Treatment of Bipolar Disorder in Pregnant and Postpartum Women: A Review Sheet

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Preconception Management

- Begin preparation at least six months before conception to ensure stability, switch to safer medications, and manage psychosocial stressors.

Course of Bipolar Disorder During Pregnancy and Postpartum

- Pregnancy: Low risk period with only about 5% relapse rate.
- Postpartum: High risk of relapse; about 1 in 3 women with bipolar disorder (BD) relapse.

Predictors of Relapse

- Early onset of illness, rapid cycling, history of multiple recurrences, and abrupt discontinuation of medications are significant red flags.

Impact on Pregnancy Outcomes

- Increased risks of substance use, low birth weight, preterm birth, and inadequate prenatal care.

Lithium and Pregnancy

- Risks: Mainly cardiac anomalies, including Epstein's anomaly. Risk is dose-dependent:
    - No significant increase in risk with a daily dose of 600 mg or less, but risk increases three-fold with a daily dose of over 900 mg
- Developmental Outcomes in children exposed to lithium in utero appear normal.
- Management: Use the lowest effective dose, obtain a fetal echocardiogram at week 18-24, and adjust doses carefully throughout pregnancy and postpartum.
    - Obtain lithium levels at least monthly
    - Lithium levels drop up to 34% by third trimester
    - Reduce lithium back to pre-pregnancy dose at delivery to avoid lithium toxicity in the mother

Other Mood Stabilizers

- Valproate and carbamazepine: High risk of neural tube defects (NTD); avoid in pregnancy.
    - Risk is linked to these medications' antifolate properties, but even high doses of supplemental folate during pregnancy don't reliably prevent the risk of NTD
- Prenatal valproate is also associated with poor school performance, lower IQ, even autism.
- Lamotrigine: No significant risk of birth defects, but clearance can increase by 250% during pregnancy, requiring dose increases as necessary for symptom control.

Antipsychotics During Pregnancy

- There's some evidence of increased rate of birth defects among antipsychotic-exposed infants, but no specific patterns, suggesting that the underlying illness or unidentified confounds might explain this excess risk of birth defects.
- Risperidone has been linked with an increased risk of cardiac malformations in one study.
- Keep antipsychotic doses at the lowest effective dose during pregnancy to minimize potential adverse sequelae in newborns like sleepiness, jitteriness and extrapyramidal symptoms.
- Haloperidol and olanzapine are reasonable options since there's a lot of information on their use in pregnancy; quetiapine is another good option as it has relatively low placental passage.
- Minimize use of medications for which there's little pregnancy data, like asenapine, paliperidone, lurasidone, clozapine.

ECT

- Safe, rapid, and effective for patients with bipolar disorder
- Main complications are preterm labor and transient fetal arrhythmias, but these are rare
- Produces minimal fetal medication exposure and rapid symptom resolution.

FDA use in pregnancy ratings

- These have been recently revised and the A, B, C, D, X categories are being phased out.
- Don't base your choice of medication use in pregnancy solely on FDA use in pregnancy ratings; information from large numbers of human exposures is far more meaningful.

Prophylactic Treatment for Postpartum Psychosis

- Patients with bipolar disorder should begin prophylactic treatment immediately upon delivery to prevent relapse if they're not already on a mood stabilizer.
- Lamotrigine and lithium are good options, but careful monitoring and dose adjustments are crucial.

Breastfeeding Considerations

- Lithium: Generally not recommended due to the potential for high serum levels in nursing infants, especially if the infant experiences dehydration from conditions like diarrhea or fever.
- Carbamazepine and Valproate: Safe to use in breastfeeding due to their high protein binding.
- Antipsychotics: Generally considered safe; monitor for dose-dependent exposure risks, like sedation in the baby.
- Medications' pharmacokinetics: Highly protein-bound medications with short half-lives tend to produce the least infant exposure through breast milk

Summary:

- Preconception: Begin management early, with a focus on switching to safer medications and stabilizing the patient.
- Pregnancy: Monitor closely for signs of relapse, adjust medication doses as needed, and avoid high-risk medications like valproate and carbamazepine. Lithium and lamotrigine levels vary widely as pregnancy progresses. First trimester exposure to lithium increases the risk of cardiac defects in a dose dependent manner.
- Postpartum: Implement prophylactic treatment to prevent relapse for patients who are not already on a mood stabilizer.
- Breastfeeding: Many medications can be safely taken during breast-feeding, although lithium is best avoided.
- Documentation: Carefully document discussions about the risks and benefits of treatment and the patient's capacity to consent. Also, document that you've informed the patient of the 2-4% baseline risk of birth defects, regardless of medication exposures. Indicate whether the patient's symptoms are improving with the medication, and if they are not improving, document that you will discontinue an ineffective medication rather than continue to expose the fetus to the medication.