THE PERISCOPE PROJECT

PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

This toolkit was produced by the Medical College of Wisconsin and is provided to health care providers through The Periscope Project. The goal of this toolkit is to provide practitioners with an up-to-date, reliable, and easy to use source of information for mental health conditions during the perinatal period. The content is based on the latest available evidence-based guidelines and research whenever possible. If you are aware of new guidelines or research or if you have suggestions that can help improve this toolkit, please contact ThePeriscopeProject@mcw.edu. Please read our disclaimer before using our toolkit.

This toolkit is for educational purposes only and does not constitute medical advice. The toolkit is not a replacement for careful medical judgments by qualified medical personnel. There may be information in the toolkit that does not apply to or may be inappropriate for the medical situation at hand.

Medication Algorithm for Depression

Complete **Depression Screen** (PHQ-9 or EPDS) **+/-** and ask **single Bipolar Screen question**.
(1) Patient is pre-conception, pregnant or postpartum
(2) Patient screens positive for depression **AND** negative for bipolar question

#1 - Is patient currently taking psychiatric medication?

YES

If medication is still low dose, increase and optimize both.

If dose has been therapeutic for 6-8 weeks without benefit, consider changing medication.

NO

If patient was formerly on a helpful medication, **re-start** with slow titration.

If no previous effective medication, start with an agent below depending upon side effect profile.

Escitalopram

Start at 10 mg daily.

Can increase to 20 mg in 2-4 weeks, maximum dose of 20 mg daily.

Short titration, as low max dose and starting dose is often therapeutic.

Generally very well tolerated.

Fluoxetine

Start at 20 mg daily in the morning.

Increase in 10-20 mg increments every 2-4 weeks, maximum dose 80 mg daily.

Long half-life, so good choice if daily compliance is a concern.

Tends to be activating.

Sertraline

Start at 50 mg daily.

Increase in 50 mg increments every 2-4 weeks, maximum dose of 200 mg daily.

Few drug-drug interactions.

May increase nausea/GI upset, particularly in 1st trimester.

Venlafaxine

Start at 37.5 mg daily.

Can increase to 75 mg after 1 week, then increase in 75 mg increments every 2-4 weeks, maximum dose of 225 mg daily.

Dose-dependent increases in BP can occur.

Withdrawal symptoms can be significant if stopped abruptly.

Mirtazapine

Start at 15 mg nightly.

Increase in 15 mg increments every 2-4 weeks, maximum dose of 45 mg daily.

Good if patient has significant nausea, low appetite, or difficulty sleeping. Monitor weight gain; discontinue if rate of weight gain is too rapid.

May be too sedating to care for baby over night.

Bupropion

Start at XL 150 mg daily in the morning.

Increase to XL 300 mg in two weeks if tolerating dose.

Good for 'couch potato depression:' helpful with motivation and increasing energy.

May exacerbate anxiety.

May cause tremor and worsen sleep.

#2 - Re-evaluate after 4-6 weeks.

If symptoms improved

Continue to monitor throughout perinatal period.

Continue to offer non-medication based therapies.

Refer back to primary provider when obstetric care complete.

Symptoms not improved/ experiencing side effects

If no/minimal side effects, increase dose and repeat cycle until maximum dose achieved.

If intolerable side effects, switch to different medication and repeat cycle.

At any point contact Periscope with questions.