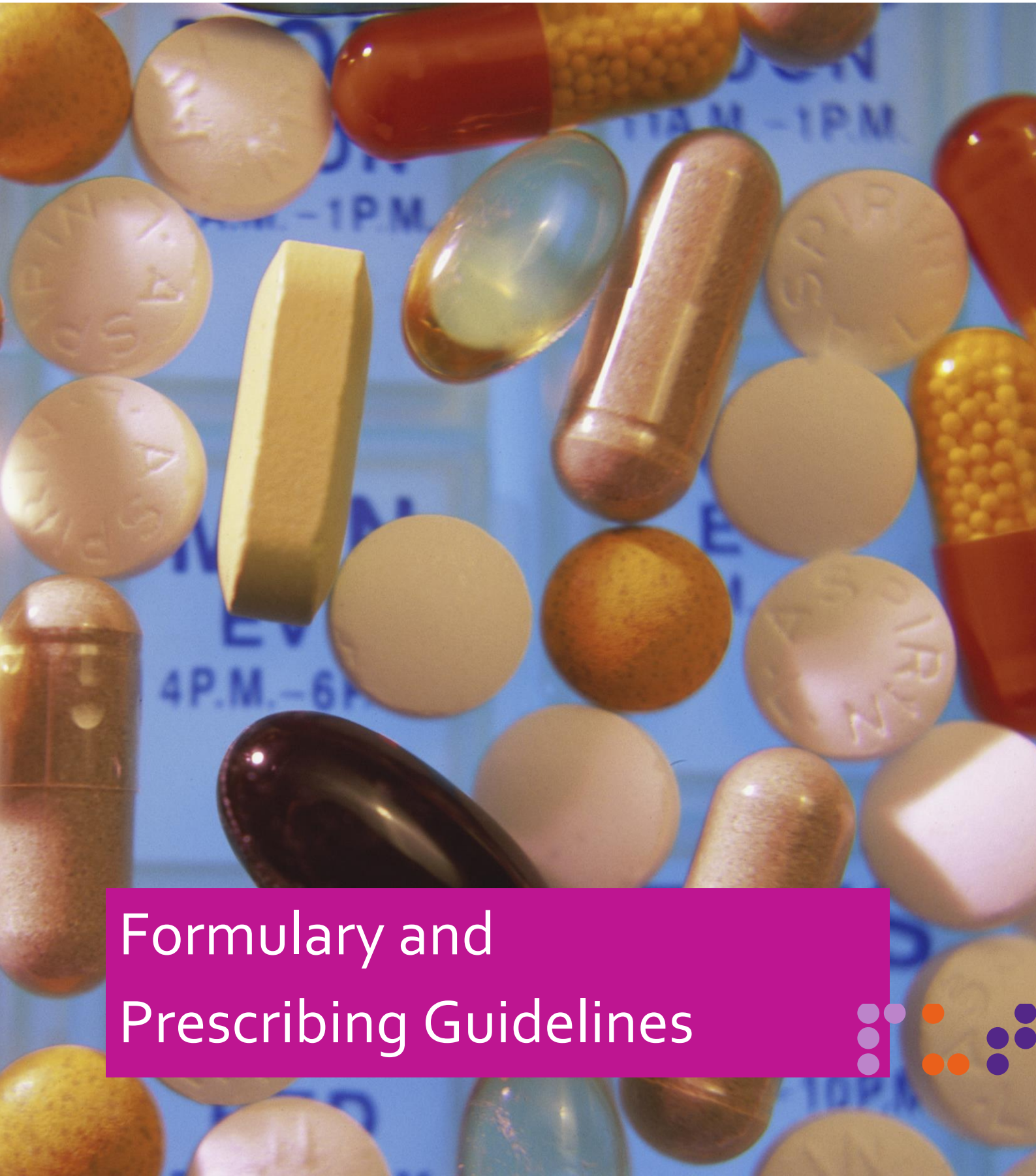
Essex Partnership University
NHS Foundation Trust

SECTION 20: PRESCRIBING IN WOMEN OF CHILD BEARING POTENTIAL INCLUDING USE DURING PREGNANCY AND BREAST FEEDING



Formulary and Prescribing Guidelines

20.1 Introduction

Significant numbers of pregnancy remain unplanned and a plans for starting a family can change very quickly. Pregnancy and the post-natal period remains a significant risk factor for precipitating a mental health condition in parents, including development of crisis situations. It is therefore always important to always consider the risk that a woman of child bearing potential may become pregnant and consider any future wishes when starting or reviewing their mental health treatment.

This guidance is intended only as a quick-reference guide and must be used in conjunction with other resources when making treatment decisions. Refer to NICE CG192 Antenatal and postnatal mental health: Clinical management and service guidance[1] and other specific guidelines where appropriate, for example the UKTIS UK Teratology Information Service, and the BAP consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum [9]. Please also refer to the section on further resources at the end of the document

Psychiatric disorders are more common in women at the reproductive age. In addition to morbidity, psychiatric illness during pregnancy is an independent risk factor for congenital malformations and perinatal mortality. Mood disorders increase the risk of pre-term delivery. The safety of psychotropic drugs in pregnancy cannot be clearly established due to lack of research and clinical trials in this specialist group. Lifestyle factors including smoking, alcohol abuse and poor eating habits can affect the outcome of a pregnancy. Concurrent use of psychotropic drugs during pregnancy may be associated with congenital malformation, long term neurodevelopmental problems and/or neonatal withdrawal symptoms depending on the agent. Most psychotropic drugs are excreted in the breast milk to some extent. It is therefore imperative, the prescriber evaluates the risks and benefits associated with all available treatments and discusses them with the service user before a treatment decision is made.

Note: there is only very limited evidence and information regarding the teratogenic potential of medicines taken by men, with the majority of medicines not thought to confer any significant risk therefore this guidance will focus on the use of medicines in women.

20.1.1 In all girls and women who are currently pregnant

- Inpatient: Add dates/stage of pregnancy to the NOTES section on the front page of the inpatient drug chart or to the patient's warning note section on ePMA, where in use. For example "PREGNANT - SECOND TRIMESTER. CURRENTLY 18 WEEKS PREGNANT, 9/5/22."
- Inpatient: Document dates/ stage of pregnancy in the electronic patient record, at least at every weekly review.
- Outpatient: Document dates/stage of pregnancy in the electronic patient record, as part of the record of the appointment. Include details of pregnancy in the healthcare related correspondence after the appointment.

20.1.2 In all girls and women who are in the first 12 months after birth

- Document breastfeeding status in both healthcare records and in the notes section on medicines charts or patient's warding notes section on ePMA, where in use.
- This should be checked at regular intervals during reviews and at appointments with any changes noted.

- Record is to be made in the following format:
    - DATE XX/XX/XX Patient is breastfeeding
    - DATE XX/XX/XX Patient is not breastfeeding
    - DATE XX/XX/XX Patient is combination feeding

20.1.3 In all girls and women of child bearing potential, including those who are pre-menarche

- Always discuss the possibility of pregnancy. Unplanned pregnancies are more common in women with psychiatric disorders. Refer to Appendix 1
- Always consider the risk of future pregnancy when considering and discussing the treatment options with the person as this will help ensure the most appropriate medicine is in place should a future pregnancy occur.
- Review the persons current and future plans at each review, but be aware of the risk of unplanned pregnancy
- Refer patients actively planning a pregnancy for pre-conception advice to the perinatal service (see contact details in the resources section)
- Do not offer drugs that are contra-indicated during pregnancy in women of reproductive age (especially valproate, topiramate, pregablin and carbamazepine – risk of birth defect 2-3 times higher).
- If these drugs are prescribed, a risk assessment should be undertaken and the person should be made fully aware of their teratogenic properties even if not planning a pregnancy.
- The GP should be contacted to provide appropriate contraceptive advice and the need for using folic acid supplements when necessary. Contraception should be in place prior to starting any potentially teratogenic medicine
- For valproate refer to specific guidance published by MHRA, and the clinical guideline for the management and review of valproate in female patients (CG96) see also section 20.8 below.

20.2 General principles of prescribing in pregnancy

20.2.1 Newly diagnosed mental health condition

- Discuss changes in risk: benefit ratio of pharmacological interventions as a result of pregnancy. Medicines should only be used in the first trimester (when major organs are being formed) after a full discussion with the patient and where appropriate any family members or carers and where it is agreed that the potential benefit outweighs any risk.
- Psychological interventions should be offered
- If psychological treatments prove ineffective, use an established drug at the lowest effective dose based on the most up to date information.

20.2.2 Service user using psychotropic drug(s) planning a pregnancy

- Pre-conception counselling with the perinatal service should be offered to all service users

- Consideration should be given to discontinuing treatment if the woman is well and at low risk of relapse. The risk of relapse however, always needs to be considered especially if the treatment is stopped abruptly.

- Discontinuation of treatment in women with a SMI (serious mental illness) and at a high risk of relapse is unwise. Consideration should be given to switching to a lower risk drug at the lowest effective dose however the risk of destabilising and causing relapse also needs to be taken into account. If discontinuation or switching is agreed his should be carefully planned and the prescriber should be aware that switching agents may increase the risk of relapse.

- Consider the risk of medicines in breastfeeding, particularly if starting a new medicine in a person who is trying to conceive.

20.2.3 Service user using psychotropic drug(s) has unplanned pregnancy

- Abrupt discontinuation of treatment post-conception for women with a SMI and at a high risk of relapse is not recommended; relapse may ultimately be more harmful to the mother and child than established drug therapy and discontinuation symptoms can occur.

- Consider remaining with current (effective) medication rather than switching, to minimise the number of drugs to which the foetus is exposed.

- Women who take multiple medications should be reviewed to establish whether all medicines need to be continued. The lowest number of medicines that are able to keep the patient well and stable should be prescribed.

- Seek advice from EPUT's specialist perinatal mental health service (see details in further information at the end of this document) if there is uncertainty about the risks associated with specific drugs

- All decisions should be documented.

20.3 General principles of prescribing psychotropic drugs in breast-feeding

- In each case, the benefits of breastfeeding to the mother and infant must be weighed against the risk of drug exposure in the infant
- Consider the risk of sedative medicines on both the parent and infant and inform parents not to co-sleep if using medicines that can have a sedative effect.
- Premature infants and infants with renal, hepatic, cardiac, or neurological impairment are at a greater risk from exposure to drugs. Infants should be monitored more intensively for adverse effects to drugs. Feeding patterns (e.g.

does the baby need to be woken to feed, adequate feeding response, is there adequate attachment), weight gain, growth and development should also be monitored. If the baby is distressed, is not settling after usual soothing techniques, nappy change or being fed then parents should seek advice from the midwife, health visitor or GP.

- In most cases where a medicine has been used throughout pregnancy it can be continued during breast feeding as the exposure is likely to be lower
- It is usually inappropriate to withhold treatment to allow breastfeeding where there is a high risk of relapse. Treatment of maternal illness is the highest priority. Timing feeds to avoid peak drug levels in breast milk or expressed milk may reduce associated risks however this can be very difficult to do in practice especially in the first few weeks, but can be used if they are concerned about limiting the amount of medication in breastfeeding. The use of combination feeding can also be considered and discussed.
- NICE recommends that reference should be made to the UK Drugs in Lactation Advisory Service, and a specialist perinatal mental health service (e.g. EPUT Perinatal Mental Health Service) for information on the use of specific drugs in breastfeeding.

20.4 Rapid tranquillisation

When choosing an agent for rapid tranquillisation in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered if non pharmacological, de-escalation techniques fail. If an antipsychotic is used, it should be at the minimum effective dose because of extrapyramidal symptoms. If a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account.

For further information on the use of rapid tranquilisation in pregnancy see the joint BAP and NAPICU https://napicu.org.uk/wp-content/uploads/2018/06/BAP-and-NAPICU-joint-guideline.pdf

20.5 Antipsychotics

20.5.1 Risks to consider

- There is growing information about the use of antipsychotics in pregnancy, whilst there is more information for certain antipsychotics such as olanzapine and quetiapine evidence does not suggest any significant difference between antipsychotics and therefore choice is often based on the patient's choice, prior history and relative adverse effects however up-to-date information should be checked at the time of prescribing.

- Raised prolactin levels with some antipsychotics (such as amisulpride, risperidone, paliperidone, sulpiride, phenothiazines and butyrophenones). Consider a prolactin sparing antipsychotic e.g. Aripiprazole

- Gestational diabetes and weight gain with all antipsychotics, especially olanzapine. Offer advice about diet and monitor for excessive weight gain. People

with a BMI above 30kg/m2 are advised to take 5mg of folic daily acid prior to conception and for the first 13 weeks of pregnancy. See https://www.rcog.org.uk/for-the-public/browse-our-patient-information/being-overweight-in-pregnancy-and-after-birth-patient-information-leaflet/ for further information

- Agranulocytosis in the foetus (theoretical) and breastfed infant with clozapine.

- A recent Europe-wide review[3] has concluded there is a risk of EPSE or withdrawal symptoms (or both) in new-borns after maternal use of antipsychotics during the 3rd trimester.

20.5.2 Actions to take

- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org, and from the Choice and Medication website www.choiceandmedication.org/eput

- Advise women taking antipsychotics who are planning a pregnancy that raised prolactin levels reduce the chances of conception. If there are side effects and levels are raised consider an alternative drug

- Doses prescribed should be kept as low as possible whilst still achieving a clinical response

- Due to the limited evidence do not offer long-acting injectable (LAI) antipsychotics to a woman who is planning a pregnancy, pregnant or considering breast feeding unless responding well to a LAI and has a previous history of non-adherence of oral medication.

- If pregnant women develop mania while taking prophylactic medication, prescribers should:

    - Check the dose and adherence

    - Consider increasing the dose of the antipsychotic or switching to an antipsychotic if not already taking one

    - If there is no response to changes in dose or drug and the patient has severe mania, consider the use of ECT

- Close monitoring of the baby in the neonatal period may be needed as antipsychotic discontinuation symptoms/EPSE can occur in the neonate (e.g. crying, agitation, hypertonia, hypotonia, tremor, somnolence, and respiratory distress). Refer to advice from the perinatal team, UKTIS on the risk for specific medicines. Patients should be referred to their midwife and obstetric team to determine a post birth monitoring plan.

- Certain drugs like chlorpromazine increase the risk of cholestasis and pruritus in pregnancy. If patient has had cholestasis/pruritus in previous pregnancies, be cautious whilst prescribing such drugs.

- **Do not** routinely prescribe:
    - Clozapine to women who are pregnant or breastfeeding. NICE recommends that pregnant women should be switched from clozapine to another antipsychotic however due to the risks of stopping clozapine this should be carefully considered.
    - Anticholinergic drugs for extrapyramidal side effects of antipsychotics, except for short-term use. Instead adjust dose and timing of the antipsychotic or switch to another drug to avoid side effects

20.6 Antidepressants

20.6.1 Risks to consider

- More than 1 in 10 women experience depression at some point during pregnancy[4].
- Relapse rates are higher in those with a history of depression who discontinue medication.
- Antidepressants should be considered for women with mild to moderate depression during pregnancy if they have a history of severe depression and they decline, or their symptoms do not respond to psychological treatments. [4]
- There is no clear SSRI of choice in pregnancy If a patient is stabilised on one SSRI it is often prudent to continue the same SSRI (except paroxetine) to avoid risk of relapse. The risk of intrauterine growth retardation (although low) is greater in untreated major depression than with drugs like fluoxetine, hence it is advisable to continue the antidepressant in major depression.
- Foetal heart defects are noted when paroxetine taken in the first trimester.
- Persistent pulmonary hypertension in the neonate is noted when SSRIs are taken after 20 weeks' gestation however it is important to note that the overall risk increase is small compared to the background risk, particularly when other confounding factors are taken into account.
- High blood pressure with venlafaxine at high doses noted, together with higher toxicity in overdose compared to SSRIs and some TCAs. Blood pressure monitoring is required for all patients taking venlafaxine.
- Some studies have suggested a link between SSRI use in pregnancy and Autistic Spectrum Disorder [6], however this link has been questioned and has not been confirmed to be related to the use of medication.
- Withdrawal or toxicity in the neonate with all antidepressants, in particular paroxetine and venlafaxine (usually mild and self-limiting).
- There is no evidence to suggest that ECT causes harm to either the mother or foetus during pregnancy although general anesthesia is not without risks

- The MHRA [13] has published reports of a small increased risk of postpartum haemorrhage with SSRI/SNRI antidepressant medicines, when used in the month before delivery. Advice for healthcare professionals:

    - SSRIs and SNRIs are known to increase the bleeding risk; observational data suggest that the use of some antidepressants in the last month before delivery may increase the risk of postpartum haemorrhage

    - continue to consider the benefits and risks for use of antidepressants during pregnancy, and the risks of untreated depression in pregnancy

    - healthcare professionals, including midwives, should continue to enquire about the use of antidepressant medicines, particularly in women in the later stages of pregnancy

    - consider the findings of the review in the context of individual patient risk factors for bleeding or thrombotic events

    - do not stop anticoagulant medication in women at high risk of thrombotic events in reaction to these data but be aware of the risk identified

    - report any suspected adverse reactions associated with medicines taken during pregnancy via the Yellow Card Scheme

20.6.2 Actions to take

- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org , and from the Choice and Medication website www.choiceandmedication.org/eput

- Patients who are already receiving antidepressants and are at high risk of relapse should be informed of the risks of discontinuing their medication and advised to continue on antidepressants during and after pregnancy. A joint decision should be made as to whether to stop or continue the medication.

- Advise a woman taking paroxetine who is planning a pregnancy or has an unplanned pregnancy to stop the drug (due to the risk of cardiovascular malformations of the foetus)

- If a woman planning a pregnancy becomes depressed after stopping prophylactic medication, psychological therapies (CBT) should be considered in preference to an antidepressant drug

- Women who are prescribed an antidepressant during pregnancy should be advised of the potential adverse effects on the neonate

20.7 Lithium

20.7.1 Risks to consider

- There are some concerns around the use of lithium during pregnancy and foetal heart defects (particularly Ebstein's anomaly) but the overall risks remain low.In the third trimester, the use of lithium may be problematic because of changing pharmacokinetics (total body water increases). An increasing dose of lithium is required to maintain the drug level during pregnancy, however the requirements return abruptly to pre-pregnancy levels immediately after delivery

- Neonatal goitre, hypotonia, lethargy, and cardiac arrhythmia can occur

- Lithium is excreted into breast milk

20.7.2 Actions to take

- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org , and from the Choice and Medication website www.choiceandmedication.org/eput

- Do not offer lithium to women who are planning a pregnancy or are pregnant unless antipsychotic medication has not been effective.

- A woman planning a pregnancy taking lithium who is well and not at risk of relapse, should be referred to the perinatal team for a specialist review. The risk of developing fetal heart malformations when lithium is taken in the first trimester should be explained along with an explanation that there may be high levels of lithium in breast milk with a risk of toxicity for the baby.

- Women taking lithium should deliver in hospital and be monitored during labour by the obstetric team. Monitoring should include fluid balance because of the increased risk of dehydration and the subsequent risk of lithium toxicity (in prolonged labour it may be appropriate to check serum lithium levels)

- If a woman maintained on lithium is at high risk of manic relapse in the immediate postnatal period, augmenting treatment with an antipsychotic should be considered

- If a woman taking lithium becomes pregnant:

    - If the pregnancy is confirmed in the first trimester refer the patient for a review with the perinatal team. Explain that stopping lithium at this point may not remove the risk of cardiac defects in the foetus and that there is a risk of relapse especially in the postnatal period, if she has bipolar disorder and come to a joint decision as to whether to stop or continue the medication.

- If she is not well or is at high risk of relapse, consider:

    - Switching gradually to an antipsychotic, particularly if lithium levels are in range and the patient is unwell or

- Stopping lithium and restarting it in the second trimester if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past, or
- Continuing with lithium if she is at high risk of relapse and an antipsychotic is unlikely to be effective.

- If a woman continues taking lithium during pregnancy:
  - High-resolution ultrasound and echocardiography should be performed at 6 and 18 weeks of gestation
  - Check serum levels every four weeks, then weekly from the 36th week, and less than 24 hours after childbirth. Adjust the dose to keep serum levels at the lowest level that keeps the patient well
  - Ensure adequate fluid intake is maintained
  - Lithium should be stopped during labour and plasma levels checked 12 hours after the last dose.

20.8 Valproate[12]

20.8.1 Risks to consider

- For information on the management of valproate in children, adolescents and women with child bearing potential, refer to specific guidance published by MHRA, and the clinical guideline for the management and review of valproate in female patients (CG96)

20.8.2 Actions to take if a woman becomes pregnant whilst taking valproate

- If the patient becomes pregnant on valproate, refer them urgently for a review with the perinatal team. Advise them not to stop taking valproate until they are reviewed
- Consider whether the patient needs high dose folic acid but be aware that this does not specifically reduce the risk of adverse foetal outcomes with valproate
- Be aware that depending on the stage of pregnancy stopping valproate may not reduce the risks of adverse foetal outcomes and may lead to relapse however may still be considered particularly if the risk of further pregnancies is high
- Consideration should be given to tapering the valproate down carefully, while introducing suitable alternative treatment.

20.9 Carbamazepine

20.9.1 Risks to consider

- Neural tube defects (risk raised from 6 in 10000 to around 20-50 in 10000) and other major foetal malformations including gastrointestinal tract problems and cardiac abnormalities

20.9.2 Actions to take

- Refer a woman taking carbamazepine that is planning a pregnancy or has an unplanned pregnancy to the perinatal service. Consider an alternative drug such as an antipsychotic
- Folic acid should be prescribed before and during pregnancy[7]
- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org, and from the Choice and Medication website www.choiceandmedication.org/eput
- Do not routinely prescribe carbamazepine for pregnant women

20.10 Lamotrigine

20.10.1 Risks to consider

- Overall the risks of lamotrigine during pregnancy are lower than with other mood-stabilising anticonvulsants but up to date information should be obtained at the time of prescribing or review
- Lamotrigine levels can change significantly during pregnancy which can lead to relapse and may need to be monitored through pregnancy.

20.10.2 Actions to take

- Refer a woman taking lamotrigine that is planning a pregnancy or has an unplanned pregnancy to the perinatal service for a review. Consider an alternative drug such as an antipsychotic. If a patient continues lamotrigine during pregnancy, monitor effectiveness and consider monitoring lamotrigine levels.
- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org, and from the Choice and Medication website www.choiceandmedication.org/eput
- Do not routinely prescribe lamotrigine for pregnant women
- Do not routinely prescribe lamotrigine for women who are breastfeeding

20.11 Pregabalin

20.11.1 Risks to consider

- A new study [14] has suggested pregabalin may slightly increase the risk of major congenital malformations if used in pregnancy. Patients should continue to use effective contraception during treatment and avoid use in pregnancy unless clearly necessary.

- The observational study [14] of more than 2,700 pregnancies exposed to pregabalin has shown use in the first trimester to be associated with a slightly increased risk of major congenital malformations compared with exposure to no antiepileptic drugs or to lamotrigine or to duloxetine

- The MHRA has provided a safety update regarding the risks of pregabalin in pregnancy after reviewing the data available on the use of pregabalin in pregnancy. They found that the risk of malformations was increased with pregabalin compared to other treatments use in epilepsy[15].

20.11.2 Actions to take

The advice from the MHRA for healthcare professionals[15]:

- continue to provide counselling to patients using pregabalin on:
    - the potential risks to an unborn baby (see separate patient safety leaflet [15])
    - the need to use effective contraception during treatment
- continue to avoid use of pregabalin during pregnancy unless clearly necessary and only if the benefit to the patient clearly outweighs the potential risk to the foetus – ensure the patient has a full understanding of the benefits, risks, and alternatives, and is part of the decision-making process
- advise patients planning a pregnancy or who become pregnant during treatment to make an appointment to discuss their health condition and any medicines they are taking
- in cases where the benefit outweighs the risk, and it is clearly necessary that pregabalin should be used during pregnancy, it is recommended to:
    - use the lowest effective dose
    - report any suspected adverse drug reactions, including for the baby, via the Yellow Card scheme

20.12 Benzodiazepines

20.12.1 Risks to consider

- Cleft palate and other foetal malformations.
- Floppy baby syndrome in the neonate.

20.12.2 Actions to take

- Do not routinely offer to pregnant women, except for short-term treatment of severe anxiety and agitation.
- Consider gradually stopping in women who are planning a pregnancy, pregnant or considering breastfeeding.
- **Promethazine** has been used in hyperemesis gravidarum and appears not to be teratogenic, and can be used if necessary as a hypnotic or anxiolytic in pregnancy
- Offer information leaflets on use of the specific drug in pregnancy, from the UK Teratology Information Service, available at www.medicinesinpregnancy.org, and from the Choice and Medication website www.choiceandmedication.org/eput

20.13 Methadone

- Methadone at a stable dose can be used in pregnancy without any additional risk to the development of the foetus. Abrupt withdrawal can be dangerous.
- Information relating to the usage of methadone should be shared with the maternity team and the possibility of neonatal withdrawal syndrome explained to the mother.
- See Formulary and Prescribing Guideline Section 10 for further information

Offer information leaflets on use of the specific drug in pregnancy, from the Choice and Medication website www.choiceandmedication.org/eput

20.15 Topiramate

20.15.1 Risks to consider

- Topiramate is indicated in the prophylaxis of migraine and in the treatment of epilepsy. and.
- Topiramate is sometimes used off-label to relieve some of the symptoms of bipolar mood disorder (as a mood stabiliser), borderline personality disorder, eating disorders, schizoaffective disorder and also to reduce weight gain with antipsychotics. It is non-formulary within EPUT for mental health conditions, but is included in the formulary for use in epilepsy.
- The use of topiramate in pregnancy has been shown to be associated with an increased risk to the baby of congenital malformation and low birth weight, as well as potential risk of neurodevelopmental disorders.

- New safety measures have been put in place to restrict the use of topiramate in women of childbearing potential and in pregnancy. The use of topiramate is now contraindicated:
    - in women of childbearing potential unless the conditions of the Pregnancy Prevention Programme (PPP) are fulfilled (for all indications)
    - in pregnancy for prophylaxis of migraine
    - in pregnancy for epilepsy unless there is no other suitable treatment

- Prescribers are to ensure that all women of childbearing potential treated with topiramate-containing medicines are using highly effective contraception, have a test to exclude pregnancy before starting and are aware of the risks from its use. A Risk Awareness Form is to be completed and signed at initiation of treatment and at annual reviews.
- For information on the new safety measures, materials to support the PPP and risk acknowledgement forms, refer to specific guidance published by MHRA
- If a women is planning a pregnancy or has an unexpected pregnancy they should be referred urgently for a review with the perinatal team.

20.15.2 Actions to take if a woman becomes pregnant whilst taking topiramate

- If the patient becomes pregnant whilst taking topiramate, refer them urgently for a review with the perinatal team.
- Consideration should be given to carefully switch to a suitable alternative treatment.

20.15 Electroconvulsive therapy

- In resistant depression, NICE recommend that ECT is used before/instead of drug combinations
- For acute mania in pregnancy use an antipsychotic and if ineffective consider ECT

20.16 Summary

The table below suggests options for treatment in women and girls with childbearing potential who are currently not taking any medication or require a switch due to clinical reasons. For women and girls with childbearing potential who are stable on medication, further information should be sought before switching even if there is a medication that has a slightly lower risk in pregnancy or breastfeeding.

Class of Drug	Recommended during Pregnancy	Recommended during Breastfeeding	Other information
Antipsychotics	Most antipsychotics can be used but olanzapine and quetiapine are used more commonly	Most antipsychotics can be used but olanzapine and quetiapine are used more commonly	
Antidepressants	Most antidepressants can be used but sertraline is used more commonly	Most antidepressants can be used but sertraline is used more commonly	CBT for moderate depression, ECT for resistant depression
Mood Stabilisers	Antipsychotics tend to be preferred, refer to sections on lithium and lamotrigine for further information on their use	Antipsychotics tend to be preferred, refer to sections on lithium and lamotrigine for further information on their use	ECT for resistant /acute mania
Sedatives	Promethazine is preferred	Lorazepam for anxiety and zolpidem for sleep but caution with all sedatives and co-sleeping	

20.17 References

1. NICE CG 192, December 2014, updated April 2018. Antenatal and Postnatal Mental Health: Clinical Management and Service Guideline.

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4. NICE eyes on evidence, Antidepressant use late in pregnancy and risk of postpartum hemorrhage – April 2014

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12. Summary of Product Characteristics, Sodium valproate (Epilim 200 gastro-resistant tablets), Sanofi, 16/5/2018. Accessed 23/5/2018.

13. SSRI/SNRI antidepressant medicines: small increased risk of postpartum haemorrhage when used in the month before delivery. Drug Safety Update volume 14, issue 6: January 2021: 5. Accessed 29/4/2021.

14. Drug Safety Update volume 15, issue 9: April 2022: 1. Pregabalin (Lyrica): findings of safety study on risks during pregnancy. Accessed 5/5/2022.

15. MHRA Guidance: Pregabalin and risks in pregnancy. Safety leaflet to help you understand the latest information about the effects of pregabalin during pregnancy. Published 19/4/2022. Accessed 16/5/2022. https://www.gov.uk/government/publications/pregabalin-and-risks-in-pregnancy

16. Drug Safety Update. Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme. Medicines and Healthcare products Regulatory Agency. Published 20 June 2024. Accessed 20/11/2024. https://www.gov.uk/drug-safety-update/topiramate-topamax-introduction-of-new-safety-measures-including-a-pregnancy-prevention-programme

20.18 Information resources

- **EPUT Perinatal services**
  For women who are planning a pregnancy, pregnant, or in the first 12 months after birth refer to the perinatal service for advice and information

  Perinatal team contact details:

  Phone no: 01245 315 637

  Team email address: perinatalteam@nhs.net

- **The United Kingdom Teratology Information Service (UKTIS)**

  UKTIS: https://uktis.org/ Health care staff can easily register for a free account, which allaows access to full UKTIS drug monographs.

  UKTIS healthcare professional help line: 0344 892 0909 – for routine queries contact during Mon-Friday 9am-5pm, outside of these hours for urgent advice only

- **UKDILAS: Medicines information service for breastfeeding queries UK drugs in lactation advisory service.**

  Phone line: UKDILAS Telephone**:** 0116 258 6491

  Email: ukdilas.enquiries@nhs.net

  Medicines Advice Service information: https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/#:~:text=ukdilas

- **Lactmed**
  https://www.ncbi.nlm.nih.gov/books/NBK501922/

- **Elactinia**
  https://www.e-lactation.com/en/

- **Patient information sources**
  - Best use of medicines in pregnancy (BUMPS) https://www.medicinesinpregnancy.org/
  - Choice and medication https://www.choiceandmedication.org/eput/

Checklist for Medicines use in Women and Girls of Childbearing Potential

Pre-checklist questions

Is there any chance the patient is or could be pregnant? - ***Offer a pregnancy test if necessary and available***	☐
Is the patient currently considering having (more) children?	☐
If the patient is pregnant or looking to start or extend their family discuss referring the patient to the perinatal team - ***Consider waiting to initiate new medicines where appropriate***	☐
Continue the checklist even if the answer to the above pre-checklist questions is no, as plans can change any time and unexpected pregnancies can occur	

Checklist questions

Inform the patient that there are risks to taking all medicines including in pregnancy and breast feeding and provide the patient with resources to refer to (BUMPs, Choice and Medication)	☐
Discuss if patient would like to look at any resources or discuss risk in pregnancy prior to initiating medicines. - ***If there is an urgent need to start the medicine this discussion may need to be done at the consultation***	☐
Discuss other risks that can impact on outcomes for pregnancy such as diet, folic acid intake, fluid intake, caffeine, alcohol, smoking, substance use and offer support for these as necessary	☐
Consider the risk of individual medicines and choose an appropriate medicine. - ***Refer to up to date resources for individual risk e.g. NICE, Toxbase, BAP guidance.*** - ***Where possible avoid initiating medicines of higher risk such as valproate, pregabalin, lithium and topiramate.*** - ***Only prescribe after the patient is fully informed and aware of the risks and is agreeing to any other actions such as the use of contraception.***	☐
For patients stabilised on higher risk medicines who are pregnant or planning a pregnancy, refer urgently for a review with the perinatal team. Advise the patient not to stop the medicines	☐
If valproate is considered, ensure all parts of the pregnancy prevention programme (incl. contraception) are in place before issuing a prescription	☐
Ensure the patient is informed to not stop taking their medicines and contact the team if their plans change and they would like have a child or have found out that they are pregnant.	☐