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ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Treating Depression in Breastfeeding Patients

ANTIDEPRESSANT CHOICE IN THE NURSING POSTPARTUM PATIENT

When treating the depressed postpartum woman who is nursing, we have 2 patients, the depressed woman and her infant. How we can choose the safest medication for both patients? Welcome to the Clinicians Roundtable.

Am Dr. Leslie Lundt host and with me today is Dr. Samantha Meltzer Brody, Assistant Professor in the Department of Psychiatry at the University of North Carolina at Chapel Hill. Dr. Meltzer Brody is the co-director of the Perinatal Psychiatry Program at the UMC Center for Women's Mood Disorders. A comprehensive Women's Mental Health Program providing clinical care and research for psychiatric disorders across the female reproductive life cycle including depression during pregnancy and postpartum premenstrual dysphoric disorder and peri menopausal mood symptoms.

DR. LESLIE LUNDT:

Welcome to ReachMD Dr. Meltzer Brody.

DR. MELTZER BRODY:

Thanks for having me Leslie.

DR. LESLIE LUNDT:

I find personally treating the nursing woman with postpartum depression one of the most challenging scenarios that we see in our practice. What kind of things should we be thinking about?

DR. MELTZER BRODY:

Well, you are right, it is challenging and for number of reasons. I think one of the first thing is that people can do it effectively and to give people hope that it can be done, but I really try hard to make sure the mother does not feel compelled to nurse and carry on in doing something if its detrimental to her mental health and so that it does not become a, "I will be a good mother if I do this and I will fail as a mother if I don't." There are enormous societal pressures to nurse and I think it is wonderful when it works out well, but if someone is suffering with severe depressive symptoms and it is really impairing their functioning, I really feel strongly that I have to evaluate on whether continuing to breast feed is in their best interest and that is on a case-by-case basis. One of the difficulties with nursing and especially if people are trying to do an exclusive type of nursing is that they are usually pretty intense sleep deprivation associated with it and not all women handle that well. Many women with mood disorders if they have previous history and certainly women with postpartum depression, sleep and not sleeping well can be an enormous problem. So, I just think that something that we always try and look at, but that being said for women who feel that nursing is something they want to continue to pursue. People can nurse and be treated for postpartum depression, can take psychotropic safely.

DR. LESLIE LUNDT:

If antidepressants are indicated, how can we be sure that the baby is going to be okay?

DR. MELTZER BRODY:

Well that is, you know, obviously the most important concern for most mothers who are not concerned necessarily how they are doing, but are very concerned how their baby is doing. We select the serotonin reuptake inhibitors, the SSRIs, in general seemed to be quite safe in lactation, in particular sertraline, which is the generic for Zoloft seems to have the least amount of transmission in to breast milk. A lot of this data is based on mother-infant diet. It's not an enormous literature so you are looking at relatively small numbers, but there are some fairly decent studies that look at the serum levels and than the breast milk levels in both the mother, the baby, and after the baby has consumed measuring things and sertraline seems to have the lowest amount of transmission, most of the study show that the dose is 100 mg or less. There is almost 0 transmission of sertraline.

DR. LESLIE LUNDT:

Now I have seen that, but I have also seen people do what seems to me is kind of crazy thing and that is a woman may be on antidepressant X during pregnancy and then decides to switch them to sertraline if they are nursing, so now the baby has been exposed to potentially 2 different medicines.

DR. MELTZER BRODY:

Right, and that is also strange thing that happened during pregnancy and to lactation. If I am seeing someone during pregnancy, I will preferentially start sertraline, partly I think it is effective, but so are the other SSRIs, but partly because I know it will work well in lactation. The one SSRI that I try not to use at all during pregnancy is paroxetine, which is Paxil. There are some conflicting reports, but there are

some published studies that show that it may increase the risk of cardiac anomalies with first trimester exposure. Interestingly, paroxetine seems to be fine during breast-feeding, but again it is easier just not to start it and then have to change if that's something that you can do. Fluoxetine, Prozac, which has been around the longest and has a fairly decent safety profile during pregnancy, there are concerns because of its long half life it sticks around longer and you can have higher levels in breast milk, so that is not something that I necessarily would pick as my first choice that being said people successfully breast feed on fluoxetine. The same thing for citalopram there are some reports of higher levels concentrating in breast milk, but again people successfully breast feed with it and with Lexapro, citalopram's cousin there is just less data.

DR. LESLIE LUNDT:

What are the most common adverse events that you do see in babies whose mother's are taking antidepressants?

DR. MELTZER BRODY:

The most common things you want to look for are sedation or opposite of that activation or increased irritability. Also, pediatricians will watch for GI side effects, so some of these things you should see in adults that is not interfering with their feeding, with their bowel movements, with their sleep, and sometimes people like to do a trial where they started and then stop it. You can actually measure concentration, see how much people are getting lot of that, required sending to an outside lab, but in general most women that I work with are able to breast feed successfully while taking an antidepressant, certainly at high doses and in people who are requiring multiple psychotropics, and I advise not to breast feed, but for some women that really want to do so at least in some capacity we can get in to all sorts of interesting things where we will have them what I called pump and dump. The breast milk at its specific time based on the half-life and the highest level of the medication that concentrate in the breast milk.

DR. LESLIE LUNDT:

So, what is pump and dump?

DR. MELTZER BRODY:

So, pump and dump would be for example with sertraline. Lets say you are taking 150 mg a day and you have been advised that at doses 100 and less there is almost 0 concentration in the breast milk, then for sertraline where we have reasonable data we know that the peak concentration in the breast milk is approximately 8 hours after you take the medication. So, women can pump 8 hours later and discard that breast milk, which is always feels very bad like you are throwing away liquid gold.

DR. LESLIE LUNDT:

Yeah, really worked hard to get that.

DR. MELTZER BRODY:

But then make a note that after that the baby is probably getting almost no sertraline in their breast milk or not at quantities that would have any effect. So, we can try and tailor that for certain medications as best we can. That again requires a very motivated mom and certainly there is enough going on I think in the first few months postpartum that most people do not necessarily want to add that to their list of things to do.

DR. LESLIE LUNDT:

Right, sounds like one of those things that make sense in the book, but in real life that would be a nightmare potentially.

DR. MELTZER BRODY:

It would be, but there are people that really just get in to habit of doing it that are concerned about and will say okay I take it at 8 am everyday, 8 hours later I pump, I discard that and then I free to nurse the rest of the time. And so I think for some people that provides peace of mind.

DR. LESLIE LUNDT:

If you are new to our channel you are listening to the Clinicians Roundtable on ReachMD XM157, The Channel For Medical Professionals. I am Dr. Leslie Lundt your host and with me today is today is Dr. Samantha Meltzer Brody. We are discussing antidepressant choice in the nursing postpartum patient.

Dr. Meltzer Brody I have question about the likely side effects in the babies with sleep or GI problems, now how would you know in a new born if they were having sleep or GI problems related to the mother's medication that seems like an impossible thing.

DR. MELTZER BRODY:

Well it is tricky and again I think that you are looking for certainly in the brand new newborn you would have great difficulty noting that. In general, you are looking for excessive irritability or excessive feeding difficulties or excessive GI upset. Again it is tricky, but for lot of people they will figure out overtime and sometimes they will hold the medication for period of time and see if things clear up or not. In general, I found especially with sertraline I have not seen that to be a big problem.

DR. LESLIE LUNDT:

One of the other major concerns that my patients have who are taking antidepressants postpartum is what to we know about the effects on these medicines on the baby's developing brain?

DR. MELTZER BRODY:

Right, so all the neural behavioral questions that are out there. You know the short answer is unfortunately they are not great longitudinal studies where we say okay these women took antidepressants during pregnancy or the baby was only exposed during lactation and we have now followed the children out 20 years that we can say 1 way or another what happened. Those studies don't exist. There are studies that have shorter followup and in general the SSRIs do not seem to cause serious neural behavior or neurodevelopmental issues. There are some concerns with fluoxetine that again may have a higher concentration in breast milk because of the long half-life, but those studies are small. I think most of the time, you could safely feel that you are not doing damage and again this all has to be weighed against the concerns of the baby's development with mother who had untreated depression.

DR. LESLIE LUNDT:

Right, and what do we know about that?

DR. MELTZER BRODY:

We know that mothers with postpartum depression have a really hard time and there is data that shows that in general their children don't do as well. That the mothers are less inclined to engage in safety practice. They have less compliance with pediatric appointments. They are less stimulated. They can have increased risk of developmental delays and other things. So, it is risky to have a mom with untreated postpartum depression too.

DR. LESLIE LUNDT:

I think so often we think about the medications in postpartum nursing patient, but what about psychotherapy. What role is there?

DR. MELTZER BRODY:

I think psychotherapy is enormously helpful and we try and have most of our women doing both. I think that if it is more mild moderate symptoms and they are at a point where they can engage in psychotherapy and the sleep appetite issues or the level of anxiety is not so overwhelming that they feel they can participate well then that can be a very good thing to do. For some of our patients who are really having enormous difficulty, the anxiety level is very high and again for lot of women with perinatal psychiatric symptoms, anxiety is an enormous component. In fact if you ask if they are depressed, they will often say no, but what they do report is overwhelming anxiety and often times we will see ruminating almost obsessive compulsive looking symptoms. And for those patients who aren't sleeping, really aren't functioning, they are not able to effectively participate in psychotherapy because they are really just suffering tremendously and I find in that group starting an antidepressant and then getting them feeling better and also adding psychotherapy can be very helpful.

DR. LESLIE LUNDT:

Makes good sense. Any final words about treating these women?

DR. MELTZER BRODY:

I just think that there are very effective treatments for postpartum depression. There is often time the reluctance of women to report this to either their pediatrician or their OB, people are terrified that they will be seen as a bad mother and I think it is important for providers to really normalize things and any one seeing postpartum women routinely to say you know one in out of 10 women will have postpartum depression. Are you having these symptoms if you are we can treat it. There is good help available. You do not have to suffer with this and to make people feel comfortable, so they will come forward and

not have to suffer in silence and you know again it is something that then helps mom, helps baby, helps family.

DR. LESLIE LUNDT:

Thank you so much for being on the show today.

DR. MELTZER BRODY:

Thank you for having me, it has been a privilege, I appreciate it.

DR. LESLIE LUNDT:

We have been speaking with Dr. Samantha Meltzer Brody about treating the nursing postpartum depressed patients. I am Leslie Lundt you have been listening to the Clinicians Roundtable on ReachMD XM157, The Channel For Medical Professionals. To listen to our on-demand library, visit us at reachmd.com. If you register with the promo code radio, you will receive 6 months of free streaming to your home or your office. If you have comments, or suggestions, or questions, give us a call at (888 MD-XM157). Thank you for listening.

This is Dr. Matthew Johnson from John Hopkins School Of Medicine in Baltimore, Maryland, and you are listening to ReachMD XM157, The Channel For Medical Professionals.