Prescribing psychotropic medication in women of child bearing potential (including girls & young women under the age of 18)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Valproate medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme is in place. Ensure all women and girls (and their parent, caregiver, or responsible person, if necessary) are fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy. MHRA April 2018 – see TEWV Medication Safety Series

In all women of childbearing potential requiring psychotropic medication:

- Always discuss the possibility of pregnancy, plans for pregnancy and contraception
- Try to avoid drugs that are contraindicated during pregnancy; if these drugs are prescribed, even if pregnancy is not planned, women 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

For planned conception:

- Discuss & document the risks & benefits of discontinuing /continuing medication e.g. relapse, teratogenicity
- 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 second & third trimester
- Decisions must balance the relative vs. absolute risk; in many cases the risk of relapse will be higher than the risk of foetal damage
- Use the lowest possible maintenance dose & 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, if before day 17 consider immediate/temporary discontinuation
- Explain to patient that stopping or switching medication after pregnancy is confirmed, may not remove the risk of foetal malformations
- If after day 60, the immediate risk has passed & decisions are less urgent
- Prescribe adequate dose folic acid
- Reduce the dose if possible, at least during high risk periods
- Consider remaining with current (effective) medication rather than switching, to minimise the number of drugs to which the foetus is exposed
- Discontinue any non-essential treatments
- Do not stop lithium abruptly; be aware of stopping some SSRIs & anticonvulsants

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Drug choice:

- There are no psychotropic medications licensed for use during pregnancy and breast feeding
- Drugs account for a very small proportion of abnormalities (around 5% of the total) & psychiatric illness during pregnancy is a risk factor for congenital malformations & perinatal mortality.
- Potential risks of drugs include major malformation (first trimester exposure); neonatal toxicity (third trimester exposure), longer-term neurobehavioural effects and increased risk of physical health problems in adult life
- For drug specific advice see current **BNF** and resources to support decision making below; decisions should be made in partnership based on the individualised risks & benefits.
- Remember to consider any harmful effects of medication on the foetus/embryo for men trying to father a child

Resources to support shared decision making in pregnancy & breast feeding:

- 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

Generalised recommendations for the use of psychotropic drugs in pregnancy & breastfeeding (see Maudsley, 2018 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 woman planning pregnancy consider previous response. Sertraline is an option.	Continue drug used in pregnancy. New initiation: Sertraline or Mirtazapine (others may be used)
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.	Continue drug used in pregnancy. If clozapine: continue, but advise against breastfeeding New initiation: olanzapine or quetiapine
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.