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Drug choice in pregnancy

The Maudsley® Prescribing Guidelines in Psychiatry, Fifteenth Edition. David M. Taylor, Thomas R. E. Barnes and Allan H. Young. © 2025 David M. Taylor. Published 2025 by John Wiley & Sons Ltd. Chapter 7 Drug choice in pregnancy A 'normal' outcome to pregnancy can never be guaranteed. The spontaneous abortion rate in confirmed early pregnancy is 10–20%, and the risk of major malformation in the newborn is 2–3% (approximately 1 in 40 pregnancies).[1] Lifestyle factors, such as smoking cigarettes, poor diet and drinking alcohol during pregnancy, can have adverse consequences for the fetus. Pre-pregnancy obesity increases the risk of neural tube defects and is associated with risk factors for the mother. Psychiatric illness during pregnancy is an independent risk factor for congenital malformations, stillbirths and neonatal deaths[2] and perinatal mental disorders are associated with a broad range of negative child outcomes, many of which can persist into late adolescence.[3] Severe mental illness is also associated with increased risk of obstetric near misses (life-threatening obstetric complications).[4] The safety of psychotropics in pregnancy cannot be clearly established because robust, prospective trials are unethical and long-term observational studies are challenging to undertake. Data are derived from database studies (many of which fail to control for confounders such as the impact of maternal mental illness, use of illicit drugs and alcohol, smoking, obesity and other medications), limited prospective data from teratology information centres and published case reports. For many drugs, the perceived association or otherwise with adverse outcomes changes over time, as more information is gathered and analysed. The patient's view of risks and benefits has paramount importance and needs to be informed by up-to-date evidence. Clinicians should be aware of the importance of prescribing medication to women with a severe mental illness. Perinatal suicides are notable for being associated with lack of active treatment, specifically the lack of treatment with psychotropic medication.[5] The American College of Obstetricians and Gynecologists (ACOG) warns against withholding or discontinuing medications for mental health conditions because of pregnancy or lactation status alone.[6] Box 7.1 provides a brief summary of the relevant issues and evidence available in early 2024. Prescribing in pregnancy and breastfeeding

714 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 7 Box 7.1 General principles of prescribing in pregnancy In all women of child-bearing potential ■ ■Always discuss the possibility of pregnancy – half of all pregnancies are unplanned[7] ■ ■Avoid using drugs that are contraindicated during pregnancy (notably valproate, topiramate and carbamazepine). If use of these drugs is unavoidable then women should be made fully aware of their teratogenic properties

even if not planning pregnancy. In addition, the prescriber should confirm the presence of an effective and stable long-term contraceptive plan If mental illness is newly diagnosed in a pregnant woman ■ ■Consider non-pharmacological interventions ■ ■Try to avoid all drugs in the first trimester (when major organs are being formed) unless benefits clearly outweigh risks (i.e. if non--drug treatments are not effective/appropriate) ■ ■Use an established drug and use the lowest effective dose ■ ■Review current medication regimen to ensure there is a clear indication for each drug and that ineffective drugs are stopped If a woman taking psychotopic drugs is planning a pregnancy ■ ■Consideration should be given to discontinuing treatment if the woman is well and at low risk of relapse, after a careful review of her history ■ ■Discontinuation of treatment for women with severe mental illness (SMI) and at a high risk of relapse is generally unwise but consideration should be given to switching to a low-risk drug. However, be aware that switching drugs may increase the risk of relapse. Any changes must be made with caution and considered in the context of the woman’s illness history and previous response to treatment ■ ■Drug-induced hyperprolactinaemia may prevent pregnancy. Consider switching to an alternative drug if hyperprolactinaemia occurs and a pregnancy is planned ■ ■For women with SMI, pre-conception advice from a perinatal psychiatrist should be sought to ensure that women are aware of their risk of relapse in the perinatal period and are able to discuss a prospective perinatal care plan If a woman taking psychotropic medication discovers that she is pregnant ■ ■Abrupt discontinuation of treatment post-conception is unwise for women with SMI and at a high risk of relapse. Relapse may ultimately be more harmful to the mother and child than continued, effective drug therapy ■ ■Consider continuing with current (effective) medication rather than switching, to minimise the risk of relapse and the number of drugs to which the fetus is exposed ■ ■Valproate (if prescribed as a mood stabiliser) must be stopped immediately ■ ■Early pregnancy can be associated with noticeable changes in mood, therefore it may be necessary to review the medication plan at this stage to ensure symptoms are well controlled If the patient smokes (smoking is more common in pregnant women with psychiatric illness8) ■ ■Smoking has been associated with the greatest proportion of excess risk of poor pregnancy outcomes9 ■ ■Always encourage switching to nicotine replacement therapy. Referral to smoking cessation services is mandated by NICE in the UK ■ ■Vaping is probably safer than tobacco smoking but is not without risk. Nicotine replacement is probably safer than vaping10 ■ ■Stopping smoking can increase plasma levels of certain drugs (e.g. clozapine)

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