Schlafprobleme: Pharmakologische Therapieansätze in der Schwangerschaft (und Stillzeit)

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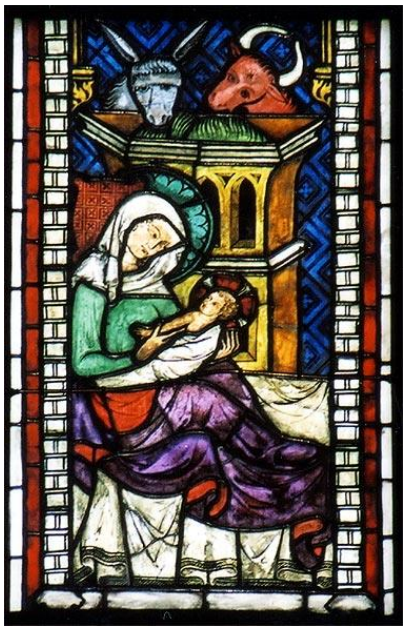

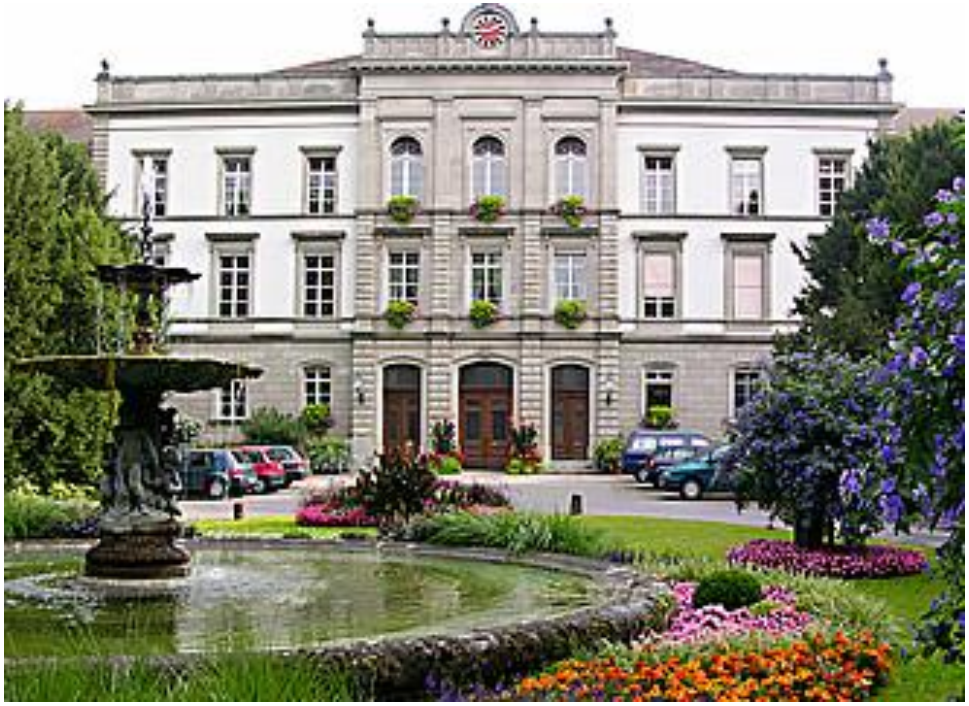

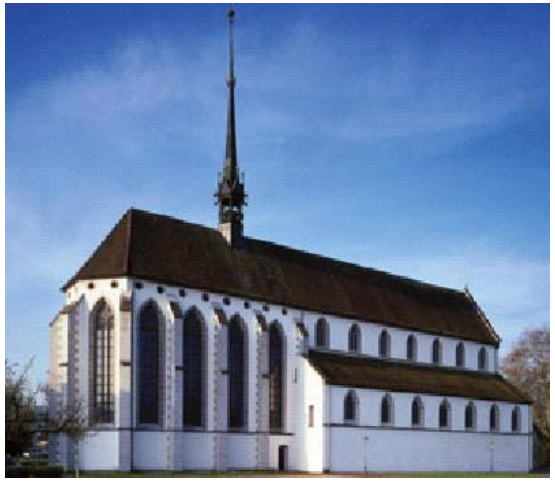

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Reasons for sleep disturbances in pregnant and postpartum women

Pregnancy related

Altered hormonal rhythm in pregnancy: e.g. estrogen decreases REM sleep, progesterone increases non-REM sleep, oxytocin, which peaks at night, causes uterine activity which contributes to insomnia during the 3rd trimester

Higher urinary frequency, backage, fetal movement, abdominal discomfort, leg cramps, heartburn

Disease related

Depression, preexisting sleep disorder, obstructive sleep apnoea, restless legs syndrome

Postpartum

Depression, child demanding care at night

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Depression, pregnancy and sleep

Prevalence of depression around pregnancy

Up to 20% of women in childbearing age (*Grigoriadis S et al., Ann Clin Psychiatry 2007;19:247-55.)*

10-15% during pregnancy and postpartum (*Bennett H et al., Obstet Gynecol 2004;103:698-709.)*

Depression in pregnancy increases risk for postpartum depression (*Robertson E et al., Gen Hosp Psychiatry 2004;26:289-85.)*

Effect of sleep on depression

Poor sleep in pregnancy is associated with postpartum depression

(Park EM et al., Arch Womens Ment Health 2013;16:539-47.)

Effect of depression on sleep

Sleep disturbances are a common feature of depression

(Sutton EL, Med Clin North Am 2014;98:1123-43.)

Incidence of pregnant women reporting disturbed sleep during pregnancy: 66-94%

(Santiago JR et al., Ann Intern Med 2001;134:396-408.)

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Depression, pregnancy and sleep

Effect of sleep disturbances on pregnancy outcome

- Women with <6h night sleep have longer labours and are 4.5 x more likely to get a caesarean delivery
- Sleep apnoea is associated with hypertension in pregnancy incl. preeclampsia, low birth weight
- Sleep disruption in first and third trimester is associated with preterm delivery

(Santiago JR et al., Ann Intern Med 2001;134:396-408.)

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Own data: Last 150 patients seen in consultation

Leading Diagnosis	**Total (n)**	**Desires child**	**Pregn.**	**Lactat.**	**Complains sleep disturb.** [% pat. with given diagnosis]	**Asks f. sleeping medication** [% pat. with sleep disturbance]
MDD/acute depression	52	13	32	7	38 [73 %]	26 [68 %]
Anxiety disorder	23	11	11	1	12 [52 %]	8 [67 %]
Bipolar disorder	16	6	8	2	9 [56 %]	5 [56 %]
Borderline	10	6	3	1	5 [50 %]	5 [100 %]
Psychotic disease	24	12	10	2	13 [54 %]	8 [62 %]
Prim. sleep disorders	6	3	2	1	6 [100 %]	6 [100 %]
Other diseases	19	7	8	4	10 [53 %]	6 [60 %]

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Treatment of sleeping disorders in pregnancy (1)

If the sleeping disturbance is due to an **underlying psychiatric disease** (depression, PTSD)

⇒ Treat the disease with the best pharmacological option for the individual patient, considering up-to-date treatment recommendations, pregnancy stage, individual medication history and teratological data

Restless legs

⇒ Folate and iron substitution. Opioids, dopaminergic or antiepileptic drugs.

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Treatment of sleeping disorders in pregnancy (2)

Respiratory problems

- CPAP, Oxigenation

Aggravation of a preexisting sleeping disorder, possibly harming mother or child:

- 1. Non- pharmacological treatment options (e.g. improved sleep hygiene, exercise, relaxation techniques, limited fluid intake in the evening, managing low back pain by massage/ heat/ pillow support; stimulus control techniques: only go to bed when sleepy…)

- 2. Pharmacological treatment options

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Psychopharmacologic treatment in pregnancy and lactation

First line

Sedating Antidepressant : **Amitriptyline, (Mirtazapine, Trazodone)**

Haloperidole in agitated psychosis

Antihistaminic: **Diphenhydramin** (do not combine temazepam and benzodiazepines!)

Second line

Benzodiazepines in single doses (avoid chronic use, be aware of floppy infant and serious adaption problems in use close to term)

Avoid

Barbiturates (teratogenic and harmful to newborn)

Zolpidem, Zopiclon, Zaleplon (breastfeeding seems to be ok with Zolpidem because of low amount excreted in breastmilk)

Chloralhydrat (chromosomal abnormalities suspected); Clomethiazol

(Riecher-Rössler A, Heck A. Psychopharmakotherapie in Schwangerschaft und Stillzeit in Riecher-Rössler A. (Hrsg): Psychische Erkrankungen in Schwangerschaft und Stillzeit, Karger 2012.)

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Benzodiazepines

First trimester

•Potential teratogenicity remains controversial, newer studies with thousands of exposed women show no teratogenicity

•Former reported risk for cleft palate (OR 2) due to concomittant anticonvulsants

•Alimentary tract atresia and pyloric stenosis are linked to 1st trimester use

2./ 3rd trimester

•Delayed development

Peripartal

•Floppy infant syndrome: Lethargy, hypothermia, respiratory depression, low APGAR- score and feeding difficulties

•Withdrawal symptoms

Lactation

In single doses acceptable, no chronic use

→If needed, lowest effective dose, short term use and short- acting drugs

Källén B et al Pharmaceuticals 2013, Eberhard M et al Drug Safety 2005; Dolovic L BMJ 1998, Briggs G et al 9th Ed, Norstedt B et al Drug Safety 2007

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