cases of convulsions have been reported in the literature.

Given the multiple issues involved in the treatment of major depressive disorder during pregnancy, INESSS has been mandated to formulate recommendations and develop clinical tools in order to:

- inform healthcare professionals (e.g. family physicians, obstetricians, midwives, psychiatrists, nurses, pharmacists) about the specifics of assessing major depressive disorder during pregnancy and the pharmacological and non-pharmacological treatment options for treating major depressive disorder during pregnancy, including considerations for breastfeeding and risks for the newborn;
- promote the optimal use of medications used in the treatment of major depressive disorders during pregnancy;
- optimize and promote harmonized practice across the province.

Methodology

The clinical recommendations developed in the present document are the result of a triangulation of data from the literature, the perspective of Quebec experts and clinicians, and contextual aspects specific to Quebec. A review of the scientific literature was conducted on the basis of publications identified in MEDLINE, Embase and EBM Reviews - Cochrane Database of Systematic Reviews, PsycInfo and CINAHL Complete databases, as well as in the grey literature. The scientific literature search strategy was developed in collaboration with a scientific information consultant (librarian). The literature search focused on titles published from the date the databases were created, but systematic reviews and clinical practice guidelines published before 2017 were excluded. Document selection, evaluation of methodological quality, and information extraction were conducted independently by two scientific professionals, while analysis of

contextual aspects was conducted by one professional, then validated by a second. Where relevant, and to facilitate synthesis of various studies, a combined effect measure was calculated. The analysis and assessment of the quality of evidence on the outcomes were conducted on the basis of all the scientific data available at the time the work was conducted, according to GRADE method criteria. An Advisory Committee made up of clinicians from various specialties and areas of expertise, as well as patient partners, was set up to gather the views of stakeholders. Finally, the overall quality of the work, its acceptability, and applicability were evaluated by external readers specializing in the field of interest, as well as future users who had not been involved in the work.

Results

At the end of the analysis of all the information gathered and the iterative process with members of the Advisory Committee, the following findings and key messages were recognized as having the potential to support the enhancement and harmonization of clinical practice and the experience of care and services for the treatment of depressive disorders characterized during pregnancy. These findings, and the resulting recommendations, have been used to develop the tools described below.

Discussion as the Basis for Identification and Decision-Making

Given the prevalence of major depressive disorders during pregnancy, and the magnitude of the possible consequences for the pregnancy and the child, it is important to identify the signs and symptoms, particularly in the presence of risk factors such as a history of mental health problems. This identification should also be part of a discussion with the person concerned about their overall mental health. Subsequently, when a major depressive disorder is recognized during pregnancy, whether mild, moderate, or severe, several treatment options may be considered: psychosocial, psychological, or pharmacological. The choice of treatment should be based on a discussion between the healthcare professional, the pregnant woman and her partner, and about the benefits and risks associated with each treatment option.

Non-Pharmacological Interventions Essential to the Treatment of Depressive Disorder

Given their efficacy in the general population, and low associated risks, it would seem important to offer a non-pharmacological psychosocial or psychological intervention to all pregnant women with major depressive disorder, regardless of the severity of their condition. However, the addition of pharmacological treatment to psychological treatment could provide additional benefits, particularly for those with severe condition. A decision-making algorithm has also been developed to support decision-making and clarify, among other things, the various non-pharmacological interventions that can be considered depending on the severity of the depression. In addition to encouraging healthy lifestyle to promote good physical and mental health, complementary stress reduction approaches can be added to pharmacological, psychosocial, and psychological treatments.

Use of Antidepressants During Pregnancy: Is it Safe?

When a pharmacological agent is the chosen option for the treatment of a major depressive disorder during pregnancy, the choice of antidepressant should be made on the basis of several factors, including the individual's previous response and the documented safety of antidepressants during pregnancy. The systematic review of primary studies published up to October 2023 shows that the use of selective serotonin reuptake inhibitors (SSRIs) during pregnancy would have no significant effect on several outcomes in mother and child, notably the risk of preeclampsia, post-partum hemorrhage, low birth weight, persistent pulmonary hypertension of the newborn (PPHN), autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), major depressive disorder in children, or problems with psychomotor development in children. However, a statistically significant increase in certain signs and symptoms of serotonergic appearance, including respiratory disorders, muscle tone disorders, and neonatal adaptation syndrome, has been observed with the use of SSRIs, serotonin, and norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants (TCAs). Although these signs are generally mild and transient, it should be noted that a statistically significant increase risk of 5-minute Apgar score of less than 7 and need for monitoring in neonatal intensive care unit, has also been observed with the use of SSRIs during pregnancy. However, no statistically significant difference in the risk of convulsions in the newborn was observed. Furthermore, although an increased risk of prematurity (defined as birth before 37 weeks' gestation) was observed with SSRI use, the risk of extreme prematurity (birth before 32 weeks' gestation) was comparable to that of the general population. Finally, although the risk of major congenital malformations and major cardiac malformations associated with SSRI use during pregnancy appears similar to the baseline risk, an increased risk of certain specific congenital malformations has been observed with the use of certain antidepressants. The baseline risk, the magnitude of this increase, and the level of certainty of the evidence are very low, however, and limit the conclusions that can be drawn.

Antidepressant Choice: Not Just a Safety Issue

The systematic review of safety data conducted as part of the present study provides guidelines for the use of SSRIs in the pharmacological treatment of major depressive disorder during pregnancy. Although all antidepressants are associated with certain risks, sertraline, citalopram and escitalopram should be preferred if the patient has no history of mental health problems. However, the use of other antidepressants may be considered if active treatment is being continued, or if there has been a previous response to treatment of depressive disorder, after discussion with the patient of the risks and benefits of each treatment option. To limit the risks associated with the use of antidepressants during pregnancy, it is important to remember certain key principles: 1) use of a single molecule, if possible, and the minimum effective dose of pharmacological agents; 2) in the case of polypharmacy, re-evaluation throughout pregnancy of the indication, efficacy, and dosage of each drug, to optimize their efficacy while limiting their adverse effects.

Recommendations and Clinical Tools

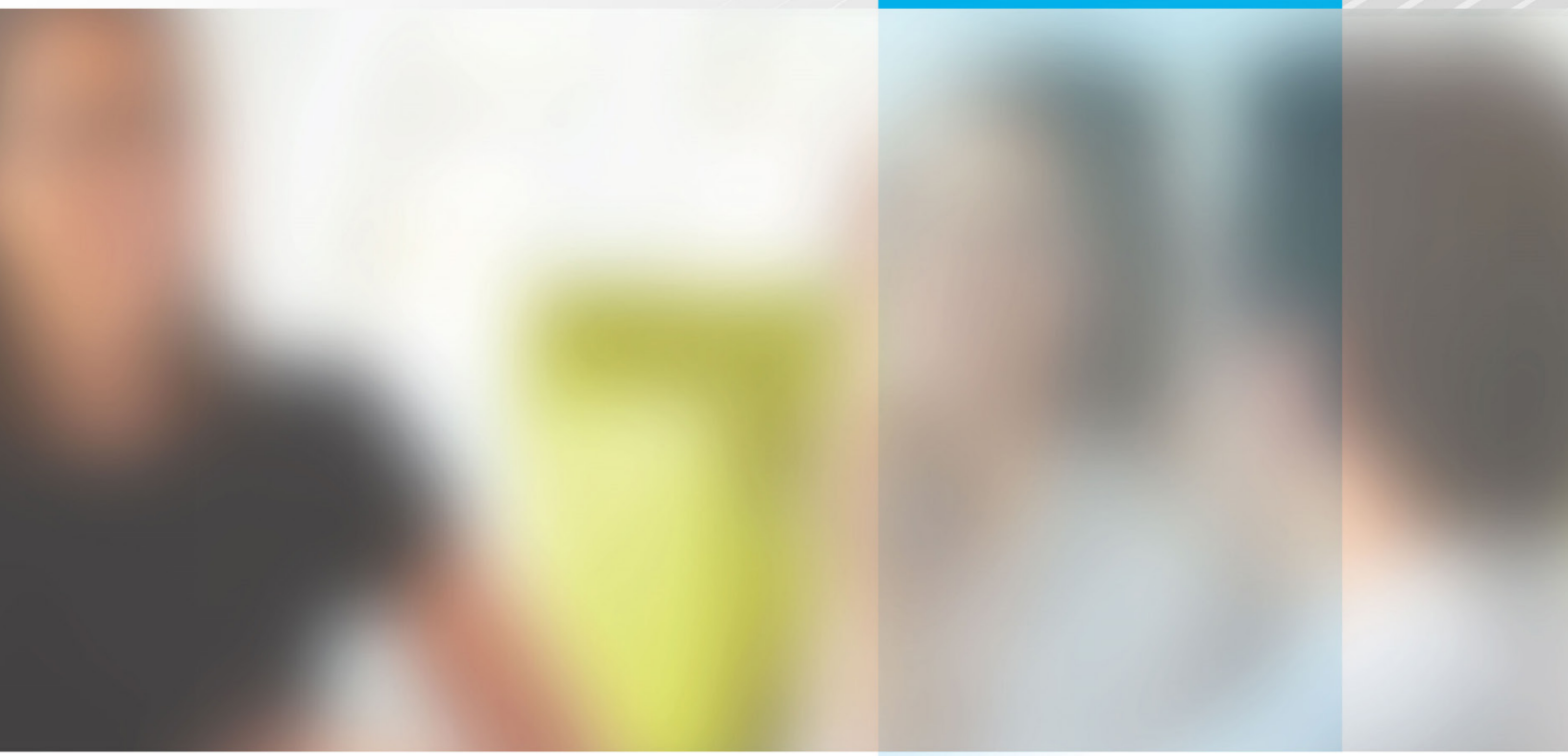
Following an iterative process with members of the Advisory Committee, during which scientific data, information, and recommendations drawn from the literature consulted, contextual aspects, and the perspective of various stakeholders consulted were triangulated, a series of recommendations were formulated. These recommendations, which are the focus of the report, are also summarized in a decision-support tool aimed primarily at front-line clinicians. In addition, a tool has been developed for women who are pregnant or planning to become pregnant. It provides information deemed necessary to support informed decision-making, given the fears that may arise from taking a drug during pregnancy.

Conclusion

Although the present document is not a substitute for clinical judgment, it should support healthcare professionals in making optimal use of pharmacological and non-pharmacological interventions for the treatment of major depressive disorder during pregnancy and, ultimately, improve the care experience of mother and child. Application of the recommendations presented will depend on distribution of the clinical tool, adherence to these recommendations, and their appropriation by the healthcare professionals involved. Moreover, as psychosocial and psychotherapeutic interventions should be offered from the outset when treating a major depressive disorder during pregnancy, ease of access to these services could also influence the application of the recommendations.

Update

The relevance of updating the recommendations will be evaluated in four years' time from the date of publication, depending on the advancement of scientific data and the evolution of clinical practices, the listing of new drugs, or significant changes in the criteria for reimbursement by the public drug insurance plan. The appropriateness of a more rapid update of the recommendations will, however, be evaluated when the updated CANMAT (Canadian Network for Mood and Anxiety Treatments) guidelines on major depressive disorder in pregnancy are published, currently scheduled for publication by the end of 2024.



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