Prescribing in the Perinatal Period

Most Perinatal PCL calls include questions about the effects of medications and about prescribing during pregnancy and breastfeeding. Each Perinatal PCL care guide module that focuses on a specific disorder provides the most up to date information, as of the time of writing, about medications used to treat that disorder. In this section, we outline general guidelines for prescribing during the perinatal period and provide some resources to use in looking up the most recent information, and in finding medication fact sheets to give to your patients. The guidelines below reflect our overall approach, which is to use the lowest number and dosages of medications possible, while effectively treating the psychiatric disorder(s).

What are some general rules of thumb about prescribing during the perinatal period?

1. **Consider risks during pregnancy whenever prescribing medication for someone of childbearing potential.** About 50% of pregnancies are unplanned. Considering, and informing people of childbearing potential about, risks of their medication(s) during pregnancy helps to maximize prescribing of safer medications and avoid patients' suddenly discontinuing needed medication if they find out they are pregnant.

2. **Make any medication changes before pregnancy if possible.** This minimizes the number of exposures for the baby and maximizes stability for the parent. Changing a newer medication with less data regarding safety in pregnancy to an older medication with more safety data can be done before pregnancy, if desired. Making this change once the patient is already pregnant involves exposing the baby to two medications instead of one and potentially causing worsening of the parent's psychiatric condition during pregnancy.

3. **Remember that an untreated/undertreated psychiatric disorder also poses risks to the parent and the baby.** Untreated/undertreated psychiatric disorders pose significant risks for parents and babies. For example, perinatal depression is associated with higher rates of preterm birth, low birth weight, problems with attachment and bonding, and increased rates of psychiatric disorders in childhood and adolescence. For this reason, it is important to treat psychiatric disorders effectively during the perinatal period.

4. **Ideally, the patient should be psychiatrically stable for at least 3 months before trying to conceive.** Although this is not always possible, it decreases the risk of relapse and exposure of the baby to risks of untreated/undertreated psychiatric illness.

5. **Avoid polypharmacy whenever possible.** Prescribing the fewest medications possible to effectively treat the patient's psychiatric disorder reduces exposures for the baby. Reviewing the need for each medication is especially important when someone is taking multiple medications and/or more than one medication in a class (e.g., two or more antidepressants, two or more antipsychotics, multiple antianxiety/hypnotic medications, etc.)

6. **Avoid Depakote.** Depakote (valproic acid) is a commonly prescribed mood stabilizer for patients with bipolar disorder. Depakote is a known teratogen (rate of malformations elevated in all dosage ranges and 25% at doses above 1450 mg/day) and is associated with significantly decreased IQ in children exposed in utero.

7. **Optimize non-medication treatments.** At all times, and especially during the perinatal period, we want to maximize the use of evidence-based non-medication treatments such as psychotherapy. Most people with mild to moderate depression and anxiety respond to evidence-based psychotherapy and do not need medication if psychotherapy is available. Even if someone requires medication for effective treatment of their condition, non-medication treatments can help minimize numbers and dosages of medications and increase effectiveness of treatment.

8. **If you are thinking of stopping your patient's psychotropic medications because they are pregnant, please call us first.** Discontinuing medications abruptly can precipitate relapse (another exposure for the baby and risk for the parent). Also, stopping some medications can cause withdrawal symptoms that are potentially dangerous (e.g., benzodiazepines) or unpleasant (e.g., antidepressants). We would be happy to help you sort out which medications to discontinue and safe tapering schedules.

9. **Prescribing during the perinatal period requires a risk-risk discussion.** Informed consent during the perinatal period involves collaborating with the patient in discussing and weighing risks of medication for the fetus/baby, risks of the psychiatric disorder, and possible alternative treatments.

10. **Use a patient-centered and team approach.** In addition to collaborative decision-making with, and support of, the patient, this includes involving family members and communicating with other care providers. It is important to educate the partner and/or family members about the risks and benefits of treatment as well as warning symptoms of relapse. Communication with obstetric and pediatric providers minimizes the patient's hearing conflicting opinions and being confused and concerned.

References and resources:

Payne JL. Psychiatric medication use in pregnancy and breastfeeding. Obstet Gynecol Clin N Am 2021; 48:131-149.

InfantRisk apps for healthcare providers and parents about safety of medications during pregnancy and breastfeeding. https://www.infantrisk.com/infantrisk-center-apps

LactMed database about safety of medications during breastfeeding. https://www.ncbi.nlm.nih.gov/books/NBK501922/

Reprotox database about medications during pregnancy, breastfeeding, and development. Requires subscription. https://reprotox.org/

MotherToBaby fact sheets for parents regarding risks of drugs (including non-prescribed drugs) during pregnancy and breastfeeding. https://mothertobaby.org/fact-sheets/