



Mood stabilisers in pregnancy and breastfeeding for GPs

Fact Sheet for Professionals

Introduction

The safety of mood stabilisers during breastfeeding and pregnancy is inherently difficult to study, therefore well-researched information regarding their use in the perinatal period remains limited.

Safety relates to increased rates of birth defects (above 2-3% found in “normal” population) and longer term neurobehavioural sequelae. In addition newborns may experience withdrawal effects with anticonvulsant medication exposure in pregnancy.

This fact sheet summarises what is currently known about the use of these medications in pregnancy and breastfeeding. Nevertheless, the decision to prescribe mood stabilisers during pregnancy always requires multidisciplinary consultation including psychiatric and obstetric involvement.

Women with known bipolar illness or a previous postpartum psychosis should be encouraged to plan pregnancy prior to conception so that they can make informed choices about their treatment during the perinatal period. A comprehensive management plan can combine strategies to minimise the risk of relapse together with taking into account the effects of treatment on the developing foetus.

Lithium

Lithium is the mood stabiliser with the least reported increase in birth defects for women requiring a mood stabiliser during pregnancy.

In pregnancy:

First trimester use of lithium is associated with an increase in cardiac defects, particularly Ebstein’s Anomaly which is increased from 1: 10-20,000 to 1: 1000. For this reason a foetal echocardiogram is warranted for women taking lithium in early pregnancy in addition to the regular 18 week morphological scanning.

Changed renal clearance in pregnancy may require increasing the Lithium dose as pregnancy progresses. Lithium levels, renal and thyroid function need to be monitored regularly throughout the pregnancy.

Due to risk of toxicity with rapid shift in maternal fluid volumes at pregnancy, the Lithium dose needs to be decreased 24-48 hours prior to a planned delivery, or ceased at the onset of spontaneous labour and recommenced at pre pregnancy levels after delivery.

The limited data available regarding the long term neuro-developmental sequelae of lithium use during pregnancy is generally reassuring.

Breastfeeding:

Consideration needs to be given to the overall impact of breast feeding in women with bipolar disorder given the impact of sleep deprivation and loss of circadian rhythm.

Lithium is transmitted in highly variable concentrations in the breast milk (RID 10%-80% or more). It can however be used with caution during lactation, paying particular attention to the infant’s hydration and monitoring infant renal and thyroid function in conjunction with a neonatologist .



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Valproic Acid

In pregnancy:

Valproate should *not* be used to treat mood disorders in pregnancy as the risks are too high, both in terms of increased malformations (9% and may be up to 15% cf. 2-3% in unexposed population) including neural tube defects, limb defects, cardiac defects and facial dysmorphism and also significant risk of neuro-developmental sequelae such as developmental delay and autism spectrum disorders.

Breastfeeding:

Valproic Acid appears in low concentrations in breast milk and infant serum level is generally low. Monitoring for hepatotoxicity and thrombocytopenia has been suggested.

Lamotrigine & Carbamazepine

In pregnancy:

Data on the use of lamotrigine during pregnancy is still emerging. Overall it is associated with a small increase above population norms for absolute risk of birth defects (~ 5-6%). A similar rate of birth defects is found with exposure to carbamazepine. Some studies have shown an increase in oral cleft defects with lamotrigine although the absolute risk remains low. There has been some reassuring data on neuro-developmental outcomes following monotherapy with lamotrigine

Breastfeeding:

Although infant plasma levels can be relatively high (30-35% of maternal plasma level), few adverse events have been reported in infants whose mothers were taking lamotrigine while breastfeeding. When weaning during treatment with lamotrigine, gradual reduction of breastfeeding is preferable to abrupt withdrawal.

Atypical Antipsychotic Medications

The atypical antipsychotic medications such as quetiapine and aripiprazole have less effect on prolactin than the older antipsychotics. Some of these medications can result in significant additional weight gain throughout the pregnancy and may increase the risk of gestational diabetes. Very little is known about their safety as adequate birth defect or long term neuro-developmental data is not yet available.

Breastfeeding:

Antipsychotic medications are sedating and have relatively long half lives. However, only small concentrations of atypical antipsychotics cross into breast milk. If combined with other sedating medication the effects can be additive and babies should then be observed for lethargy, sedation and appropriate developmental milestones particularly if multiple antipsychotic drugs are used.