



with you through the highs & lows

BIPOLAR DISORDER AND PREGNANCY

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If you are thinking of becoming pregnant and you have bipolar disorder, there is a lot to consider. You may have many questions such as: Can I take my medication during pregnancy? Will it harm my baby? Can pregnancy and childbirth lead to a relapse of my bipolar disorder? Can I take medication while breastfeeding? This booklet gives general guidance and is a good starting point but for specific medical advice suited to your individual situation you will need to speak to the experts involved with your care: psychiatrist, community psychiatric nurse, obstetrician, midwife, GP etc.

Before you become pregnant

At the point at which you are thinking of having a baby you should discuss it with your GP and psychiatrist. You should have a discussion about any medication you are taking and whether or not any changes need to be made. The risks to the baby of taking medication during pregnancy will be weighed against the risk to you (and baby) of relapse without medication. All options, from stopping all medication throughout pregnancy to staying on the usual regime, are possible. Certain medications such as sodium valproate must be taken with a long acting contraceptive to guard

against unplanned pregnancies and is not suitable for use during pregnancy due to the risks to the baby. If you are usually on a mood stabiliser it will be best for you to discuss your plans to conceive, with your psychiatrist, before you become pregnant.

After assessment, discussion and agreement on changes to medication, a period of three months on continued contraception is advised to ensure that the changes will not trigger an episode of illness.

During pregnancy

If you are on medication and discover you are pregnant, do not stop medication suddenly. Instead seek advice from your GP or psychiatrist as soon as possible. During pregnancy, you are no more or less likely to suffer a relapse of your bipolar disorder than if you were not pregnant. However, if there have been changes made to your medication because of your pregnancy, there is a possibility that this may increase the risk of relapse. This is one reason why it is so important to involve your health team in your decision to have a baby as early as possible. They will be able to help you weigh up the benefits and disadvantages of changing medication, support you in the decisions you make and agree with you

on a plan of management if your mood should begin to deteriorate.

Treatments used in bipolar disorder and their effects on a pregnancy

Any pregnancy has a 3-5% risk that the baby will be born with health problems, and a decision to continue a medication during pregnancy may potentially increase this risk. Since it is not ethical to test medications on pregnant women, most information about safety of medications in pregnancy is gathered over years, from women who choose to stay on their medication during this time. Consequently we know most information about those medications that have been around the longest time.

The safety of any medication during pregnancy cannot be guaranteed. The first trimester of pregnancy is when the baby's organs are forming, so in general the risks of taking medication are highest during this period. However some medications may also pose risks later on in pregnancy. In general, if medication is to be taken during pregnancy, keeping medication regimes as simple as possible and at the lowest effective dose is best.

Lithium

It is clear that the use of lithium during the first three months of pregnancy increases the risk of heart

malformations in the newborn child. One estimate of the risk is as high as 7-10%. There is a definite increased potential for the child to have Ebstein's malformation, which is a malformation of one of the major chambers of the heart. This condition can, though not always, be life threatening for the baby.

Lithium is also associated with a higher than expected frequency of stillbirths and deaths soon after birth. If lithium is given in late pregnancy, there is a risk of dangerously high levels of lithium occurring in the mother and the baby. If lithium is to be given at any stage of pregnancy, very careful and frequent monitoring of lithium levels is needed to avoid toxicity.

If after discussion with your doctor it is agreed that lithium should be withdrawn, this should be done gradually over 6-8 weeks prior to conception. There is a risk of an attack of mania occurring soon after rapid lithium withdrawal and this should also be planned for. In the case of an unplanned pregnancy where the mother is taking lithium, a doctor should be immediately consulted. An early ultrasound test should be asked for which can identify possible problems in foetal development, some of which will benefit from early identification and treatment.

If, after the first three months of pregnancy, it is decided to restart lithium, it may be necessary to increase the mother's usual lithium dose to take account of changes during pregnancy in the way in which the kidneys clear lithium from the body.

In late pregnancy it is very important that the doctor who is prescribing and monitoring the lithium dosage consults closely with the obstetrician. In childbirth, the way in which the kidneys clear lithium alters again, this time suddenly. In order to minimise the risk of toxic effects in both mother and child, lithium may be reduced or withdrawn in the weeks leading up to the estimated date of delivery. Lithium should always be stopped as soon as labour begins. It is likely that a hospital birth rather than a home birth would be recommended if the mother was taking lithium during pregnancy because the monitoring is more easily done in a hospital.

After the birth of the child, a decision can be made on restarting lithium without the complications of any risk to the baby, although breast feeding will be discouraged.

Carbamazepine (Tegretol)

It is known that carbamazepine can be associated with a number of different problems for unborn

babies, some of which are quite serious, but there is not enough evidence to estimate just how high the risk is likely to be. You should consult your psychiatrist for up to date advice.

Sodium Valproate It is not advisable to take this drug during pregnancy because of the high risk of serious danger to the unborn baby.

Antidepressants (Tricyclics, MAOI's and SSRI's)

Tricyclic antidepressants (eg amitriptyline and imipramine) have been in use for at least 40 years, and until recently no studies had shown any association with significant difficulties for an unborn baby. However, one recent large study has suggested there may be similar small suspected risks to those found with SSRIs.

There is not enough available information to determine whether the antidepressants known as Monoamine Oxidase Inhibitors (MAOIs) (eg moclobemide and phenelzine) pose risks to the unborn baby, but the manufacturers do advise their avoidance during pregnancy.

There is some information to suggest that the SSRI medications (fluoxetine, sertraline, paroxetine, citalopram, escitalopram, fluvoxamine)

are associated with septal heart defects if taken in the first trimester of pregnancy. There is also a possibility that these medications slightly increase the risk of the newborn suffering breathing problems (Persistent Pulmonary Hypertension of the Neonate or PPHN) if the mother takes SSRIs in the second half of her pregnancy. These possible risks are small and suspected, not definite.

There is a possibility that if any antidepressant medication is taken at the end of pregnancy, the baby may suffer neonatal adaptation syndrome. Symptoms include restlessness, irritability, agitation and difficulty feeding, and are usually mild and short-lived.

Benzodiazepines

Benzodiazepines (eg diazepam, temazepam and nitrazepam) do not seem to be associated with an increased risk of birth defects, but if taken later in pregnancy there is a slightly increased risk of premature birth, low birth weight and low Apgar scores. Babies may also experience withdrawal effects. If a woman has been taking benzodiazepines for a significant period of time, the process of reducing and ceasing this medication may need to be done gradually, and it is important to take this into account if you are planning to become pregnant.

Antipsychotic medication

In general these medications do not seem to be associated with an increased risk of birth defects. They carry a small possibility that the newborn baby may experience side effects from the medications, but these effects are likely to be mild and self-limiting.

Olanzapine is known to be associated with weight gain, and this is thought to increase the risk of gestational diabetes in the mother. There also seem to be potential risks to babies who are born after their mothers have taken Clozapine in pregnancy and this is a risk that must be discussed with your psychiatrist as early as possible, ideally before you conceive.

After birth

Most people are aware that all women are at increased risk of suffering difficulties in their mood after their babies are born. Up to 80% of women suffer "baby blues", which tends to occur in the first week after birth and can make a woman tearful and changeable in her mood. This usually goes away on its own after a few days.

There is increasing awareness of postnatal depression, which can affect up to 10% of women

after their babies are born. Health care professionals routinely check for this and ensure that those who develop this condition get rapid treatment so it does not progress.

A postnatal condition that is less well known is postpartum or puerperal psychosis. This affects 0.2% of women after their babies are born, but is much more common in women who have a diagnosis of bipolar disorder and those who have previously experienced postpartum psychosis.

Without plans put in place to address the condition should it arise, the risk of postpartum psychosis can be as high as 50%, even in women who have been well for many years. However, with the right planning during pregnancy and careful postnatal management, this risk can be significantly reduced. In practice, this usually means taking the most effective medication to prevent relapse, starting towards the end of pregnancy or immediately after delivery, whatever decision has been taken about medication during pregnancy.

Postpartum Psychosis

Of those women who develop postpartum psychosis, 50% will show symptoms in the first week after giving birth, and 90% within the first month after giving birth. This means there is a

very clear period of time in which new mums, families and health care professionals need to be mindful of the symptoms to watch for. These can include high anxiety, restlessness, confusion or disorientation, strange ideas, excessive worries about the baby or fears of not being safe. Sometimes women can also hear voices or see things that are not really there. These symptoms can develop over several hours and often do not resemble the usual pattern of symptoms that the woman and her family would recognise as being a sign of a relapse of bipolar disorder.

In many cases these symptoms can come and go quite frequently. This can falsely reassure families and health care professionals that the illness has passed when in fact it is vital to get help as quickly as possible if you think symptoms of postpartum psychosis are beginning. This illness is very treatable but can sometimes make women behave in a way that can be risky, so the sooner symptoms are addressed the better.

Breastfeeding

All medications used to manage mood disorder in the mother can pass into breast milk but to varying extents according to the type of drug.

It is not advisable for a woman who is taking lithium to breast feed her baby. If she is keen to do so, a

discussion needs to take place between herself and her doctor about the benefits and disadvantages of this course of action. If she chooses to proceed her baby will need to have regular blood tests to check its level of lithium.

There is insufficient evidence that breastfeeding while taking sodium valproate, carbamazepine or lamotrigine is safe, and this is often advised against. Antidepressants and benzodiazepines are generally thought to be safe in breastfeeding if the baby is healthy and born at term, though it is wise for health care professionals to make sure the baby is not oversedated. An exception to this is doxepin, which seems to be present in higher amounts in breast milk and can cause the baby to suffer vomiting, drowsiness or breathing problems.

Again it is important to speak to your doctor before making any decisions about breastfeeding while taking medication or ceasing medication in order to breastfeed.

Conclusion

The message of this booklet is simple: plan ahead. Seeking the best medical advice as early as possible and following it gives you the best chance to avoid an episode. Specialist perinatal services are available. Ask your GP or psychiatrist for a

referral. If you should become unwell and require hospital admission after the baby is born, mother and baby units are available although these may not be local.

During your pregnancy and postnatally it is especially important that all the healthcare professionals looking after you and your baby share information and work together. This will give you and your baby the best possible chance of staying well.

All new mothers need additional help during the period of adjustment after giving birth. There is no need to be “supermum”. Allow yourself time to recover, make the health of you and your baby a priority and other things can be taken care of in your own time or by others. Enlist the help of family and friends to support you during this time and accept the help you need. Most of all enjoy this special time.

Where can I find more information/support?

Bluebell at Parentline Scotland Helpline for Postnatal Depression

T: 0800 345 457

Scotland's dedicated postnatal depression helpline. This support service is available to anyone in Scotland affected by postnatal depression.

National Childbirth Trust

T: 0300 330 0770

W: www.nctpregnancyandbabycare.com

The National Childbirth Trust provides information and support on all aspects of pregnancy, childbirth and early parenthood. They also provide support groups in Scotland.

Action on Puerperal Psychosis

W: www.app.-network.org

A patient organisation aimed at building up a pool of women who have experienced puerperal psychosis (also known as postpartum psychosis) and are interested in helping with research. Aims to provide up to date research information to women who have experienced puerperal psychosis.

For more details of organisations who can help, contact Bipolar Scotland or go to our website www.bipolarscotland.org.uk

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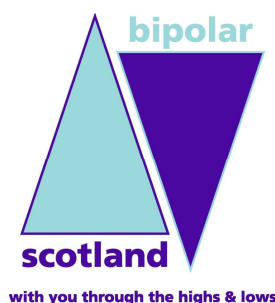
Bipolar Scotland was established in 1992 as a Scottish Charity and as a Company Limited by Guarantee in 1994. Initially known as Manic Depression Fellowship Scotland the name was changed to Bipolar Fellowship Scotland in 2004 and subsequently in 2010 to Bipolar Scotland.

Bipolar Scotland is “user led” with the Board of Directors comprising people with bipolar disorder and carers. Bipolar Scotland is run from a central office based in Paisley and provides various services to members and others who have been affected by bipolar disorder. To date this has included an information service, production of leaflets/booklets and a quarterly newsletter, On the Level. The organisation supports an ever growing network of self help groups throughout Scotland, and delivers self management training to people who have experienced bipolar disorder. Bipolar Scotland also provides awareness training and talks to external organisations.

Bipolar Scotland is represented on a number of national forums that cover mental health, social care and research into bipolar disorder.

Vision Statement

Bipolar Scotland’s vision statement is to enhance the quality of life of people with bipolar disorder and their carers, including friends and relatives, by offering appropriate support at both individual and group level.



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