

## S26.02

### Advances in treatment in bipolar pregnant patients

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The perinatal period is a time of psychic vulnerability, in particular with regard to bipolar mood disorders. Chemotherapeutic treatments cannot always be avoided, and raise the question of the influence of the impact of psychotropic drugs on child during pregnancy. The impact study of the drugs on the embryo, the foetus and the new-born baby raises obvious ethical problems, and there is very few work which is often of a debatable methodological quality, because mainly retrospective. The use of mood stabilisers treatments remains discussed, especially with regard to the anticonvulsivants. If the use of neuroleptics are now quite well defined during pregnancy, antipsychotics remain, for the most, molecules in course of evaluation.

Practical and ethical issues of those chemotherapeutic treatment strategies will be discussed, as well as other approaches, as specific pregnancy psychoeducation.

## S26.03

### Antidepressant treatment during pregnancy: Pros and cons

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**Background:** The prevalence of mood disorders (anxiety and depression) during pregnancy seems to be similar to the women of the same group without pregnancy. Women with recurrent depression and euthimic women who discontinued antidepressants medication during pregnancy are particularly at high risk for depressive illness. Data about perinatal effects of SSRI antidepressants are gradually accumulating and are controversial. Two meta-analyses and some controlled studies don't find increased risk for major malformations in SSRI-exposed newborn. However, other studies find an increased risk of congenital malformations, poor birth outcomes and neonatal complications.

Neonatal morbidity in infant newborn of women treated with antidepressant drugs.

We examine the relation between the pharmacological treatment of the maternal anxiety/depression during the pregnancy and acute morbidity in infant newborns.

**Materials and Methods:** Study group of 66 infant newborn of pregnant women with a diagnoses of major depressive episode or defined anxiety disorders according to DSM-IV, who were in treatment with antidepressant drugs during pregnancy. Control group: 120 newborn of healthy pregnant women, who did not receive any treatment, and were contemporary of the same gestational age and sex. Criteria of exclusion: demonstrated toxic consumption (alcohol, cocaine, cannabis, opiates, drug of synthesis). Studied variables: Type of childbirth and analgesia; weight and age of gestation; pH of umbilical artery and Apgar test; presence of malformations; morbidity; feeding; withdrawal syndrome.

**Results:** Infant newborn of mothers exposed to the antidepressant treatment suffered from more pathology than those of the control group (16/66 vs. 14/114; 24.2% vs.12.3%;  $p=0.038$ ). Two smaller

malformations in the study group were observed, a preauricular appendix (group A) and one moderate pielocilicilar ectasy (group C), both in mothers who received paroxetine (2/60; 3.3% vs. 0/114; 0%,  $p=0.05$ , Fisher  $p=0.118$ , NS). Only one infant newborn displayed compatible clinical signs with moderate withdrawal syndrome (irritability, vomits) from a mother treated with venlafaxine. No case of convulsions was observed. Breast feeding was less frequent in the group of antidepressant treated mothers (38/66, 57.6% vs. 86/116, 74.1%,  $p=0.032$ ).

**Conclusions:** The treatment with antidepressant drugs during pregnancy is necessary for some women. The clinician must weigh the relative risks of various treatment options and take into account individual patient wishes. Although the antidepressant drugs suppose an increased risk for the newborn, it could be assumable for the benefit that represents maintain the mother in an euthimic situation.

We propose to discuss the clinical management, as well as, the accuracy of the psychiatric and obstetric controls to minimize the neonatal complications.

## S26.04

### Antidepressant treatment response of postpartum depression: Clinical and genetic factors

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Pharmacologic treatment of mood disorders reduces morbidity of depressive disorders and improves quality of life. Not all patients benefit from treatment. Close to 30% to 40% does not improve enough to the first antidepressant they receive. Many factors are assumed to contribute to this. In the last years it has been studied genetic factors predisposing to drug response or side effects in mood disorders. The efficacy of antidepressant action has been associated to several polymorphisms located in candidate genes related to serotonin pathway.

The prevalence of major depression occurring in the postpartum (PPD) is estimated at 4%-6% and results in considerable morbidity for women, their infants and families. The period of higher risk of PPD appear to occur close to the time of birth between 8 to 24 weeks. It seems that PPD episode is severe and longer than episodes outside this period of life. Initial results showed that women with PPD experienced fewer episodes during illness course compared to non postpartum women and less comorbidity with personality disorders.

We presented preliminary socio-demographic, clinical and genetic data (5-HTTLPR polymorphism) of a case control studied of women with PPD naturalist treated with SSRI visited at the Perinatal Psychiatric Unit. All women were diagnosed by a DSM-IV structured interview and assessed for personality traits. Therapeutical SSRI response was evaluated by the Edinburgh Postnatal Depression Scale and the Hamilton rating Scale for depression at baseline, 8 weeks and 24 weeks of treatment.

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