GROW-WI
GATHERING THE RURAL OB WORKFORCE IN WI

Project ECHO®

Gathering the **R**ural **O**B **W**orkforce in **WI**
GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code VEPREL to 608-260-7097.

Session Date: June 24, 2025
Facilitator: Rachel Hartline, MD

	Topic	**Presenter**
Case Presentation		Christine Trautman, MD OB-GYN, Reedsburg Area Medical Center
Educational Presentation	Psychopharmacology Principles for Perinatal Patients	Christina Wichman, DO Periscope Project

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Agenda:

7:30 – 7:35 AM – Welcome and Introductions
-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:
To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional
Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
Psychopharmacology Principles for Perinatal Patients
June 24, 2025
Christine Trautman, MD; Christina Wichman, DO

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
- Identify risks to the fetus of in utero exposure to antidepressants.
- List the principles related to psychiatric medication use in lactation.

Policy on Disclosure
It is the policy of the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP) to identify, mitigate and disclose all relevant financial relationships with ineligible companies* held by the speakers/presenters, authors, planners, and other persons who may influence the content of this accredited continuing education (CE). In addition, speakers, presenters, and authors must disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. For this accredited continuing education activity, all relevant financial relationships have been mitigated and detailed disclosures are listed below.
** I**neligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Christine Trautman, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	6/18/2025
Christina Wichman, DO	Presenter	No relevant financial relationships with ineligible companies to disclose.	Yes	4/22/2025
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Korina Bauer, RN, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/8/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/17/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/15/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/26/2025
Rebecca Pfaff, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/6/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/29/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/31/2025
Shannan Stephens, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/10/2025

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The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1.0 ANCC contact hour(s).

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, specialty/role, and practice location in the chat.

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- The planning committee has no conflicts of interest to disclose.

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Attendance

- For attendance purposes please text the code VEPREL to 608-260-7097
- Please text for attendance, **even if you are *not* claiming** continuing education (CE) credit.
- Email Jenny for instructions on creating ICEP account for attendance and CE.

Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit.**
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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Planning Team

Korina Bauer, RN, CPM, LM – WI Guild of Midwives, Iola, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – Upland Hills Health, Dodgeville, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Rebecca Pfaff, MD – Forks Community Hosp, Forks, WA

Allegra Ponshock, MD* – Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN

Shannan Stephens, MD – Gundersen OB GYN, La Crosse, WI

Jenny White* – UW DFMCH

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* Core Facilitation Team

Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success." -** Henry Ford

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Announcements

- Next Month:

Vaginal Breech Delivery

Dennis Hartung, MD, Western Wisconsin Health

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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Psychopharmacology Principles for Perinatal Patients

CHRISTINA L. WICHMAN, DO

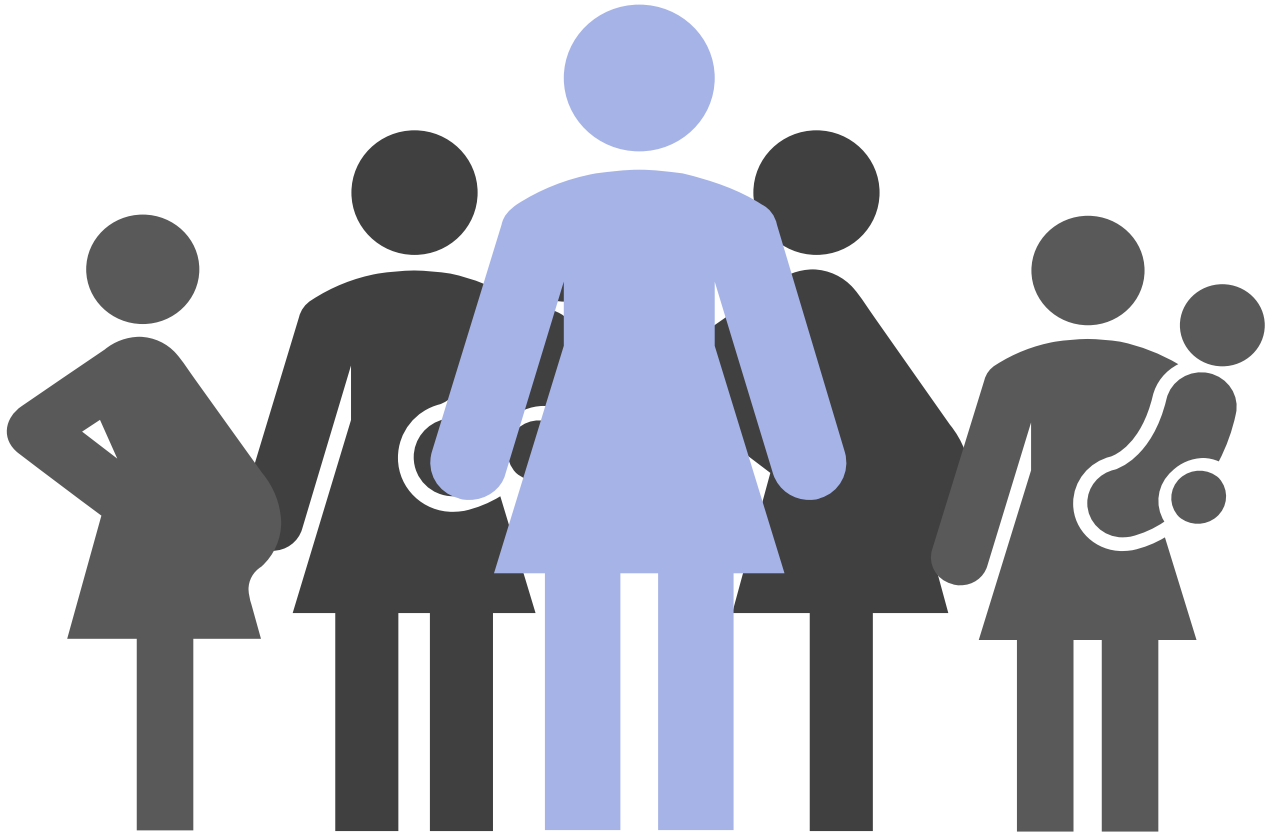
PROFESSOR OF PSYCHIATRY & OBSTETRICS AND GYNECOLOGY
MEDICAL DIRECTOR, THE PERISCOPE PROJECT

Objectives

Identify risks to the fetus of in utero exposure to antidepressants.

List the principles related to psychiatric medication use in lactation.

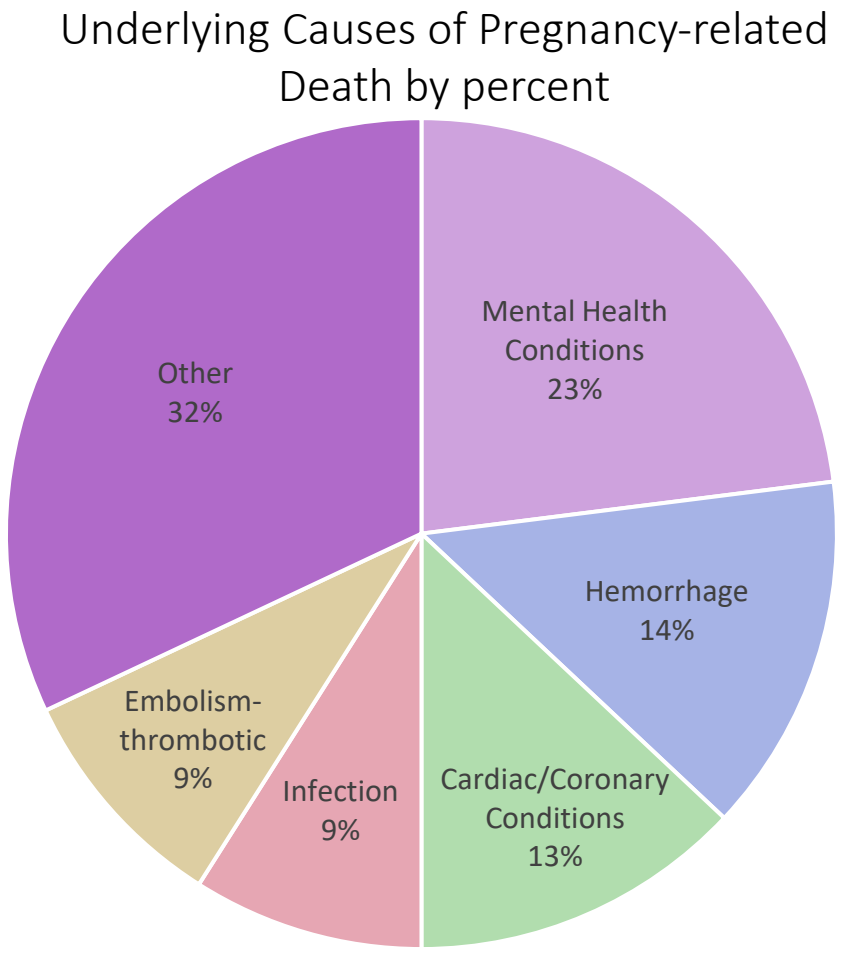
Maternal mental health is important and impacts the entire family!



1/5 Experience Mental Health Condition

75% Go Untreated

Mental Health Conditions are the Leading & Most Preventable Cause of Pregnancy-Related Death



The **highest risk of death in the perinatal period occurs 9-12 months postpartum** (suicide and overdose) – when patients are no longer under obstetrical care.

Continue to screen for mental health and substance use disorders.

DAVIS NL ET AL. PREGNANCY RELATED DEATHS: DATA FROM 14 US MMRCS, 2008-2017

Pre-conception Planning!

50% of pregnancies are unplanned in the US

ASK: “Would you like to become pregnant in the next year?”

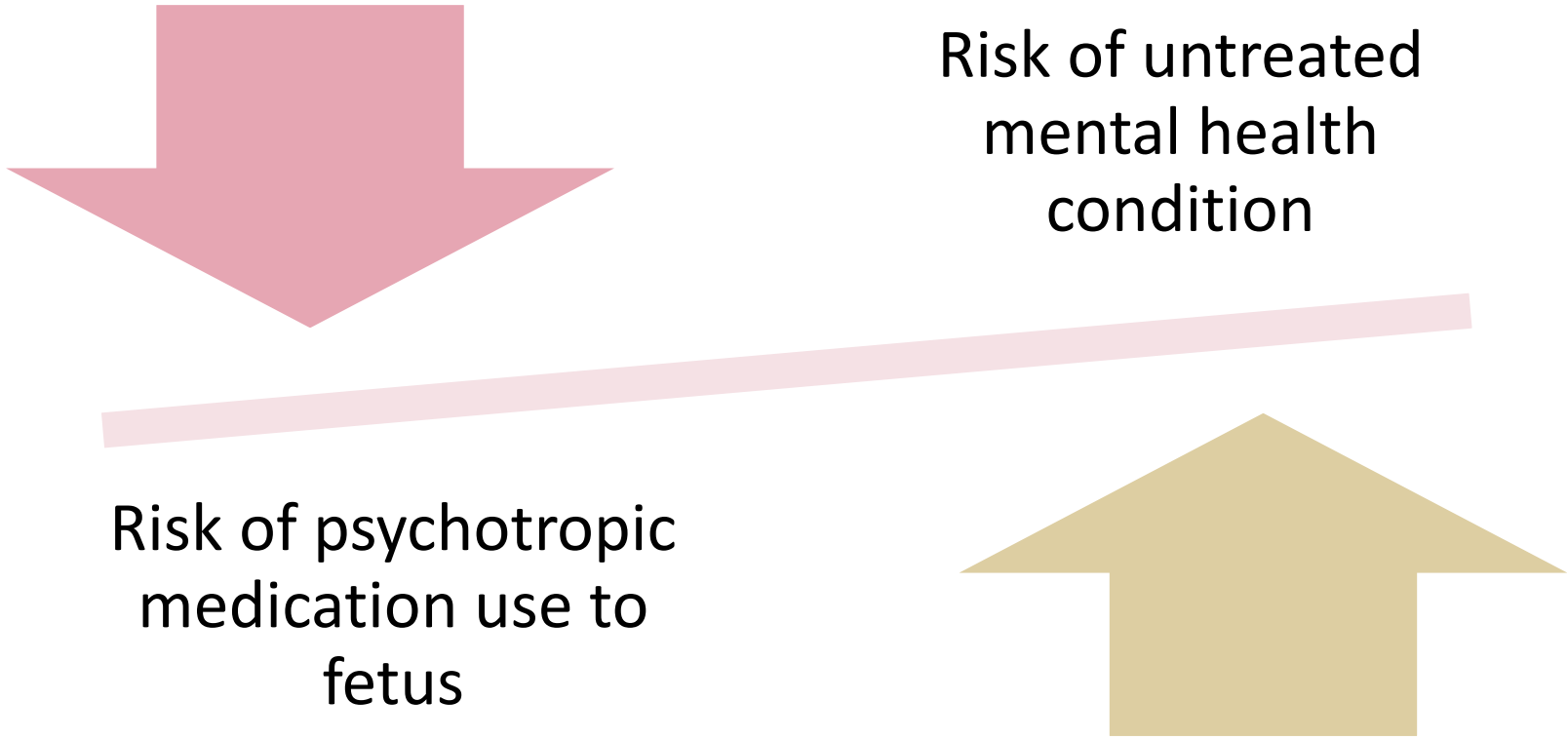
- www.onekeyquestion.org

DOCUMENT about birth control and/or conception planning

Discussion of risks at time of administration of medications, rather than awaiting conception

Encouragement of women to prescribing provider upon learning of their pregnancy prior to discontinuation of any medication

Risk – Risk Conversation



SSRI: Serotonin Specific Reuptake Inhibitors

Represent over 60-70 % of new prescriptions for depression

Easy to use and dose

High therapeutic index

Common side effects:

- Headaches
- GI upset
- Weight gain dependent on anti-cholingeric activity
- Sexual dysfunction
- Withdrawal syndrome

Fluoxetine (Prozac)

Sertraline (Zoloft)

Paroxetine (Paxil)

Citalopram (Celexa)

Escitalopram (Lexapro)

Fluvoxamine (Luvox) ***

Potential Risks of SSRI Exposure

No increased risk of major malformations

No (or very limited) risk of persistent pulmonary hypertension of the newborn (PPHN)

Untreated severe maternal depression *in utero* and during early childhood is associated with worse cognitive and behavioral outcomes than antidepressant medications

- When limited to sibling studies, no increased risks of autism in children exposed to SSRIs in utero

Most COMMON effects of SSRI use in pregnancy

Poor Neonatal Adaptation

- Occurs in 30% late-pregnancy exposed infants
- Begins minutes to hours after birth
- Lasts usually 1-4 days, Inconsistent reports of signs > 1 week
- Can occur with any antidepressant
- NOT dose dependent
- Supportive treatment only

Postpartum Hemorrhage

- Serotonin impacts platelet function

SNRIs in Pregnancy

MOA: Serotonin-norepinephrine reuptake inhibitor

October 2015 systematic review, risk of major congenital malformations after first-trimester exposure to venlafaxine or duloxetine.

- Eight cohort studies were identified
- N = 3186 exposed to venlafaxine and N = 668 exposed to duloxetine.
- Venlafaxine-exposed group = 107 major malformations
  - 3.36% risk of major malformations. RR = 1.12. 95% CI = 0.92-1.35.
- Duloxetine-exposed infants and observed 16 major malformations
  - 2.33% risk of malformations. RR = 0.80. 95% CI = 0.46-1.29.

Possible increase in miscarriage

Possible increased risk of hypertension

- Monitor BP closely with initiation
- Concern if patient becomes pre-eclamptic

No behavioral studies

Venlafaxine (Effexor)

Desvenlafaxine (Pristiq)

Duloxetine (Cymbalta)

LASSEN D. FIRST-TRIMESTER PREGNANCY EXPOSURE TO VENLAFAXINE OR DULOXETINE AND RISK OF MAJOR CONGENITAL MALFORMATION: A SYSTEMATIC REVIEW. BASIC CLIN PHARMACO TOXICOL. 2016; 118(1): 32-6

Antidepressant Use Clinical Pearls

Return to previous effective medication if appropriate.

SSRIs are first line management of depression and anxiety

- Need to reach at least mid-range dosing prior to declaration of treatment failure; high doses for management of anxiety
- Initial choice = escitalopram (Lexapro) d/t least side effects and tight therapeutic range

If failed two trials of SSRIs at appropriate doses, consider switch to another class (SNRI, TCA, mirtazapine, etc)

If partial remission, could consider augmentation with second agent

- Most commonly = bupropion or mirtazapine
- Choose based on symptoms and side effect profile

Utilize lowest EFFECTIVE dose of medication.

- Risks NOT dose dependent
- Avoid exposure to patient/fetus of symptoms and medication

Bupropion

MOA: enhances both noradrenergic and dopaminergic neurotransmission via reuptake inhibition of the norepinephrine transporter and the dopamine transporter

Indication: Major depressive disorder, smoking cessation

- Can be useful in management of mild ADHD symptoms and smoking cessation

Causes increased energy, motivation: good for “couch potato depression”

- Side effects: insomnia, decreases seizure threshold, increased jitteriness, anxiety
- Dosed in AM in order to minimize effect on sleep

No increased risk of congenital anomalies

Decreased birth weight at higher doses

Elevated rate of spontaneous miscarriage (p=0.009)

Lowers seizure threshold – possible risk in women with pre-eclampsia

CHUN-FAI-CHAN. AMER J OBSTET GYNE 2005; 192(3): 932-936.

Benzodiazepines

Early reports suggested in an increase risk of cleft lip/palate

- “Worst” data suggests rate of 0.7%, but NOT confirmed by more recent studies

UK primary care database study: 1990-2010

- Compared to 19,193 children whose mothers had diagnosed depression and/or anxiety but no first trimester drug exposures; rate of malformations = 2.7%

Toxicity in newborns

- Sedation, floppy baby syndrome, respiratory depression

Concern for potential of physiological dependence and withdrawal for infant with chronic use throughout pregnancy

Clinical use guidelines:

- Sparingly, however PRN use can be appropriate
- **Recommend less than three doses weekly**

Always and Never in Perinatal Psychiatry

Always	Maternal euthymia before, during & after pregnancy
	Treat with consistency of medication across perinatal period
	Simplify regimens before pregnancy
	Consider impact of untreated psychiatric disorder

Always and Never in Perinatal Psychiatry

Never	Taper antidepressants or check plasma levels
	Use sodium valproate (Depakote) during pregnancy
	Suggest patients defer pregnancy due to psychiatric disorder
	Switch antidepressants after conception (unless ineffective!)

Considerations in Lactation

1. Relative Infant Dose

2. Impact on breast milk supply

3. Impact on ability to parent

Relative Infant Dose (i.e. Transfer Rate)

AAP : “safe” breast-feeding ratio of infant dose exposure to maternal dose (i.e. relative infant dose (RID) < 10%

MOST psychotropic agents compatible: lithium and lamotrigine are exceptions

If taking antidepressants in pregnancy, continue the same medication during lactation to limit the infant’s exposure to a single medication

Impact on Breast Milk Supply

Any anticholinergic medication will have drying effects

- Examples: diphenhydramine, hydroxyzine, doxylamine, tricyclic antidepressants

High dose of serotonergic medications may decrease supply

Medication that impact dopamine/prolactin may impact supply

- Aripiprazole with highest risk of antipsychotics to decrease supply or cause cessation – even if only utilized in pregnancy

HTTPS://WWW.NCBI.NLM.NIH.GOV/BOOKS/NBK501016/

Impact on Ability to Parent

Primary concern is one of sedation!

If prescribing a sedating medication, need to have plan to care for infant.

- Including feeding plan if infant is exclusively breastfed via breast

Partner/support system involvement

Some examples:

- Any sleep aids
- Benzodiazepines
- Tricyclic antidepressants
- Sedating atypical antipsychotics
  - Olanzapine, quetiapine, risperidone
- Mirtazapine

Perinatal Psychiatric Access Programs are Recognized and Encouraged

Wisconsin Maternal Mortality Review Team

Providers should use Periscope or telehealth consultation services when patients present with mental health concerns to initiate treatment when possible.

American College of Obstetrics and Gynecology

Use Perinatal Psychiatry Access Programs as a resources for management and treatment guidance for individuals with mental health conditions.

THE PERISCOPE PROJECT

PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

Perinatal psychiatric access program available to providers and professionals caring for pregnant & postpartum women struggling with behavioral health disorders offered at no cost.

Real time consultation between eligible provider and perinatal psychiatrist (877-296-9049 - 8am-4pm weekdays)

Community resource information

Educational materials (live didactic, web-based presentations, toolkit)