

Effects of continuation vs. discontinuation of antidepressants on postpartum depression in pregnant patients with pre-existing depression

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BACKGROUND

Up to 11% of pregnant patients have depression in their first trimester, and 8.5% in their second and third trimesters¹. Antenatal major depression has been shown to increase rates of maternal suicidal ideation, is a major risk factor for postpartum depression, and is also associated with impaired fetal growth and prematurity^{2,3}. The aim of this study is to examine the effect of continuation of antidepressants during pregnancy on risk of postpartum depression.

METHODS

- Retrospective cohort study
- Cohort: 9,831 pregnant Kaiser Permanente Northern California (KPNC) members who had alive-born delivery, received prenatal and postnatal care within KPNC, had a prescription for antidepressants in the 6 months prior to pregnancy, and had an adequate antidepressant dose in pregnancy.
- Exclusions: Patients < 18 years of age, with another mental health diagnosis, or without a documented PHQ9
- Discontinuation: no new antidepressant fill between 4 weeks after the last menstrual period and delivery
- Reinitiation: continued antidepressants after a ≥ 60 day gap.
- Continuation: no gap > 60 days between fill dates.
- Postpartum depression (PPD) was defined as a PHQ9 score ≥ 10 , or a PPD diagnosis within one year after delivery.
- Poisson regression models adjusting for confounders were conducted.

Proportion with PPD, by pregnancy antidepressant use

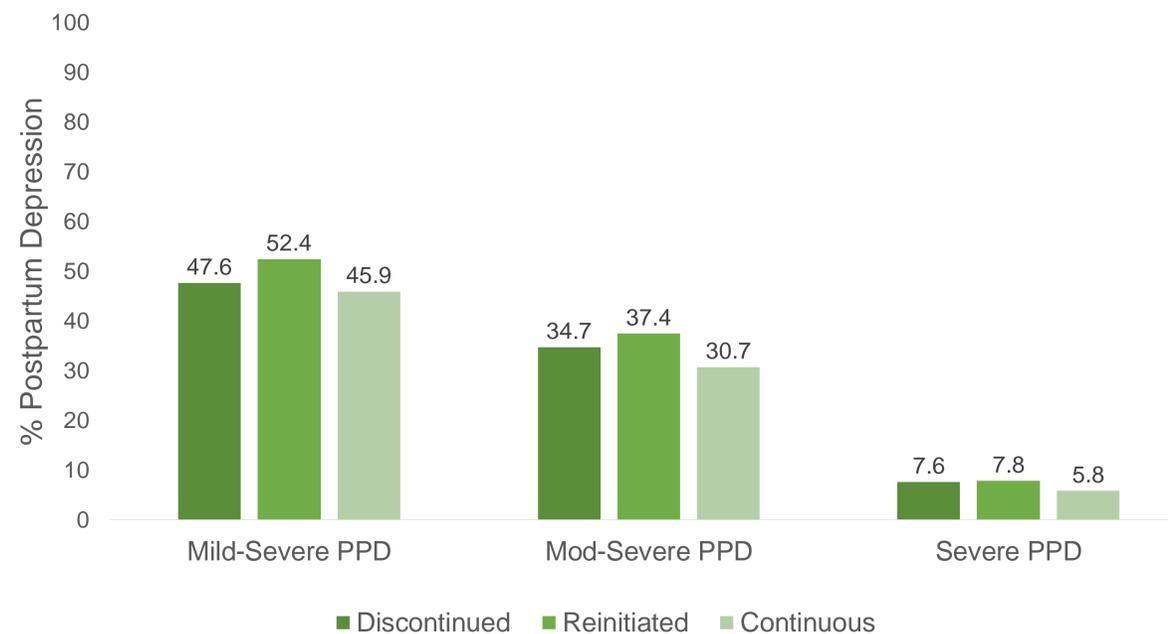


Figure 1: Prevalence by percentile of postpartum depression in all pregnancies in the discontinued, reinitiated, and continuous fill groups.

	Mild-Severe PPD*	Mod-Severe PPD**	Severe PPD***
Pregnancy antidepressant use			
Discontinued	1.06 (1.01-1.11)	1.14 (1.07-1.22)	1.32 (1.11-1.57)
Reinitiated	1.10 (1.04-1.16)	1.15 (1.06-1.24)	1.18 (0.96-1.45)
Continuous	Reference	Reference	Reference

Table 1. Relative risk ratios for postpartum depression in delayed start and discontinuation group, compared to continuous use group, adjusted for age, race, BMI, income, Medicaid coverage, neighborhood median income, parity, multiple birth pregnancy, number of prenatal visits, delay to first prenatal visit, highest pre-pregnancy antidepressant dose, first pregnancy PHQ, pre-pregnancy depression diagnosis, and history of postpartum depression. Statistically significant results bolded.

* PHQ ≥ 5 or PPD diagnosis
 ** PHQ ≥ 10 or PPD diagnosis
 *** PHQ ≥ 20 or PPD diagnosis

RESULTS

Of the women who received an adequate antidepressant dose, 48.4% (n=4763) discontinued antidepressants, 32.9% (n=3246) had continuous antidepressant use, and 18.7% (n=1822) reinitiated. A total of 33.9% (n=3330) of women had a diagnosis of PPD within 1 year postpartum. Compared to the continuous antidepressant group, the discontinuation group had 6% increase in the risk of mild PPD (adjusted Relative Risk (aRR): 1.06, 95% CI 1.01-1.11). The relative risk of severe PPD (PHQ9 ≥ 20 within 1 year after delivery) was higher, with an aRR of 1.32 (95% CI 1.11-1.57).

DISCUSSION

Our results show that discontinuation of antidepressant therapy in this population has a significantly increased risk for moderate to severe postpartum depression compared to continuation of therapy. This may be very helpful to clinicians as they discuss medications to continue/discontinue with patients during pregnancy and will provide an evidence base on which decisions can be made⁴.



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