09 - Pregnancy and alcohol use

Pregnancy and alcohol use

492 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Baclofen Baclofen is a GABA-B agonist that does not have a licence for use in alcohol dependence but is nevertheless used by some clinicians as second-line treatment for those who have not responded to either naltrexone or acamprosate, or where there are contraindications for first-line treatment. A 2023 Cochrane review suggested that baclofen may help people with AUD in maintaining abstinence, particularly in people who are already detoxified.33 A 2022 meta-analysis32 also suggested baclofen is effective but is associated with higher rates of adverse effects including depression, vertigo, somnolence, numbness and muscle rigidity. Antiseizure medications There is currently insufficient evidence to support the use of antiseizure medications in the treatment of alcohol dependence, although they may reduce the number of drinks per drinking day compared with placebo.34 The majority of the research has been carried out on topiramate. Topiramate acts as a GABA/glutamate modulator that has demonstrated safety and efficacy in reducing heavy drinking in patients without AUD.35 It may as effective as naltrexone in AUD.36 There have been fewer studies on gabapentin,37 valproate and levetiracetam.30 Although these drugs have been used elsewhere in the world, they are not routinely used in the UK owing to lack of evidence and concerns regarding safety profiles for both gabapentin and valproate. Pregnancy and alcohol use Evidence indicates that alcohol consumption during pregnancy may cause harm to the fetus. The Department of Health advises that women should not drink any alcohol at all during pregnancy.1 Drinking even 1–2 units/day during pregnancy can increase the risk of having a preterm, low birthweight or small for gestational age baby. For alcohol-dependent pregnant women who have withdrawal symptoms, pharmacological cover for detoxification should be offered, ideally in an in-patient setting in collaboration with an antenatal team. The timing of detoxification in relation to the trimester of pregnancy should be risk-assessed against continued alcohol consumption and risks to the fetus.9 Chlordiazepoxide has been suggested as being unlikely to pose a substantial risk, however dose-dependent malformations have been observed.11 The UK Teratology Information Service (UKTIS)38 provides national advice for Box 4.3 Disulfiram: NICE Clinical guideline 115 (2011)2 Disulfiram should be considered in combination with a psychological intervention for patients who wish to achieve abstinence, but for whom acamprosate or naltrexone are not suitable. Treatment should be started at least 24 hours after the last drink and should be overseen by a family member or carer. Monitoring is recommended every 2 weeks for the first 2 months, then monthly for the following 4 months. Medical monitoring should be continued at 6-monthly intervals after the first 6 months. Patients must not consume any alcohol while taking disulfiram.

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