Individualized Mental Health Care is Essential in Pregnancy

Mental health conditions are real health issues that deserve appropriate and individualized medical care. Making informed healthcare decisions requires that women and their healthcare providers be aware of the available safety information for each specific medication they might be considering. We encourage pregnant women and those planning a pregnancy to have open conversations with their healthcare providers to carefully weigh any potential increased risks of medications, as well as the risks of untreated or undertreated mental health conditions.

SSRIs – including commonly prescribed medications such as Zoloft (sertraline), Lexapro (escitalopram), Prozac (fluoxetine), Paxil (paroxetine), and others – are among the most well-studied medications used in pregnancy. Decades of research have shown that SSRIs, when used appropriately and under the care of a healthcare provider, can be part of an effective treatment plan for managing mental health conditions before, during, and after pregnancy, and can contribute to better outcomes for women and their babies.

As always, MotherToBaby and the Organization of Teratology Information Specialists (OTIS) stand with women and their healthcare teams by providing up-to-date, evidence-based information on the use of medications and other exposures during pregnancy and while breastfeeding.

MotherToBaby offers free, expert-reviewed fact sheets on SSRIs and other medications, as well as on conditions such as depression, anxiety, and stress. You can find many of our mental health resources here: https://mothertobaby.org/pregnancy-breastfeeding-exposures/mental-health/. Individuals can also reach out to a MotherToBaby specialist via phone, live chat, text, or email to receive personalized, confidential support.

Individualized Mental Health Care is Essential in Pregnancy

A Guest Blog by the Allo Hope Foundation's Bethany Weathersby

I grew up in a large family, loving both the chaos and the built-in friendships that came with having four siblings. My mom had five normal pregnancies and five healthy children, and I always (naively) assumed my experience would be the same.

Seven weeks ago my dream of having five kids — just like my mom — became a reality when I delivered my fifth living child, a beautiful 8-pound boy we named August. But while my mom's path to five children was smooth and uneventful, my journey to five kids was painful, rocky and tumultuous. I found myself faced with a question I never expected I would have to answer: what do I do when my baby is attacked by my own immune system?

The Diagnosis

My first two pregnancies were free of complications as I carried and birthed two healthy boys, Liam and Asher. It was when I was 9 weeks pregnant with my third child — our first girl — that my obstetrician gave me the news I was not expecting. My first trimester blood work came back positive for anti-Kell (or anti-K) antibodies, and I now had a condition called maternal alloimmunization.

Maternal alloimmunization, commonly known as Rh disease or isoimmunization, occurs when a woman makes red blood cell antibodies after being exposed to a blood type different from her own. This exposure to a foreign blood type usually occurs during a blood transfusion or a previous pregnancy. The woman's immune system views the foreign blood as a threat and creates antibodies to destroy it. This can be a serious problem if the woman becomes pregnant with a baby who has the offending blood type. In these cases the antibodies can cross the placenta in the second or third trimester and destroy the baby's red blood cells. This is called hemolytic disease of the fetus and newborn (HDFN). HDFN can have devastating consequences for the baby, including anemia, fetal hydrops and even death.

I knew about the more common anti-D antibodies or Rh disease, which can be prevented with the administration of Rhogam, but I had never heard of anti-Kell antibodies. Anti-Kell is one of the many other red cell antibodies that are similar to anti-D, but cannot be prevented. The more I learned about my diagnosis, the more discouraged I became. I realized that while my body was growing and nurturing my daughter, it was simultaneously trying to destroy her. I felt desperate to protect her from my antibodies.

Options and Questions

I immediately began researching treatment options. I learned that women with red cell antibodies should be closely monitored and treated by a maternal fetal medicine (MFM) specialist. Antibody titers show how many antibodies are in the mother's blood. Titers are checked regularly until they reach the critical level. Once titers are critical it means that there is a risk of the baby developing severe fetal anemia. The baby can be monitored for anemia by special ultrasounds called MCA doppler scans. These scans measure how quickly the baby's blood is flowing through the middle cerebral artery in the brain. If it is flowing too quickly, the doctors know the baby is anemic and in need of a blood transfusion. Blood transfusions can be done in utero if the baby becomes anemic before birth.

The critical titer for Kell is 4. My titer was 1,024 right from the start of the pregnancy. My husband and I were terrified thinking through the possibilities.

I was referred to an MFM an hour away. In the online research I'd done to try to understand my diagnosis, I came across information about treatments called plasmapheresis and IVIG. These treatments had been used in severe cases to protect the baby from the mother's antibodies until the fetus was big enough for an intrauterine blood transfusion.

I printed off a copy of the study I found showing the efficacy of the treatments and brought it to my MFM appointment at 16 weeks. I asked if we should start the treatments to protect my baby in case she was becoming anemic. The MFM said the treatments were unnecessary and considered experimental. He also explained that they would not be checking the baby for anemia until further along in the pregnancy because nothing could be done to help anemic babies before 20 weeks. The smaller the baby, the more difficult and dangerous intrauterine blood transfusions are.

I left my appointment feeling uneasy, not knowing whether or not my baby was anemic. My mind buzzed with anxiety as I thought through my unanswered questions. I had read other women's accounts of successful intrauterine blood transfusions as early as 16 and 17 weeks gestation. Why did my doctors think that nothing could be done for my baby before 20 weeks? Why couldn't we be proactive and try the plasmapheresis and IVIG treatments I had read about online?

My fears grew day by day as I worried about my baby girl. I wanted to know exactly what was happening inside my body. Was my daughter safe and thriving? Or was my womb an unseen battleground where she fought for her life, unaided by all of us here on the outside?

I finally convinced my MFMs to do an MCA scan at 18 weeks to check our baby for fetal anemia. The results were devastating. The scan confirmed that our girl was extremely anemic and had started to develop fetal hydrops as a result. Our MFMs were not very hopeful about the outcome since the anemia was already so severe. They attempted an intrauterine blood transfusion the next day, but our little girl, Lucy Dair, died a week later at 19 weeks gestation.

Grief

Lucy was beautiful. She weighed one pound and was 9 inches long. My husband and I were completely overcome with grief. There is no pain in the world like losing a child.

To make matters worse, we not only lost our beautiful daughter Lucy; we also lost our hopes for future children all in one day. We were told that we could not have any more biological children since the antibodies tend to become more aggressive with each subsequent pregnancy.

Trying Again

Even after the doctors warned us of the dangers of future pregnancies, I could not let go of my dream for a big family. Five kids. How could we try again knowing that my own immune system would attack and possibly kill my next baby? I felt guilty for still wanting to grow my family despite having two living children while desperately wishing for better treatment options for alloimmunized women.

The plasmapheresis and IVIG treatments that we hadn't tried during my pregnancy with Lucy kept coming to mind. Could they be effective in a future pregnancy?

After many months of research, discussion and prayer, my husband and I decided to try again for another baby. This time we had a plan: we would use a different team of MFMs in a different state, and we would start plasmapheresis and IVIG treatments early in the pregnancy. Intrauterine blood transfusions can actually be done as early as 15 weeks so we would start weekly MCA scans at 14 weeks to monitor for fetal anemia.

We traveled 11 hours to Houston, Texas to find an MFM who was an expert on alloimmunized pregnancies. It turns out many women have to travel to other cities, states and sometimes even other countries in order to find MFMs who have experience treating alloimmunization and HDFN.

Our new team of doctors was extremely cautious and proactive, monitoring the baby carefully week after week. Our hope grew as the treatments seemed to be working, and, we found out we were having another baby girl.

The treatments kept her safe from my antibodies until 24 weeks when she became anemic and needed her first intrauterine blood transfusion. In total, our daughter had five intrauterine blood transfusions and was born healthy at 38 weeks. We named her Nora Juliet, our little light bringing joy back into our family. But she was also a reminder of the outcome that we could have had with Lucy if we had received the same care during my first alloimmunized pregnancy.

We went on to have two more little boys with the help of plasmapheresis and IVIG treatments as well as the help of our incredible MFMs. Our third son, Callum, had 3 intrauterine blood transfusions and was born at 34 weeks and our fourth son, August, was born at 37 weeks after seven intrauterine blood transfusions.

Hope and Advocacy

Over the years I have become an advocate for other women around the world who are facing alloimmunization and HDFN. I have seen familiar stories play out in their families: the shock of the unexpected complication, the terror that comes with a new diagnosis and the fear of not knowing how to protect their children.

Unfortunately, due to the rarity of alloimmunization and the variation in care practices around the world, well-managed pregnancies and ideal infant outcomes are not universal, but I have hope that they can be. Treatment options are improving for families facing alloimmunization. New clinical trials are underway to hopefully provide less invasive treatments for babies threatened by HDFN. In 2019, I started a non-profit organization called The Allo Hope Foundation in order to bring awareness to the disease and provide support and education to families facing alloimmunization and HDFN.

If I could go back in time to the moment I first learned about my antibodies and if I could tell myself anything it would be this: You are your baby's best advocate and you have to be her voice. With the right medical care there is hope for your baby and it is up to you to find the doctors who will provide that care. Research, learn and speak up. These antibodies do not have to determine the size of your family.

To learn more about maternal alloimmunization and HDFN visit https://allohopefoundation.org.

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If you are an athlete and/or have a physically active lifestyle, you may have wondered: 'Should my exercise routine change during pregnancy and breastfeeding?' As a former division 1 athlete and now teratogen information specialist, I sure have. You may have seen news reports about professional athletes who trained and competed at the highest level at least for some time during or shortly after their pregnancies. Serena Williams won the Australian Open while 8 weeks pregnant; Alysia Montano ran the 800 meter race at a national meet in her third trimester and Allyson Felix won a gold medal at the World Championship in track only 10 months postpartum, breaking the world record for number of gold medals won at world championships. At the same time, you may hear concerns that vigorous/strenuous physical

activity can be harmful to a pregnancy. So, what is really recommended for pregnant women who have a very physically active lifestyle?

Intense Exercise and Pregnancy

Benefits of Exercise

In general, exercise is an essential element of a healthy lifestyle and is encouraged during pregnancy as a component of optimal health. Women who frequently engaged in high-intensity aerobic activity or who were physically active before pregnancy can continue these activities during and after pregnancy. Studies show many benefits: it reduces the risk of excessive weight gain, preterm birth, low birth weight, risk of C-section and developing diabetes and high blood pressure during pregnancy. Additionally, physical activity can also help with the aches and pains of pregnancy and reduce the risk of postpartum depression. Concerns that physical activity may cause miscarriage, preterm delivery or growth problems have not been proven for women with uncomplicated pregnancies.

While exercise during pregnancy is associated with minimal risks, some changes to your routine may be necessary because of normal body changes during pregnancy. Consult with your healthcare provider to determine if/how you need to adjust your exercise routine. This is even more important for women who have pre-existing health conditions.

Level and Duration of Activity

It's important to listen to your body during pregnancy. Every pregnancy and every pregnant woman is different. The body goes through many changes during pregnancy: blood volume increases, your heart pumps harder, heart rate increases and aerobic capacity (fitness level) decreases. Additionally, many women experience nausea and fatigue throughout their pregnancy making it difficult to maintain prior exercise levels, not to mention proper nutrition and hydration. Listen to your body and don't push it past its limits.

It's difficult to compare vigorous/strenuous exercise between individuals. Jogging 10 miles may seem like a piece of cake for a marathon runner but could be extremely difficult for an Olympic lifter. For this reason, 'vigorous' activity is most frequently defined as up to 85% of capacity. While maximum effort is difficult to measure, capacity is often described in terms of maternal heart rate.

Another way to check your intensity level is the "talk test." If you're breathing hard but can still have a conversation easily—but you can't sing—that's moderate intensity. An activity would be considered vigorous if you can only say a few words before pausing for a breath.

If you were in the habit of doing vigorous-intensity exercise or were physically active before your pregnancy, vigorous exercise appears to be ok for most healthy women. However, there is limited information on individuals who exceed the accepted 85% capacity and an upper level of 'safe' exercise intensity hasn't been established.

In general, it is recommended to exercise 30-60 minutes 3-4 times a week to up to daily.

What to Consider When Exercising

- Stick with what your body is used to. If you are used to long-distance running, pregnancy is not the time to turn into a power lifter and vice versa.
- Stay hydrated. Drink plenty of fluids before, during and after exercising.
- Avoid overheating. Even if you are used to exercising in 90-degree heat with 70% humidity, you may have to look for an alternative method such as air-conditioned gyms. Don't use steam rooms, hot tubs, and saunas.
- Avoid exercises that call for you to lie flat on your back in the second and third trimester of your pregnancy because this allows less blood flow to your womb.
- Don't engage in sports where you could fall or get injured, or sports where you might get hit by a fast ball.
- Reduce weight load. There is limited data on the effects of resistance training (e.g. weightlifting) on pregnancy. There is a concern that holding your breath during heavy lifts can possibly result in baby's heart rate slowing down. Because of this, you may have to reduce the resistance load.
- Allow enough time for your body to recover after each training session.
- Make sure you have enough caloric intake. If you regularly participate in vigorous-intensity exercise, you will likely have to adjust your caloric intake to allow for appropriate weight gain for your pregnancy.
- Continue to fuel your body. Prolonged high-intensity exercise can result in low blood sugar. Make sure you fuel your body if you plan on exercising over 45 minutes.
- Check with your healthcare provider before continuing any supplements such as pre-workout protein shakes. Also, see our MotherToBaby blog on this topic.
- Stop exercising if you feel dizzy, have a headache, develop chest pain, have calf pain or swelling, have muscle cramps, or you experience vaginal bleeding, leakage of fluid, contractions or shortness of breath before exertion. Call your healthcare provider with any concerns.

Postpartum and Breastfeeding

In general, exercise can be resumed gradually after delivery as soon as it is medically safe – consult with your healthcare provider on when they may be. This may depend on mode of delivery (c-section vs. vaginal birth) and any additional health problems or complications. When exercise can be resumed varies among women, with some being able to start exercising within days after delivery.

Regular exercise has not been shown to affect breast milk production or quality and hasn't been shown to affect baby's growth either. It is extremely important to remain hydrated during breastfeeding, especially when regularly exercising. All women who are breastfeeding should also focus on the correct amount of caloric intake which may vary depending on level of activity.

Bottom line is, we are all different athletes and will all have different needs during pregnancy and the postpartum period. There is no 'one-size-fits-all' recipe for vigorous exercising during pregnancy. The best things you can do are to consult with your healthcare provider frequently and listen to your body. For more information, see our MotherToBaby Fact Sheet on exercising. You can also find some information on which foods/drinks to limit/avoid, the appropriate amount of weight to gain, and the recommended amount of exercise here.

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As a teratogen information specialist, I provide the most up-to-date information about exposures during pregnancy, breastfeeding, before pregnancy or in cases of adoption. Over the years, I have been asked questions about hair dye, heroin, and lots of things in between. I never thought I would be getting questions from multiple people about tear gas and pepper spray exposure during pregnancy. But here we are.

Protests happening in many cities in the United States right now are resulting in some exposure to riot control agents such as tear gas and pepper spray. Even if women who know they are pregnant do not participate in a protest, about 50% of pregnancies in the US are unplanned. This means some women who are participating in the protests may not even know they are pregnant at the time of exposure.

Common protest-related exposures that we have been asked about include:

Tear Gas

There are multiple chemicals in tear gas. It can cause tearing of the eyes, irritation of mucous membranes, cough, difficulty breathing and irritation to the skin. A common chemical in tear gas is called 2-chlorobenzalmalononitrile (also called o-chlorobenzylidene malononitrile or CS for short).

In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. Based on the very limited information we have, exposure to CS gas is not expected to increase the chance of birth defects over the background risk. A report looking at CS exposure found no major increases in miscarriages, stillbirths, or birth defects.

Pepper Spray

The active ingredient in pepper spray is capsaicin, a chemical that comes from chili peppers. Effects from pepper spray exposure can include irritation of the eyes, skin, and mucous membranes, coughing, and trouble breathing or speaking. Like tear gas, there is very limited information on the use of capsaicin in pregnancy and from what we do know, it is not expected to increase the chance of birth defects over the background risk. Please see our fact sheet on capsaicin for more information.

The Centers for Disease Control and Prevention (CDC) has more information on riot control agents such as tear gas and pepper spray, as well as tips on how you can protect yourself and what to do if you are exposed.

Trauma

Trauma can be caused by physical injury, such as being hit (by a hand or fist or by objects such as a baton or a rubber bullet) or falling. Trauma can also be psychological, which can stem from violence or from mental/emotional stress. There are individual reports of babies born with and without birth defects following trauma. Pregnancy outcomes may differ based on the type of trauma experienced and based on the severity of the trauma. Our fact sheet on trauma has more information.

Stress

For most of us, stress is a part of “normal” life. However, the world is anything but normal right now. While it is unlikely that stress alone will increase the chance of birth defects, being under a lot of stress over time can affect your health and well-being. Stress can increase the chance for developing conditions such as high blood pressure or depression. If you already have medical problems, stress may make them worse. If stress is causing you to have any medical problems, it’s suggested that you talk to your healthcare provider. More information about stress during pregnancy and breastfeeding can be found in our fact sheet.

COVID-19

As crowds gather, it’s important to practice social distancing and other safety techniques to prevent the spread of COVID-19. Please visit our MotherToBaby Fact Sheet on COVID-19 in pregnancy for recent information.

Of course, it’s suggested for women who are pregnant to minimize these exposures as much as possible. However, sometimes it’s unavoidable. Just know that even during these troubled times, if you have questions for us at MotherToBaby, we are here to answer them as best we can.

We’re all in this together. Please be safe out there.

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A couple of weeks ago, a friend of mine who is in her second trimester of pregnancy, called me in a panic. Due to her recent medical history, it was recommended that she get an MRI in addition to her yearly mammogram as a way to screen for breast cancer. She, like many women who have the same question, was relieved and grateful to get this information. She then asked, “do women get diagnosed with cancer in pregnancy? Can they be treated?”

What We Know about Cancer in Pregnancy

Yes, cancer occurs in about one in a thousand pregnancies every year. The most commonly diagnosed cancers in pregnancy are breast, cervical, Hodgkin’s disease, malignant melanoma, and leukemias. It can be tricky to diagnose cancer during pregnancy because common cancer symptoms such as fatigue, changes in the breasts, bloating, headaches, rectal bleeding, blotchy skin, and achy joints can also be symptoms of pregnancy.

Diagnosis

Cancer can be diagnosed in different ways, including physical exams, biopsies, blood tests, ultrasounds and pap smears – all of which are used in pregnancy. But what about other tests?

- X-rays can be used to diagnose cancer during pregnancy. The level of radiation used during an x-ray is too low to cause any known harm to the developing baby. When possible, women can use a lead shield that covers the abdomen during x-rays.
- Computed tomography (CT or CAT) scans of the head or chest do not directly expose the developing baby to radiation. CT scans of the abdomen or pelvis can be done in pregnancy if absolutely necessary.

- Magnetic resonance imaging (MRI) does not use radiation and can be used in pregnancy.

Once diagnosed, the next thing to consider are various treatment options. Cancer can be successfully treated during pregnancy, but there are some important things to think about such as the size and location of the tumor, if the cancer has spread to other body parts, how far along you are in the pregnancy, and any other health conditions you may have.

- Many medications used for cancer treatment (chemotherapeutic agents) are usually not given in the first trimester of pregnancy, because that's when a lot of the baby's development is happening. However, it's possible to use them in the second or third trimesters. This can vary based on many factors, including the medication itself.
- Surgical procedures (including using anesthesia) can usually be done during pregnancy.
- For treatments such as radiation, hormone therapy, and targeted therapies, it's often suggested to wait until after the baby is born.
- Depending on the exact treatments and medications, breastfeeding may or may not be recommended.

Thankfully, my friend's MRI is normal at this time. She was reminded to watch for any changes in her breasts and keeping an eye on any symptoms. Remember, whether you are pregnant or not, it's always best to report any concerns to your healthcare provider as soon as possible. This way you can be properly evaluated, and treated if necessary, because most of the time a healthier mom leads to a healthier baby.