Psychotropic Drugs May Be Needed in Pregnancy

Maternal psychiatric illness, if inadequately treated or untreated, may result in poor compliance with care.

BY GREG MUIRHEAD Contributing Writer

KOLOA, HAWAII — Although labeling typically doesn’t support the use of psy-
chotropic drugs in pregnant women, the drugs might be needed during pregnancy,
according to an observational study done at Emory University, Atlanta.

“What I want you to recognize is that you’re going to expose the child to some-
thing, be it illness or treatment, and in the context of that, some decisions are far worse than others,” Dr. Zachary N. Stowe said at the annual meeting of the Ameri-
can College of Psychiatrists. “Abruptly stopping or changing treatment at knowl-
edge there may exert an effort on your part to reduce your anxiety. It doesn’t change outcome. In fact, it probably worsens outcome,” Dr. Stowe asserted.

The need for treatment cannot be ig-
nored. A large number of women who be-
come pregnant have a mental health prob-
lem.

“We’re talking about [400,000] or 500,000 women every year with a neu-
ropsychiatric illness that begins before family planning, or that might have been treated or needed to be treated during family planning,” said Dr. Stowe, who is di-
rector of the women’s mental health pro-
gram at Emory University.

And with 4 million U.S. deliveries per year, he pointed out, “over 50% of preg-
nancies are unplanned.”

Studies of antenatal depression and its consequences led the American College of Obstetricians and Gynecologists to issue the following guideline statement in No-
tember 2007:

“Maternal psychiatric illness, if inade-
quately treated or untreated, may result
in poor compliance with prenatal care, inadequate nutrition, exposure to addi-
tional medications or herbal remedies, increased alcohol and tobacco use, disrupted mother-infant bonding, and disruptions within the family environ-
ment.”

Other antenatal depression study find-
ings include increases in suicide, postpar-
tum depression, premature birth, low birth weight, neonatal complications, and fetal demise, said Dr. Stowe.

In the observational study that he and his colleagues conducted, pregnant women who had depression decided for themselves whether to discontinue their antidepressant medication.

Of women who discontinued, 68% became “sick” before delivery, said Dr. Stowe. The other 32% were able to stop taking their antidepressant safely, but 25% who stayed on their antidepressant still be-
came sick.

For women with bipolar disorder who discontinued their mood-stabilizing med-
ication, 85% became sick before delivery.

A big problem, of course, is the typical drug labeling statement that “use in preg-
nancy is not recommended unless the poten-
tial benefits justify the potential risks to the woman,” which Dr. Stowe called “hand-
washing.”

There’s no question that psychotropic drugs will reach the fetus. Psychotropic medicines are designed to get past the blood-brain barrier and reach the brain, which means they will likely pass through the placental barrier without any difficul-
ty. His own unpublished research has sup-
ported this, but he wondered if it is always harmful.

“You can actually statistically argue that antidepresants reduce your risk of birth

defects,” he said. “To date, we have no confirmed evidence of increased birth de-
fects on our antidepressants.”

In some psychotropic categories, how-
ever, outcomes are better than others or much worse.

“Valproate has consistently the highest placental passage of any medicine we’ve studied, and it has the worst outcome,” said Dr. Stowe. “It is worse than Acuta-
cene.”

“In my opinion, there is no justification for first-line use of valproic acid in women of reproductive years,” he continued. In babies whose mothers used valproic acid during preg-
nancy, “the mean IQ drops 15 points. One in 10 chil-
dren is mentally retarded,” he said.

On the other hand, “lam-
ottine is the con-
trast we’ve seen. It is emerging as the number-
one treatment for epilepsy during pregnancy. The overall malformation rate is lower than the national av-
erage,” he pointed out.

A recent, not-yet-pub-
lished study of the use of lamotrigine in 26 women with bipolar disorder found that they did well if they continued the drug throughout pregnancy but not if they discontinued.

A higher dosage is needed for treat-
ment of bipolar disorder, just as it is need-
ed for epilepsy, Dr. Stowe said.

Another unpublished study found that pregnant women using olanzapine “failed their blood sugar test, independent of dose,” he said. “We should not trade ges-
tational diabetes to treat mental illness during pregnancy, because what we are actually trading is the risk for adult-onset diabetes after pregnancy. Gestational dia-
betes is a well-known risk factor for that.”

For medication purposes, ‘You
should treat all women as though they are pregnant, starting at age 9.
From 9 to 49, they are pregnant until proven otherwise,’ he said.

Regarding the possibility of passing medicines to infants during breast-feeding, “the dose in pregnancy is huge compared to the dose in lactation. Worrying about the medicine in lactation, you used it in pregnancy, is really a waste of time. Our medicines in the blood-
stream for antidepressants are nanograms per milliliter; for anticonvulsants they are in micrograms per milliliter. That’s what gets into breast milk,” he said.

Dr. Stowe is on advisory boards for Brit-
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Induction Protocol Fails to Avert C-Sections, but Aids Ors

BY PATRICE WENDLING Chicago Bureau

DALLAS — Use of the AMOR-
IPAT protocol did not significan-
tly reduce cesarean deliveries in a prospective randomized tri-
al of 270 women.

AMOR-IPAT, (Am. J. Obstetr. Perinatal Manage-
ment of Risk in Pregnancy at Term), a controversial approach, involves prostaglandin-assisted preventive labor induction based on a risk-scoring system. Dr. James Nicholson reported at the annual meeting of the Society for Maternal-Fetal Medicine.

The women enrolled in the study had at least one of six spe-
cific risk factors for delivery and were randomized at 37 weeks, 4 days’ gestation to either the AMOR-
IPAT (n = 146) or usual care (n = 134). Their mean age was 23 years.

As expected, the AMOR-IPAT group experienced significantly higher rates of labor induction (60% vs. 22%) and prostaglandin usage (40% vs. 16%), and were delivered, on average, 1 week earlier than the usual-care group.

In an intent-to-treat analysis, the rate of cesarean delivery was not significantly dif-
ferent between the AMOR-IPAT and usu-
al-care groups (10% vs. 15%).

However, the AMOR-IPAT group had significantly lower neonatal intensive care unit ad-
mission rate of 1.5% compared to the AMOR-
IPAT (n = 146) or usual care (n = 134). Their mean age was 23 years.

‘Clearly there is a conflict between our current methods of care and this method of care, so there would need to be changes … for structure and process.’

Not much is known about the use of atypical antipsychotic drugs during preg-
nancy, he said.

As for pregnant women using lithium,
be aware that current methods at birth can cause lithium toxicity in the infant, he said. (Am. J. Psychiatry 2005;162:1162-70).

Switching drugs during the course of pregnancy with the thought that drug B has increased safety data than drug A is con-
troversial, Dr. Stowe said, “because all the data for med-
cines B were not derived from babies that first got medicine A. Everything we know about teratology says two medicines are worse than one. And please remember, the later trimesters can be just as important as the first trimester.”

Given the uncertainties of switching, the possibility of undetected preg-
nancy in female patients, you should treat all women as though they are pregnant, starting at age 9. From 9 to 49, they are pregnant until proven otherwise,” he said.

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... and I would suggest that if the AOI scores are really improved to the level seen in this study that we might take a look at our processes of care and consider some significant changes,” Dr. Nicholson commented.

Two previous retrospective, nonrandomized studies showed a significant decrease in cesarean deliveries with the AMOR-IPAT protocol (Ann. Fam. Med. 2007;5:130-9; Am. J. Obstet. Gy-

The study was funded jointly by the National Institutes of Health and the First Hospital Foundation.

Dr. Nicholson disclosed that Forest Pharmaceuticals provided free samples of its dinoprostone containing generic of prostaglandin E2 to the university’s hospital, but that none of the samples were used during the study.

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