Anxiety and Panic Disorder in OB

Background
1. Definition
   o Normal anxiety
     • Universal response to danger
     • Adaptive & necessary for survival
       • Fight or flight response
   o Pathologic anxiety
     • Maladaptive response to a stimulus that does not actually represent danger
     • Associated with disturbances of serotonin, norepinephrine and GABA
2. Considerations in pregnancy
   o PTSD may develop related to traumatic obstetric event
   o Approx 10-20% of pregnant women develop extreme fear of delivery, which may be considered a type of phobia

Pathophysiology
1. Incidence/prevalence
   o Statistics in pregnancy similar to non-pregnant
   o GAD: 5%
   o PANIC: 5%
   o OCD: 2%
   o PTSD after childbirth: 1.5-6%
2. Morbidity/mortality
   o Anxiety disorders are associated with:
     • Higher incidence of pre-eclampsia
     • Pre-term delivery
     • Lower birthweight babies
     • Poor intrapartum pain control
     • Hyperemesis gravidarum is more prevalent in OCD

Diagnostics
1. History
   o Key to diagnosis, with basis in DSM-IV criteria
2. Physical exam
   o To exclude underlying medical condition
3. Diagnostic testing
   o GAD-7
     • Score of ≥10 on GAD-7 represents a reasonable cut point for identifying cases of GAD
       • This cut off provides sensitivity of 89% and specificity of 82%
       • This tool has not been specifically studied in pregnant women
   o Thyroid studies
     • Interpretation in pregnancy can be difficult to interpret due to changes in binding globulin
       • Need to get full panel and not just TSH
Differential Diagnosis
1. Unique to pregnancy
   • Supine Hypotensive Syndrome of Pregnancy
2. Hemodynamic related rhythm disorders
   • SVT and PVCs
3. Domestic violence can be exacerbated during pregnancy
4. PTSD or fear of labor and delivery

Therapeutics
1. Non-pharmacologic: 1st line
   • Thorough explanation of disorder & reassurance
   • Counseling and psychotherapy if available
     ▪ Cognitive behavioral therapy useful for panic and GAD, but not for OCD
   • Doula:
     ▪ Possibly helpful, no evidence
2. Pharmacotherapy considerations
   • General considerations
     ▪ Dose may need to be incr in 3rd trimester
     ▪ No set rules, just be aware and adjust dose to achieve symptom control
   • Acute tx
     ▪ Benzodiazepines, useful for short term Tx, but potential for abuse
       • Evidence is conflicting about whether benzodiazepines have teratogenic effects
         ▪ Risk, if any, is relatively small
       • Neonatal withdrawal symptoms, incl seizures, have been reported postpartum
   • Long-term tx
     ▪ Sertraline
       • 1st line SSRI recommended per an expert panel
     ▪ Paroxetine
       • FDA warning about exposure during 1st trimester because of an incr risk of cardiac defects (ASD and VSD)
       • This should be SSRI of last resort
     ▪ Fluoxetine
       • Weak data on poor maternal weight gain and lower birthweight and earlier gestational age at delivery
       • 2001 consensus statement recommended fluoxetine as first line pharmacotherapy, but subsequent data has implicated fluoxetine and paroxetine with complications
       • Due to some evidence of neonatal withdrawal Sx from SSRIs, tapering and discontinuation of antidepressant dose over 10 days to 2 wks before delivery date has been suggested
       • Most importantly, if using meds, one needs informed decision making and monitoring for effectiveness
         • If it doesn't work, don't use it
Prognosis
1. Findings suggest that women with PTSD entering pregnancy are at incr risk for engaging in high-risk health behaviors, such as:
   - Smoking
   - Alcohol consumption
   - Substance use
   - Poor prenatal care
   - Excessive weight gain

Prevention
1. Some evidence that counseling based interventions after a traumatic birth experience may help prevent future depression or PTSD

References
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