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726 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 7 Anxiety and insomnia during pregnancy and postpartum Anxiety disorders and insomnia are commonly seen in pregnancy.196 Preferred treatments are cognitive behavioural therapy (CBT) and sleep-hygiene measures, respectively. Sedatives ■ ■First-trimester exposure to benzodiazepines has been associated with specific malformations197 such as oral clefts in newborns,198 although other studies198–202 have failed to confirm this association. Benzodiazepine use in pregnancy may be a marker for cardiac and total malformation risk.203 ■ ■Benzodiazepine use in pregnancy has been associated with caesarean delivery, spontaneous abortion, neonatal intensive care admission, neonatal ventilatory support, low birth weight, preterm delivery, small head circumference and small for gestational age babies.199,204–208 Third-trimester use is commonly associated with neonatal difficulties (floppy baby syndrome).209 A Taiwanese population-based study which accounted for confounding factors such as indication reported that benzodiazepine or Z drug use in early pregnancy was not associated with a substantial increase in the risk of stillbirth and preterm birth but there was an increased risk of small for gestational age. Exposure during late pregnancy was found to be associated with a substantially elevated risk of stillbirth and preterm birth.210 ■ ■Note that, in the UK, NICE advises that benzodiazepines are not offered to women in pregnancy and the postnatal period except for the short-term treatment of severe anxiety and agitation. It also suggests gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding.51 ACOG recommends that benzodiazepines be avoided or prescribed sparingly as a treatment for perinatal anxiety. ■ ■Promethazine has been used in hyperemesis gravidarum and appears not to be teratogenic, although data are limited. ■ ■If valproate is the only drug that works for a particular woman, and this is seen as the only option for her during pregnancy, then the patient should be given a clear briefing of the risks and give written consent confirming that she understands the risk of malformations and developmental delays. Having said this, it is difficult to imagine any situation where the benefits of valproate outweigh the huge risks presented by using valproate in pregnancy ■ ■NICE advises that carbamazepine not be offered to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding. NICE advises discussing the possibility of stopping carbamazepine if a woman is planning a pregnancy or becomes pregnant. If carbamazepine is used, prophylactic vitamin K

should be administered to the mother and neonate after delivery. ACOG recommends against discontinuing mood stabilisers (except for valproate) during pregnancy due to the risk of recurrence or exacerbation of mood symptoms ■ ■NICE advises if a woman is taking lamotrigine to check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times ■ ■In acute mania in pregnancy use an antipsychotic and, if ineffective, consider electroconvulsive therapy ■ ■In bipolar depression during pregnancy use cognitive behavioural therapy for moderate depression and a selective serotonin reuptake inhibitor for more severe depression. Lamotrigine is also an option

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