# Anxiety and Panic Disorder in OB

**Background**

1. Definition
    - Normal anxiety
        - Universal response to danger
        - Adaptive & necessary for survival
            - Fight or flight response
    - 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
    - PTSD may develop related to traumatic obstetric event
    - Approx 10-20% of pregnant women develop extreme fear of delivery, which may be considered a type of phobia

**Pathophysiology**

1. Incidence/prevalence
    - Statistics in pregnancy similar to non-pregnant
    - GAD: 5%
    - PANIC: 5%
    - OCD: 2%
    - PTSD after childbirth: 1.5-6%
2. Morbidity/mortality
    - 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
    - Key to diagnosis, with basis in DSM-IV criteria
2. Physical exam
    - To exclude underlying medical condition
3. Diagnostic testing
    - GAD-7
        - Score of $\geq$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
    - 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

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**Author: Philip Reilly, MD,** *Swedish FM Cherry Hill Providence Campus, WA*

**Editor: Kara Cadwallader, MD,** *Rural FMR of Idaho*