Pregnancy


In all women of child bearing potential
- Always discuss the possibility of pregnancy; half of all pregnancies are unplanned
- Avoid using drugs that are contraindicated during pregnancy in women of reproductive age, (especially valproate and carbamazepine). If these drugs are prescribed, women should be made fully aware of their teratogenic properties even if not planning pregnancy. Consider prescribing folate. Its use in younger women should be treatment of last resort.

If mental illness is newly diagnosed in a pregnant woman
- Try to avoid all drugs in the first trimester (when major organs are being formed) unless benefits outweigh risks.
- If non-drug treatments are not effective/appropriate, use an established drug at the lowest effective dose.

If a woman taking psychotropic drugs is planning a pregnancy
- Consideration should be given to discontinuing treatment if the woman is well and at low risk of relapse
- Discontinuation of treatment for women with severe mental health and at a high risk of relapse is unwise, but consideration should be given to switching to a low risk drug. Be aware that switching drugs may increase the risk of relapse.

If a woman taking psychotropic medication discovers that she is pregnant
- Abrupt discontinuation of treatment post-conception for women with severe mental illness and at a high risk of relapse is unwise; relapse may ultimately be more harmful to the mother and child than continued, effective drug therapy.
- Consider remaining with current (effective) medication rather than switching, to minimise the number of drugs to which the foetus is exposed.

If the patient smokes (smoking is more common in pregnant women with psychiatric illness)
- Always encourage switching to nicotine replacement therapy, smoking has numerous adverse outcomes, nicotine replacement therapy (NRT) does not. Referral to smoking cessation services is very desirable.

In all pregnant women
- Ensure that the parents are as involved as possible in all decisions.
- Use the lowest effective dose.
- Use the drug with the lowest known risk to mother and foetus.
- Prescribe as few drugs as possible both simultaneously and in sequence.
Be prepared to adjust doses as pregnancy progresses and drug handling is altered. Dose increases are frequently required in the third trimester when blood volume expands by around 30%. Plasma level monitoring is helpful, where available. Note that hepatic enzyme activity changes markedly during pregnancy; CYP2D6 activity is increased by almost 50% by the end of pregnancy while the activity of CYP1A2 is reduced by up to 70%.

- Consider referral to specialist perinatal services
- Ensure adequate foetal screening
- Be aware of potential problems with individual drugs around the time of delivery
- Inform the obstetric team of psychotropic use and possible complications
- Monitor the neonate for withdrawal effects after birth
- Document all decisions

**NICE guidance BIPOLAR disorder**

Offer an antipsychotic in line with the recommendations in using pharmacological treatments for bipolar disorder in the NICE pathway on bipolar disorder as prophylactic medication if a woman with bipolar disorder if:

- becomes pregnant and is stopping lithium, or
- plans to breastfeed.

If a pregnant woman with bipolar disorder develops mania while taking prophylactic medication:

- check the dose of the prophylactic medication and adherence
- increase the dose if the prophylactic medication is an antipsychotic
- suggest changing to an antipsychotic if she is taking another type of prophylactic medication
- consider lithium if there is no response to an increase in dose or change of drug and the woman has severe mania
- consider electroconvulsive therapy if there has been no response to lithium.

Also see balancing risks and benefits of psychotropic medication in the pathway.
NICE recommends the use of mood-stabilising antipsychotics as a preferable alternative to continuation with a mood stabiliser

VALPROATE - Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential (who are planning a pregnancy, pregnant) or considering breastfeeding.
If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy.
If a woman is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes.

CARBAMAZEPINE - Do not offer carbamazepine to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding. If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, discuss with the woman the possibility of stopping the drug (because of the risk of adverse drug interactions and fetal malformations).

LAMOTRIGINE - If a woman is taking lamotrigine during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times.

LITHIUM - Do not offer lithium to women who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective.
If antipsychotic medication has not been effective and lithium is offered to a woman who is planning a pregnancy or pregnant, ensure guidance in NICE Guideline CG192 is followed.
If a woman taking Lithium becomes pregnant, follow the guidance in NICE Guideline CG192.
### Class of Drugs

#### Antidepressants

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk (for information only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flupentixol low dose</td>
<td>Imipramine</td>
<td>Paroxetine</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine SSRI with lowest known risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sertraline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Escitalopram</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citalopram</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mirtazapine</td>
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</tr>
<tr>
<td></td>
<td>Paroxetine</td>
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</tr>
</tbody>
</table>

Consider the risk of discontinuation with most tricyclic, SSRI and SNRI’s, in particular paroxetine and venlafaxine.

**St Johns Wort** is a popular herbal remedy on sale to the public for treating mild depression. It should not be prescribed or recommended for depression because it can induce drug metabolising enzymes and a number of important interactions with conventional drugs, including antidepressants, have been identified. Furthermore, the amount of active ingredient varies between different preparations and switching from one to another can change the degree of enzyme induction. If a patient stops taking St Johns Wort, the concentration of interacting drugs may increase, leading to toxicity.

#### Antipsychotics – recommendation:

Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication. If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic. When assessing risks/benefits of antipsychotics for a pregnant women, consider risk for gestational diabetes and excessive weight gain.

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk (for information only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>Quetiapine IR</td>
<td></td>
</tr>
</tbody>
</table>

1. Lower Risk
2. Moderate Risk
3. Higher Risk (for information only)
<table>
<thead>
<tr>
<th>Anxiolytics &amp; Hypnotics</th>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk (for information only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zolpidem (^2) – MHRA advise short term use only</td>
<td>Zopiclone – MHRA advise short term use only Promethazine (^2,*)</td>
<td>Lorazepam Temazepam Diazepam</td>
<td></td>
</tr>
</tbody>
</table>

Advise pregnant women who have a sleep problem about sleep hygiene (including having a healthy bedtime routine, avoiding caffeine and reducing activity before sleep). For women with a severe or chronic sleep problem, consider promethazine.

Do not offer benzodiazepines to women in pregnancy and the postnatal period except for short term treatment of severe anxiety and agitation. Consider gradually stopping benzodiazepines in women planning a pregnancy, pregnant or considering breastfeeding.

**Mood Stabilisers**

NICE recommends the use of mood-stabilising antipsychotics as a preferable alternative to continuation with a mood stabiliser.

**Anticholinergics**

Procyclidine – Data are insufficient for risk assessment. NICE recommends anticholinergic drugs should not be prescribed for the extrapyramidal side effects of antipsychotic drugs except for acute short term use. Instead, the dose and timing of the antipsychotic drug should be adjusted, or the drug changed.
Anticonvulsants in Pregnancy

Recommendations for treatment of epilepsy in pregnancy (Maudsley 12th Edition)

- For women who have been seizure free for a long period, the possibility of withdrawing treatment before conception, and for at least the first trimester, should be considered.
- No anticonvulsant is clearly safer. Valproate should be avoided if possible. Women prescribed valproate or carbamazepine should receive prophylactic folic acid, ideally starting prior to conception. Prophylactic vitamin K should be administered to the mother, and neonate after delivery.
- Valproate and combinations of anticonvulsants should be avoided if possible.
- All women with epilepsy should have a full discussion with their neurologist to quantify the risks and benefits of continuing anticonvulsant drugs during pregnancy.

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk (for information only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamotrigine</td>
<td>Gabapentin</td>
<td>Valproate</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Oxcarbazepine</td>
<td>Topiramate</td>
</tr>
<tr>
<td>Oxcarbazepine</td>
<td>Levetiracetam</td>
<td>Phenytoin (folate and Vitamin K supplementation required)</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>Pregabalin</td>
<td>Carbamazepine</td>
</tr>
</tbody>
</table>

Key

1. NICE Guidance
2. Other Guidance
3. Trust Guidance
* Off Label
** Unlicensed