TOP TIPS USING PSYCHOTROPIC MEDICATION IN THE PERINATAL TIME

Using medication to treat mental health problems in pregnancy and the postnatal time is a complex area that many GPs may find pushes the limits of their knowledge and understanding. It is imperative that GPs recognize these limits and where appropriate, look to find further information from colleagues in perinatal psychiatry, medicines information team, or online from resources such as:

- **UK Teratology Information Service:**

- **BUMPS - patient facing information about drug use in perinatal time:**
  - [http://www.medicinesinpregnancy.org/Medicine--pregnancy/](http://www.medicinesinpregnancy.org/Medicine--pregnancy/)

- **Lactmed: US based website re medication in breastfeeding**

- **UK Drugs in Lactation service:**
  - [http://www.midlandsmedicines.nhs.uk](http://www.midlandsmedicines.nhs.uk)

- **The Breastfeeding Network:**
  - [https://www.breastfeedingnetwork.org.uk/](https://www.breastfeedingnetwork.org.uk/)

**Antidepressants:**

Although no antidepressant has a specific license to be used during the perinatal time there are some options considered safer than others with most but not all SSRIs being the most often chosen. Approximately 7/10 women who stop taking antidepressants in pregnancy will relapse at some subsequent point (1) and so women should be advised to not stop medication they are taking for mental health issues without discussing first with their GP. It is important that GPs counsel women against sudden cessation of antidepressants during the perinatal time as this may lead to relapse or withdrawal symptoms. If women stop medication at the time of delivery there is risk the infant may suffer neonatal abstinence syndrome which may present as irritability, tremor, muscle weakness, persistent crying and difficulty in sucking/sleeping (2).

There has been some association with exposure to SSRIs in pregnancy and unwanted consequences for infants but the evidence to support these associations is far from robust.
Studies in this area are often large but observational therefore causation cannot be proven and confounding bias impossible to exclude.

MHRA advice in 2014 (3) included discussion of the risks of Persistent Pulmonary Hypertension of the Newborn (PPHN) which has a background incidence 1-2/1000 which rises to about 5/1000 with exposure to SSRIs in utero, particularly after the 20th week. PPHN presents within the first 24 hours of life and symptoms include tachypnoea, poor feeding, poor sleep, a blue tinge to the skin and vomiting. The mechanism of action of SNRIs is similar so although there is no similar evidence to support an association, it is thought that a similar risk exists.

The evidence base looking for causal association of SSRI exposure and congenital malformations in the infant exposed the drug is complex with several conflicting messages. However a systematic review of 23 studies covering the last 5 decades found that exposure to paroxetine in the first trimester may be associated with a slight increase in risk in malformations particularly cardiovascular and so use is usually avoided in the pregnancy (4).

One area of debate is the association between SSRIs and autistic spectrum disorder. Again the data is complex and there are many confounding factors that make interpretation of some trial data more difficult. There is no definitive proof of a causal link currently but even if a statistical association is found, the absolute risks are likely to be low.

These are only a few of the areas of discussion around the subject and part of the challenge is that the evidence base is constantly expanding with 120 papers published last year on antidepressants in pregnancy alone. It is not feasible for GPs to keep up with the latest evidence and so they need to know how to access the latest advice and the above references will help.

For further education in prescribing in this area there are 5 e-learning modules available open: http://www.e-lfh.org.uk/programmes/perinatal-mental-health/open-access-sessions/

**Antipsychotics:**

The initiation, support and repeat prescribing of antipsychotics in the perinatal time remains within the remit of secondary care. There is limited data on the safety of these drugs in pregnancy and the postnatal period. Women taking these medications should be referred to specialist services ideally preconception but otherwise as soon as possible after presenting pregnant to a GP or health professional. They will need information and advice on the safety profile within pregnancy and after particularly if they intend to breastfeed. It may be the psychiatry team recommends a switch to a more appropriate drug and this is preferable to do before conception. In addition, the risk of gestational diabetes and excessive weight gain should be assessed and monitored throughout pregnancy in accordance to NICE guidance involving obstetric colleagues as necessary.

**Mood Stabilisers:**

The initiation, support and repeat prescribing of mood stabilisers in the perinatal time remains within the remit of secondary care. Women taking these medications should be referred to
specialist services ideally preconception but otherwise as soon as possible after presenting pregnant to a GP or health professional. They will need information and advice on the safety profile within pregnancy and after particularly if they intend to breastfeed. It may be the psychiatry team recommends a switch to a more appropriate drug and this is preferable to do before conception.

Importantly new guidance advises against prescribing sodium valproate and carbamazepine in a woman of child potential due to the high risks of teratogenicity. If a woman is already taking antiepileptic mood stabilisers for a mental health problem and she becomes pregnant, she should be urgently referred to psychiatric services (for a medication review) and obstetric services (for fetal monitoring). Current evidence suggests up to 10% of infants exposed to valproate in utero may develop congenital abnormalities including cardiac and up to 40% may develop neuro-developmental problems such as autism (5).

Lithium is not considered first line in women who are planning a pregnancy or who are already pregnant due to the risk of congenital cardiac malformations from exposure in the first trimester. It is important to advise women that the levels may be high in breast milk with a risk of toxicity and levels are needed throughout the pregnancy and postnatal period (2).

**Practical Prescribing Considerations:**

When discussing the use of psychotropic medication in the perinatal time it is helpful to frame the conversation around the four points NICE highlight in their guidance in 2014 (2).

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly.

In addition other factors to be taken into consideration include the stage of pregnancy, the severity of symptoms, any previous response to medication, any previous side effect of medication, the risk of continuing to woman/fetus/infant, the risk of sudden cessation to woman/fetus/infant and above all – patient preference (2).

Intention to breastfeed is important to ascertain as it may affect choice of medication and dosing particularly if the infant is born smaller than expected with IUGR or Preterm as the bioavailability of the drug may differ. As well as highlighting the benefits of breastfeeding, GPs should discuss the potential risks with taking psychotropic medication and treatment options that allow continuation of breastfeeding. There is an excellent piece in the Toolkit on Infant Feeding to be found in section 4 to support this approach highlighted in NICE guidance.
Once a decision to prescribe has been made, the following approach suggested by NICE may be helpful (2):

- choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication
- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to 2 or more drugs

References:

1. [http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx](http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx)
2. NICE guidance CG192 Antenatal and postnatal mental health, 2014
   a. [https://www.nice.org.uk/guidance/cg192](https://www.nice.org.uk/guidance/cg192)
3. 4. Medicines and Healthcare Products Regulatory Agency (MHRA). Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs): use and safety. London: MHRA; 2014

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