Should we stop using tricyclic antidepressants in pregnancy?

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A new Swedish study by Reis & Källén (2010) describes approximately 15,000 women (and their babies) that, between 1995 and 2007, reported the use of antidepressants, or were prescribed such drugs, during pregnancy. In this study, pregnancy and teratogenic outcomes after exposure to tricyclic antidepressants are, for most measures, equal or worse than after exposure to selective serotonin reuptake inhibitors or other antidepressants. Based on this and on a review of the few other studies available (admittedly, a relatively small number of women on which conclusions can be based), the authors of this Editorial challenge the ‘perinatal myth’ that tricyclics are the safest choice in pregnancy.

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between TCA use in pregnancy and structural malformations’ (Yonkers et al. 2009). However, they cite only two papers: Altshuler et al. (1996) and Simon et al. (2002). The first paper is a meta-analysis of studies published between 1966 and 1995. The authors also conclude that tricyclic antidepressants do not seem to confer increased risk for ‘organ dysgenesis’, but this is based on 414 patients exposed during the first trimester, collected across 13 small studies. The second study examines a total of 209 infants exposed to tricyclics (and 185 to SSRIs) and finds no evidence of congenital malformations for either class of drugs. So, no superiority for tricyclics here. The recently published Maudsley Prescribing Guidelines (Taylor et al. 2009), in its section on ‘Drug choice in pregnancy’ (to which the authors of this editorial have contributed), again conclude that tricyclics ‘have been widely used throughout pregnancy without apparent detriment to the foetus and have for many years been agents of choice in pregnancy’. They also cite two studies: Kallen (2004) and Davis et al. (2007). The paper by Kallen (2004) includes data which are used in Reis & Källén’s larger dataset, and therefore we will discuss the overall findings below. The study by Davis et al. (2007), comparing 805 mothers exposed to SSRIs and 167 exposed to tricyclics, concludes that SSRIs and tricyclics do not show a ‘consistent link with congenital anomalies’ (so, again, no superiority of tricyclics). It is of interest that, of the studies mentioned so far, two also examine other pregnancy outcomes: Davis et al. (2007) find that both SSRIs and tricyclic exposures during the third trimester are associated with an increased risk for respiratory distress syndrome, endocrine and metabolic disturbances, with no differences between classes; and Simon et al. (2002) find evidence that tricyclics are better than SSRIs, as only SSRIs during pregnancy are associated with earlier delivery and consequent lower birth weight and lower Apgar scores.

So, what does this new Swedish study by Reis & Källén (2010) add, and should we indeed stop tricyclic use in pregnancy? This study describes approximately 15000 women (and their babies) that, between 1995 and 2007, reported the use of antidepressants, or were prescribed such drugs, during pregnancy. These women were compared with all other women who gave birth in the same period: approximately 1 million women and 1.2 million babies. Most women took SSRIs (n = 10 170) but a reasonable number (and the largest published so far) took tricyclics (1662 women, which for 1208 was clomipramine); 1351 took other antidepressants, mostly venlafaxine (n = 859). This paper has three very interesting findings. First, there is an association between antidepressant treatment and pre-existing diabetes and chronic hypertension. This indicates that, in addition to the biological and behavioural consequences mentioned above (or, perhaps, because of those), depression in pregnancy is itself associated with higher medical morbidity – an additional confounder in this already complex set of questions. Second, the increased risk of persistent pulmonary hypertension of the newborn after SSRIs has been confirmed. Considering that this is a rare event and the previous literature has been inconclusive, this is a definitive and irrefutable step forward. It is important to emphasize, however, that the absolute risk of persistent pulmonary hypertension after SSRIs remains low, with an odds ratio of 3.4 (the baseline rate in the Swedish population is 0.56 per 1000). Finally, and most relevant to this editorial, outcomes after exposure to tricyclics are, for most measures, equal or worse than after exposure to SSRIs or other antidepressants. For example, there is a tendency for a higher risk of preterm birth and low birth weight after tricyclics than after SSRIs. Moreover, the risks for hypoglycaemia, respiratory diagnoses and low Apgar score are significantly increased primarily after the use of tricyclics, but also of SSRIs; and an increased risk for jaundice is present after exposure to tricyclics and other antidepressants, but not SSRIs. Even more important, the risks for a relatively severe malformation, for any cardiovascular defects, for ventricular septum defects, or for atrial septum defects, are all significantly increased only for tricyclics and for one SSRI, paroxetine. Paroxetine is already considered contraindicated in pregnancy (National Institute for Health and Clinical Excellence, 2007; Taylor et al. 2009).

In their paper, Reis & Källén (2010) discuss the main limitations of their study – most notably, that the findings could be confounded by ‘indication’, that is, that women prescribed tricyclics could be clinically different from those prescribed SSRIs. Moreover, most women receiving tricyclics were, in fact, receiving clomipramine, a tricyclic with a strong serotonergic component and, anecdotally, not widely used in the UK. Finally, even if this is the largest published sample of mothers prescribed tricyclics, this study is based on a relatively small number of women, and therefore we still have only limited data on which we can base our conclusions. However, the notion of a ‘superiority’ of tricyclics has been challenged, and this cannot be ignored in clinical practice. Other authors have clearly argued that SSRIs, when used in the general population, are much safer drugs, especially in overdoses, than tricyclics, and that continuing to prescribe tricyclic antidepressants in the general population has scandalous consequences, including an excess of 3500 deaths by overdose in the decade up to 2004 (Nutt, 2005). The NICE Antenatal and Postnatal
Mental Health Guidelines (National Institute for Health and Clinical Excellence, 2007) also clearly state that ‘most tricyclic antidepressants have a higher fatal toxicity index than SSRIs’. In view of the lack of any evidence indicating superiority of tricyclics for pregnancy or teratogenic outcomes, we believe that this class of drugs can no longer be considered the safest choice in pregnancy.

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Declaration of Interest

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References


