Mood Disorders in Women during the Reproductive Years – participants

Objectives:

- 1 – to improve the participants' awareness of the impact of, manifestations of, diagnostic criteria and treatment options for mood disorders in reproductive-age women
- 2 – to review factors which increase suicidal risk
- 3 – to highlight specific mood disorders associated with or affected by hormonal fluctuation during the menstrual cycle, pregnancy, postpartum and perimenopause
- 4 – to define PMS, recognize its impact on health and society, review the etiology and pathophysiology, highlight clinical assessment tools and explore treatment options
- 5 – to apply learning pearls through case

Role of Neurotransmitters:

- Serotonin – involved primarily with mood, sleep, neg. cognition, anxiety, obsessions
- Norepinephrine – involved with mood, sleep, cognition, energy, attention
- Dopamine – involved primarily with motivation and drive, appetite
- All neurotransmitters are involved with anhedonia; their effects often interact
- ***Stahl's Essential Psychopharmacology 2009

Screening/Monitoring of Depression:

- HAMD-7
- PHQ 9
- MDQ
- Edinburgh Postnatal Depression Scale – a 10 item self-rating scale; score >12 indicative of MDD; used cross-culturally, multilingual, easy, convenient, sensitivity 86-100%; specificity 78-90%

Suicide Screening – Questions to Ask:

- ***Have you ever thought that life is not worth living?***
- ***Do you ever wish you could just go to sleep and never wake up?***
- ***Is death something you have thought about recently?***
- ***Are things so bad that you've thought about harming yourself?***

PMS/PMDD:

- ***75% of women experience some mild symptoms of PMS; 20-40% have PMS; only 3-9% are severely affected***
- ***There are more than 200 symptoms that have been associated with PMS of which the most common is abdominal bloating***

PMS involves psychological symptoms such as depressed mood/loss of pleasure in life, anxiety, mood swings and irritability as well as physical symptoms such as fatigue, appetite changes, sleep disturbances, breast tenderness, bloating, headaches, joint/muscle pain, weight gain

PMS/PMDD Diagnosis
"DIAL SOAP" – total 5 symptoms

- ***DIAL***
- ****Need ¼ following psychological Sx:***
- ***Depression***
- ***Irritability***
- ***Anxiety***
- ***Lability of Mood***

- ****Then need 4 more Sx including the column above***
- ***SOAP***
- ***Sleep disturbances***
- ***Oedema***
- ***Appetite changes/cravings***
- ***Physical Sx (other) – headaches, mastalgia, bloating, bowel Sx, chills/sweats, nausea***
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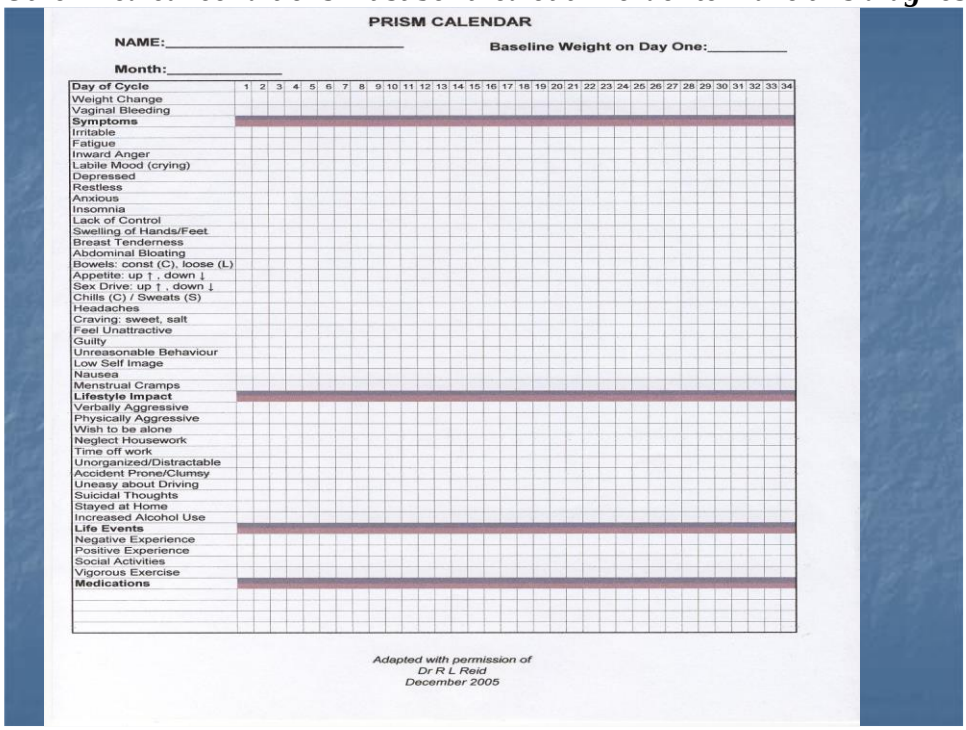
- ***These symptoms must occur during the luteal phase of the menstrual cycle (between ovulation and the onset of the period), in other words, they must be cyclic in nature***
- ***PMS can be diagnosed using a self-administered rating scale like a PRISM calendar to chart symptoms at various times of the month***
- ***Other medical conditions must be ruled out in order to make this diagnosis.***


PRISM CALENDAR

NAME:_____ Baseline Weight on Day One:_____

Month:_____

Day of Cycle	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34
Weight Change																																		
Vaginal Bleeding																																		
Symptoms																																		
Irritable																																		
Fatigue																																		
Inward Anger																																		
Labile Mood (crying)																																		
Depressed																																		
Restless																																		
Anxious																																		
Insomnia																																		
Lack of Control																																		
Swelling of Hands/Feet																																		
Breast Tenderness																																		
Abdominal Bloating																																		
Bowels: const (C), loose (L)																																		
Appetite: up ↑ , down ↓																																		
Sex Drive: up ↑ , down ↓																																		
Chills (C) / Sweats (S)																																		
Headaches																																		
Craving: sweet, salt																																		
Feel Unattractive																																		
Guilty																																		
Unreasonable Behaviour																																		
Low Self Image																																		
Nausea																																		
Menstrual Cramps																																		
Lifestyle Impact																																		
Verbally Aggressive																																		
Physically Aggressive																																		
Wish to be alone																																		
Neglect Housework																																		
Time off work																																		
Unorganized/Distractable																																		
Accident Prone/Clumsy																																		
Uneasy about Driving																																		
Suicidal Thoughts																																		
Stayed at Home																																		
Increased Alcohol Use																																		
Life Events																																		
Negative Experience																																		
Positive Experience																																		
Social Activities																																		
Vigorous Exercise																																		
Medications																																		

Adapted with permission of
Dr R L Reid
December 2005

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PRISM Calendar Instructions

Fill in each day. Please mark all forms with the day, month, and year

1. **Day of Cycle**: Day 1 is the first day of bleeding. Mark this by filling in the amount of bleeding in the box according to the legend below

   Heavy flow – Fill in the box ■
   Normal flow –Mark an X ☒
   Scant flow – Mark a diagonal ▨
   Spotting – Mark a dot ●

2. **Weight Change:** Each morning weigh yourself after emptying your bladder and before breakfast and chart.

3. **Symptoms:** From "irritable" to "menstrual cramps" Mark 1, 2, or 3 according to the severity. Leave the box blank if you have no symptoms.

   1=Mild: Noticeable but not troublesome – realizing after the fact that you felt this at sometime during the day

   2=Moderate: Interferes with normal activity – aware of these symptoms throughout the day

   3=Severe: Temporarily incapacitating – causing a major disruption in your life

4. **Lifestyle Impact:** If you experience any of these from "aggressive towards others" to "increased use of alcohol", mark the box with an "X"

5. **Life Events:** If you experience any of these events, mark the box with an "X".

   For positive (happy), or negative (sad or disappointing) experiences unrelated to your symptoms, specify the nature of the events on the back of the calendar.

   Social activities: Imply events such as a special dinner, show or party.

   Vigorous exercise: Implies participation in a sporting event or exercise program lasting more than 30 minutes.

6. **Medications:** List medications, if any, in the bottom three rows and indicate the days they were taken with an "X".

Adapted from Dr R L Reid with permission
December 2005

Depression in Pregnancy and Postpartum:

- ***14-23% of women experience MDD in pregnancy; highest risk 28-32 wks.***
- ***Risk factors for depression in pregnancy include a history of depression; positive FH of mood disorder; childhood trauma or abuse; single motherhood; smoking; low income; age <20; domestic violence; inadequate social support; NEJM Oct. 2011***
- ***Screening tool Edinburgh Postnatal Depression Scale – also validated for use in pregnancy***
- ***Perinatal period generally defined from onset of pregnancy until about 1 year postpartum***
- ***Management should begin pre-conception with counseling for women with a personal history of mental health problems***
- ***Untreated depression in pregnancy has been associated with a number of adverse outcomes including an increased risk of miscarriage, low birth weight and preterm birth (Grote et al. Arch Gen Psych 2010); mother may get less prenatal care and be at higher risk for suicide***
- ***Babies of untreated depressed mothers found to have increased irritability; higher cortisol levels; fewer facial expressions; risk of developmental delay (Field et al. Infant Behav Dev 2006)***
- ***Potential impact of untreated mood disorders on mother, infant and family***

- ***Postpartum: poor attachment/parenting, delayed infant motor, language and cognitive development, child behaviour problems, suicide/infanticide***

Fava et al published 1 year study in Am J Psychiatry Sept. 2008 which basically concluded that treating maternal depression until remission achieved decreased psychiatric symptoms and improved function in the offspring

Perimenopause and Depression:

- ***Cross-sectional studies have found depressive symptoms in up to 70% of women during perimenopause compared with 30% of premenopausal women***
- ***Longitudinal studies have confirmed an increased risk for depressive Sx and MDD during perimenopause and early postmenopause***
- ****Bromberger Psychol Med 2015;45:1653-1664***
- ****Freeman Arch Gen Psychiatry 2006;63:375-382***
- ***Evidence to support association mixed***
- ***Recent sparse studies supportive of association***
- ***Cause of depression likely multifactorial***
- ***Psychological, genetic and physiologic influences***
- ***Perimenopausal women should be screened for depressive symptoms***
- ***SSRIs/SNRIs are considered first line treatment but hormonal therapy could be considered particularly if VMS an issue***
- ***Cross-sectional studies have found depressive symptoms in up to 70% of women during perimenopause compared with 30% of premenopausal women***
- ***Longitudinal studies have confirmed an increased risk for depressive Sx and MDD during perimenopause and early postmenopause***
- ****Bromberger Psychol Med 2015;45:1653-1664***
- ****Freeman Arch Gen Psychiatry 2006;63:375-382***
- ***Perimenopause places women at higher risk to develop MDD (but not elevated mood as reported in STEP-BD) but also allows for a window of opportunity to utilize estrogen-based Rx for mood***
- ***Estrogen is a mood enhancer acting in a variety of ways to regulate synthesis, metabolism and overall activity of neurotransmitters like serotonin, NA and DA***
- ***Randomized trials have demonstrated that transdermal E2 can have antidepressant effect on new or recurrent MDD during perimenopause (Soares Arch Gen Psychiatry 2001)***
- ***Other study found oral but not transdermal Rx was effective for MDD in perimenopause (Gleason KEEPS trial 2015)***
- ***Joffe et al. J Clin Endocrinol Metab 2011 April 27 found that the antidepressant effect of estrogen in women undergoing menopausal transition was mediated through improved sleep quality and not by reduction in hot flashes***

Depression Treatment:

- ***Resources and Source of Guidelines***
- ***CANMAT (Canadian Network for Mood & Anxiety Treatments)***
- ***Canadian Psychiatric Association***
- ***Psychotherapy***
- ***Pharmacotherapy***
- ***Lifestyle Changes***
- ***Light Therapy***
- ***Education of Depressed Individual and Family***

- ***Alternative Therapies***
- ***Stress Management***
- ***ECT (can also be useful in pregnancy)***

Psychotherapy = Drug Therapy
Psychotherapy + Drugs works the best

Psychotherapy:

- ***Cognitive Behavioural Therapy – changing negative to positive thought patterns – Level 1***
- ***Interpersonal Psychotherapy – improving quality of relationships/addressing social avoidance behaviour – Level 1***
- ***Supportive Psychotherapy – helps adaptation to present life situation/reduces stress***
- ***Brief Dynamic Psychotherapy – identifying and discussing internal conflicts often involving dependency and intimacy***
- ***www.livinglifetothefull.com***
- ***www.moodgym.anu.edu.au***

Pharmacotherapy:

- ***Tricyclic Antidepressants (TCAs)***
- ***Serotonin Antagonist Receptor Inhibitor (SARI)***
- ***Monoamine Oxidase Inhibitors (MAOIs)***
- ***Reversible Inhibitor of Monoamine Oxidase (RIMA)***
- ***Selective Serotonin Reuptake Inhibitors (SSRIs)***
- ***Serotonin Noradrenaline Reuptake Inhibitors (SNRIs)***
- ***Noradrenaline Dopamine Modulator (NDM)***
- ***Serotonin Noradrenaline Modulator (SNM)***
- ***Serotonin Reuptake Inhibitor/Serotonin Modulator***

Newer Agents:

- ***Serotonin Modulator/Reuptake Inhibitor:***
- ***Vortioxetine (Trintellix) (10-20 mg/d; 5 mg if not tolerated)***
- ***Side effects include nausea, bowel changes, dizziness, sexual dysfunction***
- ***Special properties: reported to be better for cognitive dysfunction; mood same***
- ***Noradrenaline Serotonin Reuptake Inhibitor (NSRI):***
- ***Levomilnacipran (Fetzima)(starting dose 10 mgX 2d and increasing to 20 mg and then 40 mg/d; max. 120 mg/day)***
- ***Advantages: fairly weight neutral; noradrenaline effect occurring from starting dose and up; Disadvantages: may increase pulse and BP***
- ***Serotonin Reuptake Inhibitor/5HT1A partial agonist***
- ***Vilazodone (Viibryd) (starting dose 10 mg for a few days; increase to 20 mg; max. 40 mg/day***
- ***Advantages: improves anxiety; Disadvantages: GI side effects***

- ***Treatment-related sexual dysfunction:***
- ***<10% with bupropion, desvenlafaxine, mirtazapine, moclobemide***
- ***10-30% with citalopram, escitalopram, duloxetine, venlafaxine***
- ***>30% with fluoxetine, fluvoxamine, paroxetine, sertraline***
- ******Kennedy SH et al 2007***

- ***Risks of antidepressant treatment:***
- ***Observational data that there may be a link between SSRI use and the risk of fractures – possibly up to 70% increase in relative risk***
- ***Depression is an independent risk factor for low bone mineral density***

Alternative Rx for Depression:

- ***Nahas and Sheikh published review of complementary and alternative Rx of MDD in CFP June 2011;57:659-63***
- ***St. John's wort (watch for drug interactions) and regular exercise appeared effective; acupuncture not found to be effective but had other health benefits; promising Rx included SAM-e; omega-3 fatty acid; folate supplementation in select groups***

PMS/PMDD Rx:

- ***Many similarities to treatment for other depressive disorders***
- ***Treatment options include: counselling for patients and their families, lifestyle modifications, medications***
- ***Lifestyle modifications include decreasing salt intake, refined carbohydrates, limiting caffeine, moderating use of ETOH, stopping smoking, increasing exercise, considering light Rx***
- ***Medications include:***
- ***NSAIDs – menstrual cramps, headaches***
- ***Antidepressants – affecting serotonin – SSRIs/SNRIs (continuous/luteal phase only) (Gr. A) – avoid Paxil***
- ***Birth Control Pills (monophasic)/Patches/Rings – to suppress ovulation, making woman hormonally stable especially when used continuously – drosperinone contg. (Gr. A)***
- ***Estrogen Supplements – to counteract the drop in estrogen especially late in the luteal phase***
- ***GnRH agonists injection, nasal spray, sc pellet***
- ***Danazol – headaches, ++ side effects (androgenic)***
- ***Diuretics – fluid retention***
- ***Supplements: Ca 1200 mg/day – Grade B evidence; Thys-Jacobs et al. Am J Obstet Gynecol. 1998; Vit. B6 50-100 mg/day – Grade B evidence; Wyatt et al. BMJ 1999***
- ***Pharmacotherapy in Pregnancy:***
-
- ***Study (nested case-control) by Drs. Nakhai-Pour, Broy and Berard CMAJ July 13, 2010 looked at Quebec Pregnancy Registry since 1997 and discovered that there was a 5.5% miscarriage rate amongst women who had filled at least one***

antidepressant prescription during pregnancy compared to 2.7% rate in matched controls

- ***When comparing SSRIs, 75% relative increased risk of miscarriage with paroxetine (odds ratio (OR) 1.75) and doubling of risk with venlafaxine (OR 2.11); higher doses increased the risk***
- ***Slightly increased risks of maternal complications have been reported if the woman received antidepressant during pregnancy including gest. DM, PROM, preeclampsia, bleeding, requiring induction or a C-section (Reis et al. Psych Med 2010)***
-
- ***Benefits of drug use > risks***
-
- ***TCAs have the most evidence – use of desipramine, nortriptyline give lowest risk of orthostatic hypotension***
- ***Category C risk for fluoxetine, sertraline, paroxetine, citalopram, escitalopram, trazodone, venlafaxine - overall, SSRIs have reasonable reproductive safety especially fluoxetine and citalopram in 1st trimester***
- ***Jan. 2006 FDA advisory on paroxetine - flawed data suggesting minimally increased cardiac abnormalities like ASD/VSD; possibly increased omphalocoel***
- ***Avoid MAO inhibitors - teratogenic, hypertensive crises***
- ***RIMA (moclobemide) - insufficient data to recommend***
- ***NEJM June 28, 2007 – 2 articles***
- ***"First Trimester Use of SSRIs and the Risk of Birth Defects" – U.S. study of 9849 infants with and 5860 infants without birth defects showed no increased risks of craniosynostosis, omphalocoel or heart defects with the maternal use of SSRIs overall; slightly increased risk of omphalocoel with sertraline and heart defect with paroxetine***
- ***"Use of SSRIs in Pregnancy and the Risk of Birth Defects" population-based case controlled Canadian study of 9622 infants with major birth defects and 4092 control infants from 1997 – 2002 showed no increased risks of birth defects***
- ***Antidepressant Use in Pregnancy and the Risk of Cardiac Defects study – Huybrechts et al – NEJM June 19, 2014***
- ***US population based cohort study of 949,504 pregnant women – 64,389 (almost 15%) used antidepressants during 1st trimester***
- ***72.3/100,000 infants in control group had cardiac defects and 90.1/100,000 in the Rx group***
- ***Unlike previous studies no association was found with the use of paroxetine or sertraline and cardiac defects in the infants of treated mothers***
- ***Population based study from Quebec from 1998 through 2010 published Am J Obs Gyne Jan. 2015 looking at use of sertraline during the first trimester of pregnancy was associated with an increased risk of atrial/ventricular defects and craniosynostosis above and beyond the effect of maternal depression***
- ***Nonsertraline SSRIs were associated with an increased risk of craniosynostosis and musculoskeletal defects as well***

- ***Kieler et al. BMJ 2011 Jan. examined use of SSRIs in pregnancy and the risk of persistent pulmonary hypertension in the newborn***
- ***Absolute risk of PPH newborn roughly doubled from baseline risk 1.2/1000 to 3/1000 live births***
- ***Neonatal withdrawal symptoms observed in a small number of newborn babies of mothers who took antidepressants in 3rd trimester of pregnancy – babies jittery, self-limited respiratory difficulties, feeding issues; problem resolves within a few days of birth with no lasting consequences***
- *****Kalra S et al (Motherisk) CFP Aug. 2005***
-
- ***Evidence is insufficient to recommend acupuncture, hormone therapy, light Rx, St. John's wort for antenatal depression (NEJM 365;17 – Oct. 2011)***
- ***ECT reserved for severe, treatment-resistant cases, psychotic depression and for pregnant women at high risk for suicide***
-
- ***Treatment of MDD and Breastfeeding:***
- ***Generally, drug excretion rates <10% in breast milk are considered safe by the American Academy of Pediatrics***
- ***SSRIs - *fluoxetine (accumulates in serum) (7.7%); paroxetine (2.8%); sertraline (2.2%); citalopram (3.6%); escitalopram (5.9%)***
- ***SNRIs - venlafaxine (6.4%); duloxetine (0.1%); desvenlafaxine (9.3%)***
- ***NDM - bupropion (1.9%)***
- ***sSNRI - mirtazapine (6.3%)***
- ***SARI - trazodone (2.8%)***

Pharmacotherapy Augmentation Strategies in MDD:

- ***If first antidepressant not inducing remission, increase the dose, switch to a different antidepressant, combine original with a second antidepressant or add a non-antidepressant agent***
- ***Papakostas GI. Managing partial response or non-response: switching, augmentation, and combination strategies for MDD. J Clin Psychiatry 2009;70 Suppl 6:16-25***
- ***<u>For non-response or incomplete response:</u>***
- ***1st line: switch to superior agent (duloxetine, escitalopram, mirtazapine, sertraline, venlafaxine)***
- ***2nd line: add another agent (bupropion, mirtazapine, quetiapine, T3, another antidepressant) or switch to superior agent with side effect limitations (amitriptyline, MAOs, clomipramine)***
- ***3rd line: add another agent (bupropion, modafinil, stimulants, ziprasidone)***

Pharmacotherapy Augmentation Strategie in MDD – Level of Evidence

- ***atypical antipsychotics - A***
- ***omega-3 fatty acids – A-***
- ***lithium; modafinil; triiodothyronine - B***

- ***testosterone – B-***
- ***Pindolol; lamotrigine; methylphenidate - C***

Lifestyle Changes to Help MDD:

- ***Limit alcohol and caffeine; avoid street drugs; regular exercise outdoors; stop smoking; winter vacations down south; sleep hygiene; stress avoidance; no OTC drugs unless sanctioned by physician***

Light Therapy:

- ***Though light treatment was felt to be most helpful for seasonal affective disorder, recent studies suggest it may be useful for other forms of depression***
- ***Sit under it for at least ½ hour/day in am upon arising and read whatever you like, especially in the fall and winter months***
- ***Requires 10,000 lux of light intensity***

Bipolar Disorder (BPD):

- ***BPD typically emerges in adolescence and is usually manifested as depression***
- ***Severe or psychotic symptoms in a teenager are a possible clue to emerging BPD***
- ***If teenager has presented with hypomania or mania, mood will be irritable and fluctuate between the extremes of mania and depression within days***
- ***ADHD major condition in the differential especially with pre-teens***
- ***Diagnosis may be delayed for > 20 years***
- ***15-30% of depressed patients may have BPD***
- ***Screen patients with depression for hypomanic/manic symptoms***
- ***Ask about family history of mood disorders***
- ***Ask about suicidal ideation***
- ***Get historical corroboration from family/friends***
- ***Consider alternative diagnoses***
- ***Use Mood Disorder Questionnaire (MDQ)***

BPD Rx :

- ***Mania with acute agitation – treated emergently with aripiprazole 9.75-15 mg IM, lorazepam 2 mg IM, olanzapine 2.5-10 mg IM, loxapine inhaled 5-10 mg)***
- ***Acute mania – 1st line Rx with lithium, quetiapine, valproate, asenapine, aripiprazole, paliperidone or risperidone or cariprazine (new) monotherapy or combination of lithium + atypical antipsychotic (quetiapine, aripiprazole, risperidone or asenapine)***
- ***Mania with acute agitation Rx:***
- ***Olanzapine, ziprasidone and haloperidol seen as second line options – level 1 evidence for efficacy but offset by safety/tolerability concerns***
- ***2nd line Rx haloperidol 5-15 mg IM, risperidone (rapidly dissolving tablet) 2-4 mg, ziprasidone 2-20 mg, asenapine sl 10 mg (Level 3 evidence)***
- ***Maintenance Rx for BPD:***
- ***1st line: monotherapy with lithium, lamotrigine, valproate, quetiapine, asenapine, combination quetiapine or aripiprazole + Li/DVP, aripiprazole daily or monthly***

- ***2nd line: monotherapy with risperidone LA, carbamazepine, paliperidone; combinations of lurasidone or ziprasidone + Li/DVP***
- ******Li/DVP – lithium and divalproex; LA – long-acting***
- ***New for 2018 CANMAT guidelines:***
- ***Asenapine 1st line***
- ***Aripiprazole IM 1st line***
- ***Olanzapine/risperidone/lurasidone 2nd line***
-
- ***Dosing for Mood Stabilisers: measure serum levels***
- ***Lithium: 900-1800 mg/day in 2 divided doses of sustained release; start with 300 mg bid (capsules of 150/300/600 mg)***
- ***Valproate: 750-1500 mg/day in 2-4 divided doses (250 mg capsules; 125 mg sprinkles; 250 mg/5 ml syrup)***
- ***Dosing for Atypical Antipsychotics:***
- ***Risperidone: 1-6 mg/day; 2-3 mg starting dose for mania; .5, 1.0, 2.0 mg dose 0lanzapine: 10-15 mg od starting dose; max. dose 20 mg/day; maintenance 5-20 mg/day; dosages 2.5, 5, 7.5, 10, 15, 20 mg; orally disintegrating tabs Zydis 5, 10, 15, 20 mg***
- ***Quetiapine: start with 50 mg bid, increase by 100 mg/day up to typical dose of 400-800 mg/d within 1 week; 25, 100, 200, 300 mg formulations***
- ***Aripiprazole: 15-30 mg/day or 300-400 mg/month IM***
- ***Brexpiprazole: 0.5-4 mg/day; tablets of 0.5, 1, 2 mg***
-
- ***Women in reproductive years need to be on adequate family planning method to avoid inadvertent exposure of a fetus to some drugs used for BPD; discuss risks to fetus including the risk of drugs themselves and possibility that baby could inherit genes for BPD***
- ***> 3 months before planned pregnancy discuss risks of maintenance medications, risks of relapse without Rx, management plans during pregnancy***
- ***Consider stopping drug(s) before trying to conceive and during first trimester***
- ***Women needing meds may need dose adjusted***

BPD Mood Stabilizer Teratogenicity:

- ***Lithium - Class D (overall risk 4-12%; Epstein tricuspid valve malformation .1%)***
- ***Divalproex - Class D (11%)***
- ***Topiramate – Class D (newer data in Neurology July 08 shows 11% increased risk cleft lip/palate; hypospadias)***
- ***Carbamazepine - Class D (5.7%)***
- ***Lamotrigine - Class C (2.9%)***
- ***Gabapentin, Olanzapine, Risperidone, Quetiapine - Class C (no good data)***
- ******Base Rate (no drugs) - risk is 2-4%***

- ***Lithium therapy is associated with increased risk of reduced urinary concentrating ability, hypothyroidism, hyperparathyroidism (monitor Ca levels) and weight gain; risk of end-stage renal failure is low; risk of congenital malformations uncertain; McKnight et al. Lancet Jan. 2012***
- ***Geddes JR et al. Lamotrigine for treatment of BPD. Br J Psychiatry 2009 Jan;194(1):4-9. review article - has beneficial but modest effect on depressive SxSx in BPD, although advantage over placebo larger in more severely depressed patients***

BIPOLAR DISORDER – Management Postpartum

- ***2/3 of women will relapse in postpartum period if not on medication and 1/4 if meds were continued***
- ***Benzos, antipsychotics and lithium for mania postpartum (Level 4 evidence)***
- ***Postpartum depression – quetiapine Rx (Level 4 evidence)***
- ***Maintenance Rx - start ASAP after delivery and monitor closely***

Lactation Risk Categories:

- ***SSRIs – L2***
- ***Bupropion – L3***
- ***Carbamazepine, lamotrigine, olanzapine, quetiapine, risperidone, ziprasidone – L2***
- ***Lithium, Divalproex – L4***

- ****L1 – safest; L2 – safer; L3 – moderately safe; L4 – possibly hazardous; L5 – contraindicated***