DUQUESNE UNIVERSITY
MYLAN SCHOOL OF PHARMACY

PIC QUESTION OF THE WEEK: 8/20/07

Q: What is the most appropriate SSRI for use in breastfeeding women?

A. It is estimated that 8-20% of women will develop clinical signs of depression throughout their lifetime. Because psychiatric disorders such as anxiety, depression (5-20% of women experience postpartum depression), panic attacks, obsessive-compulsive disorder, etc. are common in women during child-bearing years, the use of selective serotonin reuptake inhibitors (SSRIs) is frequently indicated. Health professionals are often reluctant to promote the use of SSRIs in pregnant and breastfeeding women; however, many studies support the safe and effective use of these agents in both situations. Paroxetine and sertraline are generally considered the preferred SSRIs during breastfeeding. The drugs are minimally excreted into breast milk and paroxetine has not been detected in the serum of breastfeeding infants. Although some women reported constipation, sleepiness, and irritability in their breastfed infants, the reactions could not be definitively attributed to paroxetine administration. The maximum reported estimated weight-adjusted exposure of sertraline for a nursing infant is 2.3% of the mother's dose. Serum concentrations of sertraline have been detected in some infants; however, only one possible case of agitation and sleep disorder has been described. The average amount of fluoxetine secreted into breast milk is higher than that of the other SSRIs. Its active metabolite, norfluoxetine, has been detected in the serum of most breastfed infants during the first two months postpartum and, in a few cases, for some time thereafter. Infants should be monitored for colic, irritability, and sedation as well as for adequate weight-gain because these effects have been reported in some case reports. If treatment with fluoxetine is necessary, there is no need to discontinue breastfeeding; however, most authors consider paroxetine or sertraline to be preferable if antidepressant therapy must be initiated during lactation. Low levels of citalopram have been detected in the serum of some breastfed infants. Minor behavioral effects such as drowsiness or fussiness and weight loss have been reported. Some authors as well as the manufacturer suggest that somnolence is not uncommon with citalopram or its active enantiomer escitalopram. Although there is limited data, fluvoxamine is also not expected to produce adverse effects in a breastfed infant. The American Academy of Pediatrics' guideline on the transfer of drugs into human milk currently lists reported adverse effects only from fluoxetine, but continues to caution about the possible effects of all psychotropic medications on the short-term and long-term CNS function of breastfed infants. Because of the extent of organ growth and development, adverse reactions are quite uncommon in infants greater than two months of age exposed to drugs administered to the lactating mother.

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