Perinatal Attention-Deficit/Hyperactivity Disorder (ADHD)

Perinatal ADHD

Less common: 3-4% prevalence in adult women is unchanged during pregnancy and postpartum
Comorbidities are common: 38% with any mood disorder, 47% with any anxiety disorder, and 15% with any substance use disorder

First, confirm the diagnosis:
*Administer Adult ADHD Self-Report Scale (ASRS)—5min, positive result warrants further consideration
*Age of onset, school history
*Impairment in two or more domains
*Rule out other causes: sleep apnea, anxiety, depression, substance abuse

Possible pregnancy outcomes associated with untreated ADHD:
*miscarriage
*preterm birth
*NICU admissions

Next, assess level of impairment
Has she ever been off medications in the past? What happened?
Does she need medications to function at work or at home?
Are comorbidities worse off of medication (e.g. substance use)?
Is she more impulsive or accident-prone off meds (e.g. driving)?

Non-pharmacologic strategies for mild, moderate, and severe ADHD:
*Psychoeducation
*Cognitive Behavioral Therapy (CBT) for ADHD
*Coaching
*ADHD Support groups
*Reduce workload or other workplace accommodations if possible
*Use public transportation if driving concerns

Mild	Discontinue medication Optimize non-pharmacologic strategies
Moderate	Assess for comorbidities Optimize non-pharmacologic strategies Consider bupropion vs prn stimulant
Severe	Assess for comorbidities Continue stimulant at lowest effective dose (skip days when possible) Monitor maternal BP and weight gain Monitor fetal growth Optimize non-pharmacologic augmentation strategies

ADHD Medications in Pregnancy

	Early Pregnancy	Late Pregnancy	Breastfeeding?
Methylphenidate	No consistent association with overall defects (~5500 exposures); possible small increased risk of cardiac septal defects (NNH estimates range from 92-333); possible increased risk spontaneous abortions.	Small increased risk of preterm birth. Possible increased risk of preeclampsia, SGA, placental abruption, low Apgar score, NICU admission, CNS disorders, induced terminations	Low levels in breastmilk, undetectable in infant serum. Limited data without adverse effects.
Prescribed amphetamines	No consistent association with malformations (~5500 exposures).	Small increased risk of preterm birth and preeclampsia. Possible increased risk of SGA, placental abruption, NICU admission, CNS disorders.	Infant dose 5-15% maternal dose. Very limited data without adverse effects.
Bupropion	No consistent association with malformations (~2300 exposures).	No adverse effects (small studies)	Nursing infant exposed to 2% maternal dose; 2 case reports of seizures at 6 months
Atomoxetine	No consistent association with malformations (~450 exposures)	Mixed evidence (~700 exposures)	Unknown
Guanfacine	Too few exposures to say (~30)	Low birth weight (very small studies)	Unknown
Clonidine	No consistent association with malformations based on data from women with HTN	Reduced fetal growth	Excreted in breast milk. Adverse events reports (hypotonia, drowsiness, apnea, seizure)