Prescribing Psychotropics for Women of Childbearing Potential

March 14, 2014
By Marlene P. Freeman, MD

Because half of pregnancies in this country are unplanned, it’s crucial to counsel women of reproductive potential about their medications—regardless of their plans to conceive.

Mood disorders frequently have a chronic or recurrent course, and women with mood disorders typically experience the onset of these disorders before or during their reproductive years. Therefore, women commonly experience mood episodes during the perinatal period (during pregnancy and postpartum). Many women plan for a pregnancy with a preexisting mood disorder and while receiving maintenance treatment with psychotropic medication. Ideally, women plan ahead to conceive and make any necessary treatment changes to maximize wellness and minimize fetal medication exposure—especially to medications that are known teratogens or have unknown reproductive safety profiles.

However, about 50% of pregnancies in the US are unplanned. This fact underscores the need to routinely counsel women of reproductive potential about their medications, regardless of their plans to conceive. It is also of major importance to select medications for women of reproductive potential that would be of least risk should they experience an unplanned pregnancy.

**Plan for the unplanned**
The psychopharmacologist should actively inquire about a woman’s plans for conceiving. If a woman is not planning to become pregnant, contraception should be discussed routinely. If a woman is using hormonal contraception, such as an oral contraceptive, there are important potential drug actions to factor into medication dosing. Many women who report that they are not trying to conceive are not using an effective contraceptive. One recent national study demonstrated that among young women, one-third were using the “withdrawal method” as their primary form of birth control. Among them, 21.4% experienced an unintended pregnancy.

Our role is 2-fold: we need to actively integrate patients’ desires for pregnancy into our treatment plans, but also extend the use of selective prescribing for women of reproductive potential regardless of stated plans.

**Pregnancy has inherent risks**
The rate of congenital malformations in the general population of the US is approximately 3% of all pregnancies. Maternal age is a known risk factor for pregnancy complications and birth defects, as are smoking, alcohol use, uncontrolled diabetes, and obesity. In most cases, causes of birth defects are unknown. Decision making around treatments for psychiatric disorders in pregnancy requires consideration of what is known about the medications in pregnancy, the disorder being treated, and exposures to the baby of both untreated maternal illness and medication. For women of reproductive age planning pregnancy, the CDC recommends the following:
• Take folic acid (higher doses are recommended when a woman is taking an anticonvulsant before trying to conceive)\(^6\)
• Maintain healthy diet and weight
• Continue regular physical activity
• Quit/abstain from tobacco use, alcohol, and drugs
• Communicate with health care professionals about screening for and management of chronic diseases

The CDC also recommends that sexually active women who wish to delay or avoid pregnancy should use effective contraception correctly.

**Treatment considerations when planning for pregnancy**

It is a major treatment dilemma when a woman decides to try to conceive or becomes pregnant while being treated with a particularly risky medication. A switch during pregnancy means that a woman will have more than one medication exposure during her pregnancy, and a trial of a medication that is new to her is complicated by the fact that the risk to benefit ratio for her is unknown. Therefore, the initial selection of psychotropics for women with psychiatric disorders should include consideration of reproductive potential and data regarding use in human pregnancy. Unfortunately, it is challenging to remain apprised of data pertaining to medication use in pregnancy, since the literature is constantly evolving. For some medications, such as SSRIs, lamotrigine, and benzodiazepines, there are a great number of published studies—some with conflicting results.\(^7\) For other medications that are known teratogens, such as lithium and valproic acid, the association with birth defects is clear, but the absolute risk of teratogenicity must be understood to make informed decisions.\(^7\) With lithium, which has a known association with a specific cardiovascular malformation—Ebstein anomaly—the absolute risk is low. Approximately 0.1% to 0.2% of pregnancies are affected when there is exposure in the first trimester. In contrast, valproate has a known and common association with neural tube defect, estimated to occur in 1% to 5% of exposed pregnancies.\(^7\)

Unfortunately, the FDA pregnancy categories (A, B, C, D, X) are of limited use and can be misleading regarding what constitutes a relative risk of one medication compared with another when used in pregnancy.\(^8\) The risks of the untreated disorder also are not reflected in this system. Most psychotropic medications are labeled as C or D. The process of category labeling is as follows for a new drug: When a new drug comes to market, a letter is assigned and usually there is a paucity of animal data at that point. Pharmaceutical companies are required to have a modest amount of human data on hand. In general, however, there is no incentive for a company to have human pregnancy data at the time of approval. In fact, women who are pregnant or who are using inadequate methods of contraception are generally barred from participation in clinical trials.\(^9\)

This means that only postmarketing surveillance data are derived from pregnant women. Pregnant women are disqualified from randomized trials of psychotropic medications. Naturalistic studies are used, which must be interpreted with care to account for variables (including the underlying disorder, factors associated with the illness, and medication use) because groups of women receiving a particular medication may not be adequately matched with controls. The effect of the FDA pregnancy categories is that some newer medications without human pregnancy data receive a relatively favorable category, such as “B,” while older medications that are well studied and may have a well characterized small risk or inconsistently reported risk may be labeled as “D.” However, it is possible—and common—that a drug in the “D” category would be preferable to one labeled “B,” especially when the older drug has received a great deal of study and has a very small absolute risk, and the newer drug labeled “B” is unknown in human pregnancy. The bottom line is that the FDA categories are seductive—they lead us to believe that the medications fall into clear and distinct categories, when in fact they rarely inform us about how to select medications for women.

In advance of a pregnancy, the following are guidelines to keep in mind\(^10\):
• Aim for remission before a pregnancy; encourage a period of wellness before conception
• Provide psychotherapy before a pregnancy
• Select the drugs that are most reasonable on the basis of the patient’s personal history of illness and treatment response (valproate is the most commonly used psychotropic agent with the highest risk of teratogenicity\(^11\))
• Minimize the number of drugs and doses while maintaining euthymia
• Arrange for careful monitoring of mood throughout pregnancy and the postpartum period

**Clinical caveats**

Pregnancy is inherently risky. Our goals are to decrease risks to and promote wellness for the
mother and baby as much as possible. We are not able to state that any medication is absolutely “safe.” When initiating treatment with medications, keep in mind that unplanned pregnancies are common. The FDA pregnancy categories are extremely limited in clinical value. The risks of untreated disorders must be taken into account in terms of fetal and infant exposure. In this area with so many unknowns, collaborative decision making with the patient is essential.

**Treating Mood Disorders in Young Women: Resources for Clinicians and Patients**

- Massachusetts General Hospital Center for Women’s Mental Health: [http://www.womensmentalhealth.org](http://www.womensmentalhealth.org)
- Centers for Disease Control and Prevention: [http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm)
- Organization of Teratology Information Specialists (OTIS): [http://www.mothertobaby.org](http://www.mothertobaby.org)
- Postpartum Progress: [http://www.postpartumprogress.com](http://www.postpartumprogress.com)

**Disclosures:**

Dr Freeman is Associate Professor of Psychiatry at the Harvard Medical School; Medical Director, Clinical Trials Network and Institute; and Director of Clinical Services, Perinatal and Reproductive Psychiatry Program at the Massachusetts General Hospital in Boston. She has received research support from GSK and Lilly; is on the advisory boards of Lundbeck, Taleeda, Otsuka, and Genentech; and does medical editing for DSM Nutritional Products.

**References:**


Source URL: http://www.physicianspractice.com/psychopharmacology/prescribing-psychotropics-women-childbearing-potential

Links: