

# Perinatal Attention- Deficit/Hyperactivity Disorder (ADHD)

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# Perinatal ADHD

**Prevalence:** 3-4% of adults (prevalence unchanged during pregnancy and postpartum, but may worsen with increased demands of pregnancy and parenting))

**Common Comorbidities:** Mood disorder (38%), anxiety disorder (47%), substance use disorder (15%)

**Medication Use:** Roughly 20% of pregnant people choose to continue ADHD meds throughout the pregnancy. Individuals with comorbid depression who stopped their stimulant had worsening depression despite taking an antidepressant.

## First, confirm the diagnosis:

- \*Administer [Adult ADHD Self-Report Scale \(ASRS\)](#)—5 min, 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
- \*poor maternal nutrition & decreased prenatal vitamin use

## Next, assess level of impairment:

- Have they ever been off medications in the past? What happened?
- Do they need medications to function at work or at home?
- Are comorbidities worse off of medication (e.g. substance use)?
- Are they 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
- \*Strategies (routines, lists, calendars, timers, taking breaks)
- \*Regular exercise
- \*Coaching
- \*Mindfulness-based interventions
- \*ADHD Support groups
- \*Reduce workload or other workplace accommodations if possible
- \*Use public transportation if driving concerns

<b>Mild</b>	Discontinue medication Optimize non-pharmacologic strategies
<b>Moderate</b>	Assess for comorbidities Optimize non-pharmacologic strategies Consider bupropion vs prn/scheduled stimulant
<b>Severe</b>	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?
<b>Methylphenidate</b>	No consistent association with overall defects (~6700 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. Longer-term neurodevelopment and growth data are reassuring.	Low levels in breastmilk, undetectable in infant serum. Limited data without adverse effects.
<b>Prescribed amphetamines</b>	No consistent association with malformations (~5600 exposures).	Small increased risk of preterm birth and preeclampsia. Possible increased risk of SGA, placental abruption, NICU admission, CNS disorders. Longer-term neurodevelopment and growth data are reassuring.	Infant dose 5-15% maternal dose. Very limited data without adverse effects.
<b>Bupropion</b>	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
<b>Atomoxetine</b>	No consistent association with malformations (~450 exposures)	Mixed evidence (~700 exposures)	Unknown
<b>Guanfacine</b>	Too few exposures to say (~30)	Low birth weight (very small studies)	Unknown
<b>Clonidine</b>	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)

## Perinatal ADHD References

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