ضد افسردگی ها، تثبیت کننده های خلق و آنتی سایکوتیک ها در بارداری

دکتر محمدرضا شالبافان- دانشیار روانپزشکی دانشگاه علوم پزشکی ایران

SSRIs

- Rates of relapse of major depression during pregnancy among women who discontinue, attempt to discontinue, or modify their antidepressant regimens are very high.
- Rates range from 68 to 100 percent of patients.
- Thus, many women need to continue taking their medication during pregnancy and postpartum.
- There is no significantly increased risk for major congenital malformations after exposure to SSRIs during pregnancy (with the exception of paroxetine).
- Thus, the risk of relapse into depression when a newly pregnant mother is taken off SSRIs is several fold higher than the risk to the fetus of exposure to SSRIs.

SSRIs

- There is some evidence suggesting increased rates of special care nursery admissions after delivery for children of mothers taking SSRIs.
- There is also a potential for a discontinuation syndrome with paroxetine.
- However, there is an absence of clinically significant neonatal complications associated with SSRI use.
- Studies that have followed children into their early school years have failed to find any perinatal complications, congenital fetal anomalies, decreases in global intelligence quotient (IQ), language delays, or specific behavioral problems attributable to the use of fluoxetine during pregnancy.

SSRIs

- Some clinicians start administering SSRIs if the postpartum blues extend beyond a few weeks or if a woman becomes depressed during pregnancy.
- The head start afforded by starting SSRI administration during pregnancy if a woman is at risk for postpartum depression also protects the newborn, toward whom the woman may have harmful thoughts after parturition.
- Babies whose mothers are taking an SSRI in the latter part of pregnancy may be at a slight risk of developing pulmonary hypertension.
- Data about the risk of this side effect are inconclusive, but it is estimated to involve 1 to 2 babies for 1,000 births.

SSRIs

- Paroxetine should be avoided during pregnancy.
- The FDA classified paroxetine as a pregnancy Category D medication in the former FDA classification system.
- In 2005, the FDA issued an alert that paroxetine increases the risk of congenital disabilities, particularly heart defects, when women take it during the first 3 months of pregnancy.
- The FDA alert was based on the findings of studies that showed that women who took paroxetine during the first 3 months of pregnancy were about one-and-a-half to two times as likely to have a baby with a heart defect as women who received other antidepressants or women in the general population.
- Most of the heart defects in these studies were not lifethreatening and happened mainly in the inside walls of the heart muscle, where repairs can be made if needed (atrial and ventricular septal defects).

SSRIS

- Except for paroxetine, the SSRIs are safe to take during pregnancy when deemed necessary for the treatment of the mother.
- There are no controlled human data regarding vilazodone use during
- pregnancy, nor are there human data regarding drug concentrations in breast
- milk. Transient QTc prolongation has been noted in newborns whose mother
- was being treated with an SSRI during pregnancy.

SNRIS

- No conclusive data but usualy those are not first line.

BUPROPION

- Group C currently but previously group B

TCA

- Although TCAs have been prescribed for several decades, their own teratogenic potential to cause structural defects remains undetermined.
- However, some signals seem to exist suggesting that prenatal clomipramine exposure may increase the risk of cardiac defects.
- Moreover, TCAs have been associated with the risk of prenatal antidepressant exposure syndrome.
- Among TCAs, clomipramine seems to be associated with more severe and prolonged neonatal symptoms.
- Among this class of antidepressants, nortriptyline seems to be safest medication for use during breastfeeding.

- Mirtazapine: C
- Nefazodone: C
- Trazodone: A prospective study did not find an association between trazodone and congenital malformations.

MOOD STABILIZERS

- At the present time, the sequence of relatively greatest to least risk for major adverse events during a pregnancy occurring on a mood stabilizer appears to be (1) valproate, (2) carbamazepine, (3) lithium, and (4) lamotrigine.

NA-VALPROATE (X)

- It is very much in the interest of a woman of childbearing age to not conceive during treatment with valproate, based on two different, very substantial risks.
- The first is that of neural tube defects and, in particular, spina bifida, which is reported to occur in about 2 percent of live births on valproate.
- Higher doses and combinations with other antiepileptic drugs may increase this risk further.
- At the same time, there is a very substantial increased risk for developmental delay in infants exposed to valproate during gestation.
- In some instances, this can be extreme, with a reduction in IQ to borderline deficient or below.
- Preconceptual education and folatevitamin B complex supplementation for all young women of childbearing potential
- may also increase the risk of autistic spectrum disorder.

Carbamazepine (D)

- approximately a 0.5 percent risk of spina bifida and also has a risk of other minor malformations and mild developmental delay, which appears readily compensated for in the early neonatal years.
- Overall, the risk of serious adverse events on this agent is estimated at 8 percent, approximately similar to the 10 percent estimate on phenytoin (Dilantin) and lower than the 22 percent on valproate.

LITHIUM (D)

- an increased risk of cardiac malformations, with the most prominent being that of Epstein's malformation or transposition of the great vessels.
- However, this is estimated to occur in only 1 in 1,200 live births and thus, while being about twentyfold higher than the risk in the general population, is still a very rare event.
- This has led some to advise careful fetal monitoring with ultrasonography and continued treatment with lithium in those women who appear at moderate to high risk of relapse should they discontinue this treatment during pregnancy.
- Very few neurobehavioral follow-up studies of children exposed in utero to lithium have been performed, but one 5-year follow-up study of 60 children showed no neurobehavioral sequelae of in utero lithium exposure.

LAMOTRIGINE (C)

- HAS THE LOWEST RISK AMONG THE MOOD STABILIZERS, WITH A 2 PERCENT INCIDENCE OF SERIOUS ADVERSE EVENTS, WHICH ABOUT EQUALS THAT OF THE COMPARISON GROUPS INVOLVED AND THE GENERAL POPULATION.
- THE ONE POTENTIAL EXCEPTION TO THIS RELATIVELY CLEAN PROFILE IS THE OCCURRENCE OF A SLIGHTLY INCREASED RISK OF CLEFT LIP AND CLEFT PALATE IN ONE OF THE FIVE EXISTING CASE REGISTRIES EXAMINING POTENTIAL BIRTH COMPLICATIONS FROM EXPOSURE TO LAMOTRIGINE.
- THIS RISK WAS NOT APPARENT IN THE FOUR OTHER CASE REGISTRIES, AND IN FURTHER FOLLOW UP DATA, SUGGESTING THAT IT REPRESENTS A STATISTICAL ARTIFACT.
- HOWEVER, SINCE THIS CONDITION IS CORRECTABLE BY SURGERY AND THE DATA WERE AMBIGUOUS ABOUT THE INCREASED RISK ON LAMOTRIGINE, IT WOULD APPEAR THAT THIS INITIAL PERSPECTIVE WOULD PUT WOMEN AT SOME EASE IN DECIDING TO CONTINUE TREATMENT WITH THIS AGENT COMPARED TO MANY OTHERS DURING PREGNANCY AND WHEN INDICATED BY THE ESTIMATED RELATIVE RISK FOR DEPRESSIVE RELAPSE IN THAT INDIVIDUAL.

ANTIPSYCHOTICS

FGAS

- There is a low correlation between the use of antipsychotics during pregnancy and congenital malformations.
- Nevertheless, antipsychotics should be avoided during pregnancy, particularly in the first trimester, unless the benefit outweighs the risk.
- High-potency drugs are preferable to low-potency drugs because low-potency drugs are associated with hypotension.

FGAS

Typical Antipsychotics		
Haloperidol	C	L2
Chlorpromazine, Fluphenazine	C	L3
Thiothixene, Pimozide, Loxapine, Thioridazine	C	L4
Perphenazine, Trifluoperazine	C	N/A

SGAS

Atypical Antipsychotics		
Olanzapine	C	L2
Aripiprazole, Risperidone	C	L3
Clozapine	B	L3
Quetiapine	C	L4
Ziprasidone	C	L4

- Shalbafan.mr@iums.ac.ir