Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- **Valproate** (MHRA advice – updated Dec 2022; MSS13) do not use in patients of childbearing potential unless the Pregnancy Prevention Programme is in place. Ensure all patients (and parent / caregiver / responsible person, if necessary) are informed of the risks and need to avoid exposure to valproate in pregnancy.
- **Topiramate** (MHRA Advice July 2022) - anyone who is able to get pregnant should have a pregnancy test before they start topiramate treatment; effective contraception should be used while taking topiramate
- **Pregabalin** (MHRA Advice April 2022) - effective contraception should be used during treatment; avoid initiation in pregnancy unless potential benefit to the patient clearly outweighs potential risk to the foetus; continuation of pre-conception treatment should be supported by a positive benefit: risk assessment
- **Antiepileptic drugs in pregnancy** (MHRA January 2021) – comprehensive safety review

Information on what is considered **effective contraception** with potential teratogenic medicines is available from the MHRA & FSRH

In all patients of childbearing potential requiring psychotropic medication:

- Always discuss the possibility of pregnancy, plans for pregnancy and use of highly effective contraception
- Try to avoid drugs that are contraindicated during pregnancy; if these drugs are prescribed, even if pregnancy is not planned, patients should be made fully aware of their teratogenic properties (with appropriate supplements e.g., folic acid prescribed where indicated) & a pregnancy test carried out prior to initiation
- Always consider the risk of pregnancy, even if not planned; up to 50% of pregnancies are not planned
- **In all cases, the best outcome for the patient and baby occurs if the patient is well during pregnancy and this should always be considered when decisions are being made**

For planned conception:

- Discuss & record the risks & benefits of discontinuing / continuing medication i.e., risk of relapse / exacerbation vs. risk of malformations
- For drugs of known significant risk or where there is little data, consider switching to a lower-risk drug before conception but be aware that switching drugs may increase risk of relapse
- Encourage proper nutrition, exercise, lifestyle changes e.g., stopping smoking & vitamin supplementation
- Avoid polypharmacy, as synergistic teratogenicity can occur

Pregnancy:

- Avoid all drugs during the first trimester if possible unless benefits outweigh risks; the maximum teratogenic period is from days 17-60 after conception.
- Behavioural teratogenesis, subtle functional disturbances & an effect on labour & delivery may occur with drug exposure in 2nd and 3rd trimesters
- Decisions must balance the relative vs. absolute risk; in many cases the risk of relapse will be higher than the risk of foetal damage
- **Ensure all benefit vs risk discussions with patients are entered fully in the patient's medical records**
- Use the lowest possible maintenance dose and monitor effects carefully, maintaining a low threshold for reintroduction or dose increase. If non-drug treatments are not effective/appropriate, use an established drug at the lowest effective dose
- The pharmacokinetics of drugs may change in pregnancy, so dose adjustment may be necessary
- Discontinuation effects have been described in the new-born with some psychotropics, e.g., benzodiazepines, these drugs should gradually be reduced or discontinued, if possible, over the weeks before delivery is due

Unexpected pregnancy:

- Confirm pregnancy. Explain to patient that stopping or switching medication after pregnancy is confirmed does not remove the risk of foetal malformations
- If before day 17 consider immediate / temporary discontinuation of medication depending on risk to patient of loss of disease control; otherwise…
- Reduce the dose of all medicines, if possible, at least during high-risk periods
- Consider remaining with current (effective) medication rather than switching, to minimise the number of medicines to which the foetus is exposed
- Prescribe adequate dose folic acid
- Discontinue any non-essential treatments
- Do not stop lithium abruptly; be aware of abruptly stopping some SSRIs and anticonvulsants
- If after day 60, the risk of congenital malformations cannot be mitigated & decisions are less urgent

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Drug choice:

- There are no psychotropic medications licensed for use during pregnancy and breast feeding
- Prescribed medicines account for a very small proportion of abnormalities (around 5% of the total), while psychiatric illness during pregnancy is a risk factor for congenital malformations and perinatal mortality.
- Potential risks of medicines include major malformations (first trimester exposure); neonatal toxicity (third trimester exposure), longer-term neuro-behavioural effects and increased risk of physical health problems in adult life. Psychiatric illness during pregnancy also increases risk of these outcomes
- For drug specific advice see UK Teratology information service and other resources to support shared decision making; decisions should be made in partnership based on the individualised risks & benefits, and should be fully documented
- Check for changes to smoking status, dose adjustment may be necessary see MSS25 and Trust medicines & smoking guidance
- Remember to consider any potential harmful effects on the foetus/embryo of medication being taken by the male partner

Resources to support shared decision making in pregnancy & breastfeeding:

- The specialist Perinatal Community mental health teams within TEWV can offer advice on having risk vs benefit discussions about prescribing in pregnancy & breastfeeding
- Choice and medication website – includes handy charts comparing drugs for managing specific conditions e.g., bipolar disorder, ADHD and specific individual drug fact sheets
- UK Teratology information service – includes abstracts regarding specific drugs for healthcare professionals and links to sister site BUMPs (Best use of medicines in pregnancy) which has a range of patient information leaflets available.
- Access to full pregnancy information documents on specific medications, chemicals & other exposures in pregnancy is available to health care professionals only www.toxbase.org
- The Specialist Pharmacy Service offers advice for healthcare professionals on assessing risks and safe use of medicines in pregnancy & breastfeeding
- Information on prescribing medication in breastfeeding is available via LactMed and e-lactancia sites
- Breastfeeding has benefits both nutritionally and with bonding, the breastfeeding network offers practical advice

Generalised recommendations for the use of psychotropic drugs in pregnancy & breastfeeding (see Maudsley Guidelines (2021) for full details):

Psychotropic	Recommendations for pregnancy	Recommendations for breastfeeding *It is usually advisable to continue the drug that has been used during pregnancy*
Antidepressants	If at high risk of relapse maintain on same antidepressant during and after pregnancy. When initiating in a patient planning pregnancy consider previous response. Sertraline is an option.	Continue drug used in pregnancy. New initiation: Sertraline or Mirtazapine (others may be used); caution with sedation if using Mirtazapine
Antipsychotics	No clear evidence that any antipsychotic is a major teratogen. Consider using/continuing drug that mother has responded to rather than switching. Arrange screening for adverse metabolic effects. Regular monitoring of clozapine plasma levels may be recommended by the monitoring service if continued during pregnancy.	Continue drug used in pregnancy. If clozapine: continue & inform monitoring service, but advise **against** breastfeeding New initiation: olanzapine or quetiapine (others may be used)
Mood stabilisers	Stop valproate if planning pregnancy or becomes pregnant – see MSS13 Consider using a mood-stabilising antipsychotic rather than anticonvulsant drug Avoid anticonvulsants unless consequences of relapse outweigh the known effects of teratogenesis	Continue drug used in pregnancy. Lithium: continue but advise **against** breastfeeding. New initiation: mood-stabilising antipsychotic; olanzapine or quetiapine
Sedatives	Non-drug measures preferred	Best avoided. Use drug with short half-life. Lorazepam may be considered.

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