Guidelines for the use of Psychiatric Medications During Pregnancy and Lactation

It is estimated that more than 500,000 pregnancies in the United States each year involve women who have psychiatric illnesses that either predate or emerge during pregnancy, and an estimated one third of all pregnant women are exposed to a psychotropic medication at some point during pregnancy (2). For these women and their physicians, there is much to consider when deciding if and when to use psychotropic medications during pregnancy. Risks of the medication to the unborn infant must be balanced against risks to the mother and fetus if the behavioral health illness is left untreated.

The American College of Obstetricians and Gynecologists (ACOG) has developed a practice bulletin on the clinical management guidelines for using psychiatric medication during pregnancy and lactation (1). It is designed to support physicians so that they may make informed decisions about the risks and benefits associated with medication usage in pregnancy. The information below is summarized from this bulletin and other references noted below. It is intended as a resource for physicians to use when making recommendations to members.

In many cases, the overall benefit to women who become pregnant while on psychotropic medication is greater than the risk, and being maintained on medication is appropriate. Maternal psychiatric illness, if inadequately treated or untreated, may result in poor compliance with prenatal care, inadequate diet, increased alcohol and tobacco use, deficits in mother-infant bonding, disruptions within the family environment and increase risk for postpartum symptoms and suicide attempts.

General recommendations / conclusions include:

- Whenever possible, multidisciplinary management involving the obstetrician, mental health clinician, primary health care provider, and pediatrician is recommended to facilitate care.
- A single medication at a higher dose is favored over multiple medications for treatment of a psychiatric illness during pregnancy.
- When possible, avoid changing medications unless necessary as multiple medications increase the exposure to the unborn infant.
- The selection of medication to minimize the risk of illness should be based on history of efficacy, prior exposure during pregnancy, and available reproductive safety information.
- Medications with fewer metabolites, higher protein binding (decreases placental passage), and fewer interactions with other medications are preferred.
- Before prescribing medication to a pregnant woman, document all fetal exposures (alcohol, over the counter and prescribed medications, environmental) in the record. This information is crucial to avoid assignment of causality to a prescribed medication in the event of a poor pregnancy outcome.

In addition, the FDA recently released a statement that they are proposing the letter

categorization of medication safety during pregnancy and breast-feeding be replaced with a systematic review of the data of each medication in pregnancy. The new labeling system would include a fetal risk summary, clinical considerations, and a discussion of the data based on the human and animal study evidence.

Antidepressant considerations include:

- Treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy should be individualized.
- Findings suggest that individual SSRIs may confer increased risks for some specific defects, specifically with paroxetine exposure. But it should be recognized that the specific defects are rare and the absolute risks are small (3).

Mood stabilizer considerations include:

- Lithium exposure in pregnancy may be associated with a small increase in congenital cardiac malformations, with a risk ratio of 1.2–7.7.
- Fetal assessment with fetal echocardiogram should be considered in pregnant women exposed to lithium in the first trimester.
- Valproate exposure in pregnancy is associated with an increased risk of fetal anomalies, including neural tube defects, fetal valproate syndrome, and long term adverse neurocognitive effects. **Valproate should be avoided in pregnancy, if possible,** especially during the first trimester. If used, the patient should be on 4mg of folate daily.
  •Carbamazepine exposure in pregnancy is associated with fetal carbamazepine syndrome. **Carbamazepine should be avoided in pregnancy, if possible**, especially during the first trimester. If used, the patient should be on 4 mg of folate daily.
  •Topiramate in the first trimester of pregnancy, alone or in combination with other epilepsy medications, may increase the risk of birth defects including cleft palates or cleft lips (4).
- Lamotrigine is a potential maintenance therapy option for pregnant women with bipolar disorder because of its protective effects against bipolar depression, general tolerability, and a growing reproductive safety profile relative to alternative mood stabilizers. There is a small risk of oral cleft palate. If used, the patient should be on 4 mg of folate daily.

Benzodiazepine considerations include:

- Prenatal benzodiazepine exposure increased the risk of oral cleft, although the absolute risk increased by 0.01%.
- Maternal benzodiazepine use shortly before delivery is associated with floppy infant syndrome.

Antipsychotic considerations include:

- Safety data regarding the use of atypical antipsychotics is extremely limited. However, treatment is often indicated when members are pregnant and psychotic.
- High potency typical antipsychotics are preferred. There are reports though

of extrapyramidal effects in infants exposed to these medications.
•The use of atypical antipsychotics should be individualized to each patient.

- No specific antipsychotic (typical or atypical) has emerged as clearly having less adverse reproductive effects than any other.

The November 2007 issue of the ACOG bulletin (1) provides more detailed information on the medication management options for the treatment of Major Depression, Bipolar Disorder, Anxiety Disorder, and Schizophrenia.

The treatment of behavioral disorders, such as major depression, during pregnancy can be accomplished safely and, according to ACOG and others, should be pursued fully according to the above guidelines. In many situations, the benefits outweigh the risks if used for selected women in these ways.

Assistance in managing behavioral health (BH) conditions during pregnancy can be obtained through your patient's BH-MCO (if on Medicaid) or through the Pennsylvania Psychiatric Society's "Psychiatrists On Call" program at 1-800-422-2900.

1 *Use of Psychiatric Medications During Pregnancy and Lactation. ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician- Gynecologists, November 2007, Number 87.*

2 *Doering PL, Stewart RB. The extent and character of drug consumption during pregnancy. JAMA 1978;239: 843–6.*

3 *Louik C, Lin AE, Werler MM, Hernandez-Diaz S, Mitchell AA. First-Trimester Use of Selective Serotonin-Reuptake Inhibitors and the Risk of Birth Defects. N ENGL J MED 2007;356: 2675-83.*

4 *Hunt S, Russell A, Smithson WH, Parsons L, Robertson I, Waddell R, Irwin B, Morrison PJ, Morrow J, Craig J. Topiramate in pregnancy: Preliminary experience from the UK Epilepsy and Pregnancy Register. NEUROLOGY 2008; 71:272-276.*