# Antidepressant Medication Chart

## Drugs Class: Selective Serotonin Reuptake Inhibitors (SSRIs)

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Trade Name</th>
<th>Usual Daily Dose</th>
<th>Benefits</th>
<th>Maternal Risks</th>
<th>Fetal/Neonatal Risks</th>
<th>Relative infant dose=(RID)</th>
<th>Half-life (t1/2)/metabolites</th>
<th>Reported side effects in breastfed infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>Celexa®</td>
<td>20–40mg</td>
<td>• No adverse morphologic consequences for infant found • Few interactions with other medications</td>
<td>• Side effects include nausea, insomnia, dizziness, and somnolence</td>
<td>• Behavioral consequences for infant unknown • Possible increased risk of growth restriction • Possible increased risk of neural tube defects and cardiac defects (ASD)</td>
<td>3.60%</td>
<td>Drug has intermediate t1/2 (1-2 days) • 3 weak metabolites with little activity</td>
<td>Somnolence • Decreased feeding • Weight loss</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Lexapro®</td>
<td>10–20mg</td>
<td>• Few interactions with other medications • No adverse morphologic consequences for infant found</td>
<td>• Side effects include nausea, insomnia, somnolence, dizziness, fatigue, diarrhea, sexual dysfunction, and dry mouth</td>
<td>• No systematic studies in human pregnancy • Morphologic and behavioral consequences for infant unknown • Possible increased risk of growth restriction • Possible increased risk of necrotizing enterocolitis</td>
<td>5.2-8%</td>
<td>Drug and active metabolite have intermediate t1/2 (1-2 days)</td>
<td>Somnolence • Decreased feeding • Weight loss</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prozac®</td>
<td>20–60mg</td>
<td>• More studies in human pregnancy, including meta-analysis and neurodevelopmental follow-up • No adverse behavioral consequences for infant found</td>
<td>• Side effects include nausea, drowsiness, and sexual dysfunction • Possible drug interactions</td>
<td>• More reports of neonatal side effects than some other antidepressants • Possible morphological changes</td>
<td>1.6–14.6%</td>
<td>Drug and active metabolites have very long t1/2 (days to weeks) • Serum levels similar to those in adults reported in some symptomatic infants</td>
<td>Severe colic • Fussiness • Crying</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>Luvox®</td>
<td>50–200mg</td>
<td>• No adverse morphologic consequences for infant found</td>
<td>• Side effects include nausea, drowsiness, anorexia, anxiety, and sexual dysfunction • Possible drug interactions</td>
<td>• Behavioral consequences for infant unknown</td>
<td>0.3–1.4%</td>
<td>Drug has short t1/2 (hours) • Major metabolite not active</td>
<td>No reported concerns</td>
</tr>
<tr>
<td>Pareoxetine</td>
<td>Paxil®</td>
<td>20–60mg</td>
<td>• None—avoid during pregnancy if possible</td>
<td>• May increase risk of miscarriage • Side effects include nausea, drowsiness, fatigue, dizziness, and sexual dysfunction.</td>
<td>• Behavioral consequences for infant unknown • More reports of neonatal side effects than most other antidepressants • Possible association with cardiovascular malformations in infant</td>
<td>1.2–2.8%</td>
<td>Drug has relatively short t1/2, but variable (hours to days) • No active metabolites</td>
<td>Numerous studies suggest minimal to no effect on breastfed infants</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Zoloft®</td>
<td>50–200mg</td>
<td>• Relatively well-studied in human pregnancy • No adverse behavioral consequences for infants found • Fewer reports of neonatal side effects than other antidepressants</td>
<td>• Side effects include nausea, loose stools, tremors, insomnia, and sexual dysfunction.</td>
<td>• Possible specific association with omphalocele and cardiac septal defects</td>
<td>0.4–2.2%</td>
<td>Drug and weakly active metabolite have intermediate t1/2 (1-2 days) • Detectable levels in some infants, but no adverse effects</td>
<td>1 report of benign neonatal sleep myoclonus (relationship unknown)</td>
</tr>
</tbody>
</table>

## Additional Information

For additional information contact: Wisconsin Association for Perinatal Care | 211 S. Paterson St., Suite 250 | Madison, WI 53703 | www.perinatalweb.org Email: wapc@perinatalweb.org
# Antidepressant Medication Chart

(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

**Data current as of April 2012**

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Trade Name</th>
<th>Usual Daily Dose</th>
<th>Benefits</th>
<th>Maternal Risks</th>
<th>Fetal/Neonatal Risks</th>
<th>Relative infant dose (RID)</th>
<th>Half-life (t1/2)</th>
<th>Reported side effects in breastfed infants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRUG CLASS: Tricyclic antidepressants (TSAs)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Desipramine</td>
<td>Norpramin®</td>
<td>100-300mg</td>
<td>• More studies in human pregnancy, including neurodevelopmental follow-up • No adverse morphologic consequences for infant found • No adverse behavioral consequences for infant found • May be useful if sedation desired</td>
<td>• Side effects include sedation, weight gain, dry mouth, constipation, and orthostatic hypotension—baseline ECG recommended • Possible drug interactions</td>
<td>• Fetal and neonatal side effects include tachycardia and urinary retention</td>
<td>0.2-0.9%</td>
<td>• Drug and active metabolite have intermediate t1/2 (1-2 days) • Not detected in infants • No reported adverse events in infants found</td>
<td></td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Pamelor®</td>
<td>50-150mg</td>
<td>• More studies in human pregnancy, including neurodevelopmental follow-up • No adverse morphologic consequences for infant found • No adverse behavioral consequences for infant found • May be useful if sedation desired</td>
<td>• Side effects include sedation, weight gain, dry mouth, constipation, and orthostatic hypotension—baseline ECG recommended • Possible drug interactions</td>
<td>• Fetal and neonatal side effects include tachycardia and urinary retention</td>
<td>1.7-3.1%</td>
<td>• Drug has intermediate t1/2 (≥ 1 day) • No active metabolites</td>
<td>• No reported adverse events in infants found</td>
</tr>
<tr>
<td><strong>DRUG CLASS: Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)</strong></td>
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</tr>
<tr>
<td>Duloxetine</td>
<td>Cymbalta®</td>
<td>40-60mg</td>
<td>• Balanced antidepressant; may be effective when selective agents are not • Low cord to maternal serum ratio suggests limited transfer across the placenta</td>
<td>• Common side effects include nausea, dry mouth, constipation, diarrhea, vomiting, decreased appetite, fatigue, dizziness, somnolence, tremors, sweating, blurred vision, and insomnia</td>
<td>• No systematic studies in human pregnancy • Morphologic and behavioral consequences for infant unknown</td>
<td>0.10%</td>
<td>• Drug has short t1/2 (hours) • No active metabolites • Relative infant dose low</td>
<td>• No reported adverse events in infants found</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Effexor®</td>
<td>75-300mg</td>
<td>• Balanced antidepressant; may be effective when selective agents are not • No adverse morphologic consequences for infant found</td>
<td>• May increase risk of miscarriage • Maternal side effects include nausea, sweating, dry mouth, dizziness, insomnia, somnolence, and sexual dysfunction</td>
<td>• No behavioral studies in human pregnancy • Possible neonatal risk of respiratory, cyanosis, apnea, seizures, and temperature instability</td>
<td>6.8-8.1%</td>
<td>• Drug and active metabolite have short t1/2 (approx 5 h)</td>
<td>• Detectable plasma levels in several breastfed infants were not associated with any adverse effects</td>
</tr>
<tr>
<td><strong>DRUG CLASS: Other</strong></td>
<td></td>
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</tr>
<tr>
<td>Bupropion</td>
<td>Wellbutrin®/Zyban®</td>
<td>300-450mg</td>
<td>• No adverse morphologic consequences for infant found • Helps with smoking cessation (never tested in pregnancy)</td>
<td>• May increase risk of miscarriage • Maternal side effects include dizziness, headache, dry mouth, sweating, tremor, agitation, insomnia, and rare seizures • Possible drug interactions</td>
<td>• Behavioral consequences for infant • Possible increased risk of CHD (left outflow tract defects) • Possible increased risk of fetal cardiac arrhythmia</td>
<td>0.6-2%</td>
<td>• Drug and active metabolite have intermediate t1/2 (1-2 days) • Plasma levels undetectable in breastfed infant</td>
<td>• One reported case of seizure in a 6 month old infant</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Remeron®</td>
<td>15-45mg</td>
<td>• No adverse morphologic consequences for infant found • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting</td>
<td>• May increase risk of miscarriage • Maternal side effects include somnolence, nausea, weight gain, and dizziness</td>
<td>• Behavioral consequences for infant unknown • May increase risk of preterm birth • Possible hyperthermia</td>
<td>1.6-6.3%</td>
<td>• Drug and active metabolite have intermediate t1/2 (1-2 days) • Very low plasma level detected in 1 of 3 infants tested</td>
<td>• No adverse effects reported • Observe for sedation</td>
</tr>
</tbody>
</table>

**Note:** Relative infant dose (RID) = Drug and active metabolite concentration in infant plasma divided by maternal concentration.
ANTIDEPRESSANT MEDICATION CHART
(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

Notes


Clinicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Treatment decisions should be based on patient characteristics and clinical judgment. Recommended dosages can be found in the most recent editions of the Physician’s Desk Reference and the Drug Information Handbook.

(2) A relative infant dose < 10% is generally considered safe to breastfeed; however, all infants must be observed for adverse events during maternal drug therapy.

(3) Reported side effects in breastfeeding infants are based on case reports and case series.

* All SSRI antidepressants (citalopram, escitalopram, fluoxetine, paroxetine, sertraline) may be associated with the following risks: possible increased risk of miscarriage; gestational age decreased by an average of one week; possible increased risk of persistent pulmonary hypertension in the newborn with exposure after 20 weeks gestation, although no teratogenicity has been found in prospective, controlled studies or meta-analyses. One case-control study found a possible increased risk of anencephaly, craniosynostosis and omphalocele, and a retrospective prescription events monitoring study found an increased risk of anomalies in general; absolute risks were small.

- Medications vary in the amount and quality of data available about effects in human pregnancy. A better-studied medication may have more reported side effects than a less-studied medication because more is known about it, not necessarily because it is riskier.

- Data presented here are based on studies during human pregnancy. The Food and Drug Administration’s Pregnancy Risk Categories, as found in the Physician’s Desk Reference, are based on a combination of animal and human studies.

Comments
This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

- Risks of antidepressants during pregnancy and lactation must be weighed against the risks of untreated symptoms. Treatment needs to be individualized.

- Monitor for dose adjustment through pregnancy. The dose of the medication may need to be increased to maintain response.

- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation side effects in the fetus or neonate. These signs can include respiratory distress, excessive crying, changes in sleep and behavioral state, difficulty feeding, increased or decreased tone, hyperreflexia, seizures, or cardiac arrhythmias. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.


- If a patient is on other medications, consult with a pharmacist or other appropriate specialists for interaction information.

- For more information on SSRIs and pregnancy, see:
  


Breastfeeding and Medications: Maternal Considerations

1. Avoid random switching of medications based on data alone. Choose drugs for which published data is available, rather than those recently introduced.
2. Most drugs are quite safe in breastfeeding mothers. The risk of not breastfeeding and instead using infant formula is much higher for the infant.
3. If the Relative Infant Dose (RID) is less than 10%, most medications are quite safe to use. The RID of the vast majority of drugs is <1%.
4. Choose drugs with a short half-life, high protein binding, low oral availability, or high molecular weight.
5. Medications used in the first 3-4 days postpartum generally produce sub-clinical levels in the infant due to the limited volume of milk.
6. Avoid using medications when possible. Herbal drugs, high dose vitamins, unusual supplements, etc. that are simply not necessary should be avoided.

Adapted from Hale, T.W. (2010). Medications and Mothers’ Milk (14th ed.).

Breastfeeding and Medications: Neonatal Considerations

1. Evaluate the infant for risks: Be slightly more cautious with premature infants or neonates. Be less concerned about older infants.
2. Inquire about the infant: Always inquire about the infant’s age, size, and stability. This is perhaps the most important criteria to be evaluated prior to using the medication.
3. Infant age: Premature and newborn infants are at somewhat greater risk. Older mature infants can metabolize and clear medications much easier.
4. Infant stability: Unstable infants with poor GI stability may increase the risk of using medications.
5. Pediatric Approved Drugs: These generally are less hazardous if long-term history of safety is recognized.

Adapted from Hale, T.W. (2010). Medications and Mothers’ Milk (14th ed.).

This chart was compiled by a multidisciplinary work group of leaders in their respective disciplines including OB/GYN, family practice, psychiatry, nursing, genetics, and pharmacy, practicing in Wisconsin and representing WAPC and/or the Wisconsin Section of the American Congress of Obstetricians and Gynecologists.

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