Clinical Guideline / Formulary Document

Pharmacy Department Medicines Management Services

USE OF PSYCHOTROPIC MEDICINES DURING PREGNANCY

Introduction

- Mental disorders are no less common in pregnant than in non-pregnant women. Anxiety and depression are very common. Women who have experience of, or are at risk of mental health problems, should get extra support before, during and after their pregnancy.
- Women with pre-existing major mental disorders are at greater risk of compromised maternity care, delivery complications and relapse in pregnancy and the postpartum period.
- Medication, including psychotropic drugs, can have harmful effects at any time during pregnancy. In early pregnancy, teratogenesis is the main concern. In later pregnancy, risks of medication include neonatal toxicity or poor neonatal adaptation following delivery and the possibility of a long term impact on the infant’s neurodevelopment. However, it is also important to ensure that maternal mental health is adequately treated because untreated mental illnesses can be harmful to both the mother and fetus or baby.
- There is a background incidence of congenital malformations of 2-3% (spontaneous abortions 10-20%), irrespective of any drug or chemical exposure.
- There are limited and sometimes conflicting data on the effects of psychotropic medication in pregnancy. Therefore, the potential benefits of treatment in pregnancy and breastfeeding should be carefully weighed against potential risks to the fetus.
- Women (and their partners and families/carers with consent), should be involved in all discussions about the risks of using pharmacological treatments for mental health disorders in pregnancy and postpartum.

Prescribing Advice - Pregnancy

- No psychotropic drug has marketing authorisation specifically for pregnant or breastfeeding women. Due to lack of experience and limited information, manufacturers generally advise women to avoid taking psychotropic medication during pregnancy and when breastfeeding. Informed consent for use should be obtained and documented.
- Wherever possible, the benefits and risks of treatment should be discussed with the service user. The risks of becoming pregnant whilst taking psychotropic medication as well as the risks from an untreated mental disorder and from stopping medication abruptly should be discussed.
- Care is needed when prescribing psychotropics to all women of childbearing potential. Some psychotropic drugs have inherent teratogenic risks in pregnancy. Contraceptive advice should be provided to prevent unplanned pregnancy.
- In most cases, if a woman is being treated successfully with psychotropic medication before pregnancy, the same treatment should continue throughout pregnancy. But this is not the case for lithium, valproate or carbamazepine.
- If pregnancy is planned and mental health is stable with a low risk of relapse, discontinuing psychotropic medication may be considered.
- Where a woman is stabilised on psychotropic medication before or during pregnancy, the risk of discontinuing or changing medication, or reducing the dose, should be carefully weighed against the risk of relapse.
Prescribing Advice – Pregnancy continued

- If a psychotropic drug is required during pregnancy, the lowest effective dose of a single drug with the lowest known risk should be used for the shortest period necessary.
- Information on the specific risks of individual psychotropic drugs can be requested from Medicines Information. However, the final decision regarding which treatment is used for an individual service user remains the clinical responsibility of the prescriber.

Prescribing Advice – Safety and Monitoring

- Some psychotropic drugs particularly anticonvulsant mood-stabilisers and lithium, have known teratogenic risks in pregnancy. Do not offer valproate or carbamazepine to treat a mental health problem in women of present and future childbearing potential. Do not offer lithium to women who are planning a pregnancy or pregnant, unless no other medication is likely to be effective.
- Where psychotropic medications with known risk are prescribed, appropriate fetal screening and monitoring of the neonate for side effects are recommended.
- Folic acid supplements are recommended for women on anticonvulsants from preconception to at least the end of the first trimester.
- Use of psychotropics in pregnancy can lead to side effects in the newborn including irritability, agitation, persistent crying, sleep disturbances, hypertonia, hypotonia, tachypnoea, tremor, somnolence, hypoglycaemia, poor thermal regulation, respiratory difficulty, and feeding problems. Therefore, neonates born to a mother taking psychotropic medication should be carefully monitored.
- Pregnancy and childbirth can affect drug pharmacokinetics and pharmacodynamics, leading to treatment failure. Therapeutic drug monitoring and dose adjustments may be required at different stages of pregnancy and following birth.

Prescribing Advice - Breastfeeding

- During breast-feeding many drugs taken by the mother are excreted in milk and ingested by the infant. However, compared with pregnancy, much smaller amounts of psychotropic drugs are thought to transfer to the offspring during breastfeeding.
- The safety of medication in breastfeeding is difficult to establish. There is little research into the immediate effects of the mother’s medication on the baby and even less research into the long-term effects on the developing infant. Therefore, careful consideration should be given to the risks and benefits of prescribing psychotropic medication during breast-feeding.
- Do not routinely offer carbamazepine, clozapine, depot antipsychotics or lithium to women who are breastfeeding.
- Depending on the medication, the infant should be monitored for sedation, irritability, respiratory distress and drug-specific side effects as well as feeding patterns, growth and development. If problems are identified, appropriate action should be taken (e.g. dose reduction, drug change, referral for advice).
- Neonates (and particularly premature infants) are at greater risk from exposure to drugs via breast milk, because of immature excretory functions leading to risk of drug accumulation.
- Women who choose to breastfeed while taking psychotropic medication should be supported, given the widely known health benefits to infants who are breast-fed.
- If possible, monotherapy with the lowest effective dose of medication should be used.
Prescribing Advice – Breastfeeding continued

- Medication should be administered as a single daily dose to be taken immediately after the infant's last feed and before the longest sleep period.
- Breast feeding is best done immediately before administering the dose and should be avoided for one to two hours after any dose of medication to avoid peak levels.
- It is best to avoid sedating drugs and those with long half-lives and long-acting preparations, especially if the drug is likely to cause serious adverse effects, as timing feeds to avoid exposure of the infant to the medication will be difficult.
- Monitor the infant carefully for developmental milestones.
- The need for continuing medication should be kept under review.

Relevant NICE Guidance


Use of Psychotropic Medication in Pregnancy – Antidepressants

<table>
<thead>
<tr>
<th>Depression</th>
<th>Notes</th>
</tr>
</thead>
</table>
| General principles | • Where possible, non-pharmaceutical management of depression is preferable unless there are clear benefits from drug therapy. Carefully consider the risks and benefits of individual treatments for depression and discuss with service user. Choice of antidepressant in pregnancy should take into account implications for breastfeeding. Individual information concerning exposure to specific antidepressants should be sought.  
  • In mild depression, withdraw antidepressant and consider watchful waiting or self help or psychological therapy.  
  • In moderate/severe depression, consider an antidepressant treatment (e.g. TCA or SSRI or SNRI) and/or psychological therapies.  
  • For treatment resistant symptoms, NICE suggest consider ECT before combination drug treatment and avoid lithium augmentation.  
  • All antidepressants can cause withdrawal reactions or toxicity in neonates, although in most cases, the effects are mild and self-limiting. Antidepressants taken in the first trimester may be associated with a small increased risk of fetal heart defects and when taken after 20 weeks’ gestation may be associated with a small increased risk of persistent pulmonary hypertension (PPHN) in the newborn baby. Antidepressants may cause increase risk of neonatal adaption syndrome in the baby.  
  • Risk of withdrawal symptoms on discontinuation of antidepressants. Gradual withdrawal is advised. |
| Tricyclic Antidepressants (TCAs) £-£££ | • Most TCAs have a higher fatal toxicity index in overdose than selective serotonin reuptake inhibitors  
  • Common side effects of TCAs include anxiety, drowsiness, dizziness, agitation, confusion, anticholinergic effects (dry mouth, constipation, urinary retention and blurred vision); cardiovascular effects, hepatic effects, changes in blood sugar, increased appetite, weight gain and sexual dysfunction can occur. |
| SSRIs £-££ Liquids £££ | • Paroxetine is associated with increased severity of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby.  
  • SSRIs are better tolerated and safer in overdose than other antidepressants. SSRIs can increase risk of bleeding.  
  • Common side effects of SSRIs are headache, nausea, and anxiety/agitation, especially when starting treatment. Other side effects are insomnia, tremor, sweating, sexual dysfunction, muscle/joint pain, manic symptoms. |
| Other antidepressants £-£££ | • Venlafaxine is associated with increased severity of neonatal adaptation syndrome in the baby  
  • Venlafaxine may be associated with an increased risk of maternal high blood pressure at high doses and higher toxicity in overdose in the woman than SSRIs  
  • There is very limited data available on the use of mirtazapine and duloxetine in pregnancy, therefore use would not be routinely recommended. Risk of PPHN and neonatal withdrawal syndrome cannot be excluded. |
<table>
<thead>
<tr>
<th>Anxiety Disorders</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **General**       | • Where possible, non-pharmaceutical management of anxiety disorders is preferable in pregnancy, unless there are clear benefits from drug therapy.  
• Offer psychological therapy (e.g. cognitive behavioural therapy -CBT) before medication for new episodes of anxiety disorders in pregnancy.  
• Where indicated, antidepressants (e.g. TCA or SSRI) are the pharmacological treatment of choice for anxiety disorders in pregnancy.  
• Consider the risks and benefits of individual drug treatments for anxiety disorder and discuss with the service user.  
• If pregnancy is planned, consider withdrawing medications for anxiety and starting CBT if this has not already been tried OR switching to a drug with a safer profile in pregnancy.  
• Use monotherapy with the lowest effective dose of medication for the shortest treatment period necessary. |
| **Antidepressants £-£££** | • Choice of antidepressant in pregnancy should also take into account implications for breastfeeding.  
• Individual information concerning exposure to specific antidepressants should be sought.  
• All antidepressants can cause withdrawal reactions or toxicity in neonates, although in most cases, the effects are mild and self-limiting. |
| **Pregabalin ££££** | • There is no information on the use of pregabalin in human pregnancy. It should therefore not be used for anxiety in pregnancy unless there is a clear indication for it. Additional risks should be discussed with the service user. |
| **Benzodiazepines £ Liquids £££** | • Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of extreme anxiety and agitation.  
• Benzodiazepine use in the first trimester may increase the risk of cleft palate, pre-term birth and low birth weight. Third trimester use carries a higher risk of neonatal withdrawal symptoms such as ‘floppy infant syndrome’ which includes hypotonia, lethargy and sucking difficulties. Benzodiazepines should not be used routinely.  
• In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible.  
• Consider gradually stopping benzodiazepines in women who are planning a pregnancy or pregnant. |
# Use of Psychotropic Medication in Pregnancy - Antipsychotics

<table>
<thead>
<tr>
<th>Schizophrenia and Psychotic Disorders</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **General**                          | • Schizophrenia and psychosis during pregnancy and postpartum should be managed similarly to treatment of psychotic disorders at any other time, but considering risks of medication use during pregnancy and breastfeeding.  
• Information on the teratogenic potential of individual antipsychotics is limited but current evidence does not suggest that antipsychotic drugs are major teratogens. Individual information concerning exposure to specific antipsychotics should be sought.  
• In general, there is more information available for first generation (typical) antipsychotics used in pregnancy  
• Abrupt discontinuation of antipsychotic medication should be avoided due to an increased risk of relapse.  
• Most women with established schizophrenia should continue treatment during pregnancy.  
• In all cases, when considering switching, take into account the risks of deterioration and maternal relapse.  
• Depots should not routinely be prescribed because of limited information about their safety and lack of flexibility in dosing. Infants may show extrapyramidal symptoms to antipsychotic depots for several months after birth.  
• Several cases of gestational diabetes have been associated with use of antipsychotics during pregnancy – so screening for gestational diabetes is recommended, particularly for olanzapine and clozapine.  
• Progress of pregnancy in women with psychotic disorders should be monitored closely for normal foetal development and to detect relapse or other pregnancy complications  
• Folate supplementation is recommended for at least 3 months before and after conception  
• Maternal use of antipsychotics in late pregnancy can cause self-limiting withdrawal effects (lethargy, tremor, paradoxical hyperexcitability), extrapyramidal and other side effects (e.g. agitation, hypertonia, hypotonia, tremor, somnolence, feeding problems and respiratory distress in the newborn  
• Breastfed infants of mothers taking antipsychotics should be monitored for sedation and extra-pyramidal effects. |
# Use of Psychotropic Medication in Pregnancy - Antipsychotics

<table>
<thead>
<tr>
<th>Schizophrenia and Psychotic Disorders</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Haloperidol £</strong></td>
<td>• Risk of extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery</td>
</tr>
<tr>
<td><strong>Phenothiazines £</strong></td>
<td>• Potential for hypotension, sedation and anticholinergic effects</td>
</tr>
<tr>
<td><strong>Olanzapine - £</strong></td>
<td>• Consider risk factors for gestational diabetes and weight gain, including family history, existing weight and ethnicity.</td>
</tr>
<tr>
<td><strong>Branded ££- £££</strong></td>
<td>• Monitor maternal blood glucose, BP and weight, and fetal growth carefully throughout pregnancy.</td>
</tr>
<tr>
<td><strong>Clozapine ££</strong></td>
<td>• Do not prescribe clozapine routinely during pregnancy due to a theoretical risk of agranulocytosis in the fetus. Consider switching to another drug and monitor carefully for relapse.</td>
</tr>
<tr>
<td></td>
<td>• Consider risk factors for gestational diabetes and weight gain, including family history, existing weight and ethnicity.</td>
</tr>
<tr>
<td></td>
<td>• Risk of adverse reactions including extrapyramidal, seizures and/or withdrawal symptoms that may vary in severity and duration following delivery.</td>
</tr>
<tr>
<td></td>
<td>• Clozapine is excreted in breast milk and can cause side effects and withdrawal effects on the infant. Women who are taking clozapine should not usually breast feed due to the risk of agranulocytosis and seizure in the infant.</td>
</tr>
<tr>
<td><strong>Quetiapine</strong></td>
<td>• Experience of use in pregnancy is limited and additional maternal, fetal and neonatal monitoring may therefore be advisable.</td>
</tr>
<tr>
<td><strong>Tabs £ M/R ££</strong></td>
<td>• There is very limited data on other antipsychotics in pregnancy, especially newer agents like aripiprazole. Therefore, avoid use unless there are clear benefits from use. Additional risks should be discussed with the service user.</td>
</tr>
<tr>
<td></td>
<td>• Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a history of non-adherence with oral medication. Risk of EPSE in the newborn baby that may last for several months.</td>
</tr>
<tr>
<td><strong>Other antipsychotics £-£££</strong></td>
<td>• Procyclidine should be used during pregnancy only if the indication is compelling. Where procyclidine use has occurred near delivery, the neonate should be monitored for symptoms of PNAS or anti-cholinergic syndrome.</td>
</tr>
<tr>
<td></td>
<td>• Only use anticholinergic drugs for acute short term use; instead, adjust dose and timing of antipsychotic, or switch.</td>
</tr>
</tbody>
</table>

Anticholinergics

**Procyclidine £**
## Use of Psychotropic Medication in Pregnancy – Antimanic Drugs and Mood Stabilisers

<table>
<thead>
<tr>
<th>Bipolar Affective Disorder</th>
<th>Notes</th>
</tr>
</thead>
</table>
| General                   | • In bipolar disorder, contraception, and the risks of psychotropics in pregnancy (including relapse, fetal malformations and the risks of stopping or changing medication) should be discussed with all women of child-bearing potential.  
  • Pharmacological treatments which would normally be used in the management of bipolar disorder may need to be reviewed, prioritising treatments which have evidence of less adverse effects in pregnancy and breast feeding  
  • Offer antipsychotic medication if a woman with bipolar disorder becomes pregnant and as prophylactic medication if a woman with bipolar disorder: becomes pregnant and is stopping lithium, or plans to breastfeed.  
  • Pregnant women may be maintained on their usual antipsychotic if they are stable and are considered at risk of relapse should medication be withdrawn.  
  • Detailed ultrasound scans should be considered to screen for major structural malformations and high dose folic acid 5mg daily supplementation is recommended. |
| Valproate £-££  
Depakote £££       | • Treatment with valproate is associated with risk of teratogenicity and long term neurobehavioural toxicity.  
  • Do not offer valproate to treat a mental health problem in women of present and future childbearing potential. |
| Carbamazepine £       | • Do not offer carbamazepine to stabilize mood in women who are planning a pregnancy, pregnant or considering breastfeeding. Limited efficacy in bipolar disorder and risk of neural tube defects and other malformations in the fetus.  
  • Due to enzyme induction, carbamazepine may result in a failure of the therapeutic effect of oral contraceptive drugs containing oestrogen and/or progesterone. Women of child bearing potential should be advised to use alternative contraceptive methods while on treatment with carbamazepine. |
| Lamotrigine £-££       | • Do not prescribe routinely due to limited efficacy and risk of neural tube defects and other malformations in the fetus.  
  • Lamotrigine should not be used in breast feeding due to risk of severe dermatological problems in the infant.  
  • Lamotrigine is subject to significant alterations in metabolism in pregnancy and serum levels should be monitored.  
  • If used in pregnancy, detailed ultrasound scans should be considered.  
  • If used, high dose folic acid supplementation (5 mg/day) is recommended |
# Use of Psychotropic Medication in Pregnancy – Antimanic Drugs and Mood Stabilisers

<table>
<thead>
<tr>
<th>Bipolar Affective Disorder</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **Lithium £-££**          | • Do not offer lithium to women who are planning a pregnancy or pregnant, unless no other medication is likely to be effective.  
• Use of lithium in pregnancy can cause both teratogenic effects, particularly in the first trimester and neonatal complications.  
• However, it may be prescribed under specialist supervision for women at high risk of relapse.  
• Care and monitoring is required because the dose required to achieve therapeutic levels may increase from mid-pregnancy, but high levels at delivery can be associated with toxicity in the mother and neonate.  
• Women taking lithium in early pregnancy should be offered detailed ultrasound scanning for fetal abnormality.  
• Lithium is excreted in breast milk in high levels and in view of the potential risks to the infant, mothers should be advised to avoid breast feeding or monitoring of the infant is required. |
| **Antipsychotics £-£££**  | • If a pregnant woman with bipolar disorder is stable on an antipsychotic and is likely to relapse without medication she should be maintained on the antipsychotic, and monitored for weight gain, diabetes and fetal growth.  
• Offer antipsychotic medication (e.g. quetiapine, olanzapine, haloperidol) if a woman with bipolar disorder becomes pregnant.  
• Infants should be monitored in the first few weeks for adverse effects, drug toxicity or withdrawal. |
| **Antidepressants £-££**  | • See treatment for depression. All antidepressants can cause withdrawal reactions or toxicity in neonates.  
• Quetiapine may be offered in depressive episodes in bipolar disorder.  
• Neonates should be observed for a neonatal withdrawal syndrome or serotonin toxicity. |
| **Benzodiazepines £-££** | • Do not offer BZP to women in pregnancy and the postnatal period except for the short-term treatment of extreme anxiety and agitation.  
• Benzodiazepine use in the first trimester may increase the risk of cleft palate, pre-term birth and low birth weight. Third trimester use carries a higher risk of neonatal withdrawal symptoms such as ‘floppy infant syndrome’ which includes hypotonia, lethargy and sucking difficulties. Benzodiazepines should not be used routinely.  
• In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible.  
• Consider gradually stopping benzodiazepines in women who are planning a pregnancy or pregnant. |
## Use of Psychotropic Medication in Pregnancy – Sedatives and Hypnotics

<table>
<thead>
<tr>
<th>Insomnia</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **General** | - Sleep hygiene (e.g. bed time routines, the avoidance of caffeine, and the reduction of activity before sleep) should be considered before drug treatment.  
- For women with a severe or chronic sleep problem, consider promethazine.  
- Wherever possible, avoid benzodiazepines; if clinically required during pregnancy and breast feeding, short-acting agents should be prescribed in low doses and for a short period of time. Use near term should be avoided. |
| **Benzodiazepines £-££**  
**Liquids £££** | - Benzodiazepines should not be used routinely. Benzodiazepine use in the first trimester may increase the risk of cleft palate, pre-term birth and low birth weight. Third trimester use carries a higher risk of neonatal withdrawal symptoms such as ‘floppy infant syndrome’ which includes hypotonia, lethargy and sucking difficulties  
- Diazepam has been associated with a varying risk of oral clefts, although data is conflicting.  
- Lorazepam crosses the placenta and floppy baby syndrome and respiratory depression can occur  
- In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible. Consideration should be given to gradually tapering the dose and withdrawal prior to childbirth. |
| **Z drugs £-££** | - There is limited data to assess the safety of zopiclone, zolpidem or zaleplon in pregnancy and breast-feeding  
- Neonatal withdrawal symptoms are possible following use during pregnancy.  
- Avoid use during pregnancy  
- Risk of impaired driving ability the next day |
| **Antihistamines £** | - According to published data and in combination with many years of clinical experience, promethazine at therapeutic doses has not been associated with an increased risk of congenital abnormalities above the background rate for the general population. Please note however that there is a theoretical risk of neonatal withdrawal symptoms with promethazine following use near to term.  
- NICE recommends considering promethazine for women with a severe or chronic sleep problem. |
## Use of Psychotropic Medication in Pregnancy – Drugs Used in Substance Misuse

<table>
<thead>
<tr>
<th>Substance Misuse</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **General**      | • Offer detoxification to pregnant women. Monitor closely after completion of detoxification.  
|                   | • In substance misuse acute withdrawal should be avoided in pregnancy because it can cause fetal death.  
|                   | • Substitution therapies may be appropriate during pregnancy because they carry a lower risk to the fetus than continued use of illicit drugs.  
|                   | • Withdrawal regimes should be undertaken gradually during the second trimester  
|                   | • Monitor for neonatal withdrawal symptoms |
| **Benzodiazepines** | • Do not use during pregnancy, especially during the first and last trimesters, unless there are compelling reasons.  
| e.g. diazepam and chlordiazepoxide | • If use is unavoidable, use of the lowest effective dosage, for the shortest duration possible, and in divided doses to avoid high peak concentrations.  
| Liquids £££ | • When used later in pregnancy, benzodiazepines may be associated with floppy baby syndrome and the possibility of withdrawal symptoms and restlessness in neonates. Observation of the neonate for respiratory depression, withdrawal symptoms or adaptation problems is recommended when benzodiazepines have been used up to delivery. |
| **Methadone £**  | • Recommended opioid substitution treatment  
| Tablets/Conc/Injection £-££ | • Drug metabolism can be increased in the third trimester; it may be necessary to either increase the dose of methadone or change to twice-daily consumption (or a combination of both strategies) to prevent withdrawal symptoms. |
| **Buprenorphine ££** | • Use for pregnant women stabilised on buprenorphine |
| **Lofexidine ££** | • Use in pregnancy and breast-feeding only if benefit outweighs risk |
## Use of Psychotropic Medication in Pregnancy — Drugs Used in Substance Misuse

<table>
<thead>
<tr>
<th>Substance Misuse</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disulfiram ££</td>
<td>• High concentrations of acetaldehyde which occur in presence of alcohol may be teratogenic; avoid in first trimester. Avoid in breast-feeding.</td>
</tr>
<tr>
<td>Acamprosate ££</td>
<td>• Avoid in pregnancy and breastfeeding</td>
</tr>
<tr>
<td>Naltrexone ££</td>
<td>• Use in pregnancy only if benefit outweighs risk. Avoid in breastfeeding—present in milk in animal studies</td>
</tr>
<tr>
<td>Baclofen £</td>
<td>• Avoid in pregnancy and breastfeeding</td>
</tr>
<tr>
<td>Nalmefene £££</td>
<td>• There are no or limited data from the use of nalmefene in pregnant women. Nalmefene is not recommended during pregnancy.</td>
</tr>
<tr>
<td>Pabrinex® £££</td>
<td>• Caution should be exercised when prescribing to pregnant women.</td>
</tr>
<tr>
<td>Carbamazepine £-££</td>
<td>• Do not prescribe carbamazepine for women who are planning a pregnancy, pregnant or considering breastfeeding because of the lack of evidence of efficacy and the risk of neural tube defects in the fetus.</td>
</tr>
<tr>
<td>Symptomatic relief of withdrawal symptoms - £</td>
<td>• Gaviscon and paracetamol may be given to pregnant women.</td>
</tr>
</tbody>
</table>
| NRT £-£££         | • Offer NRT after risk–benefit analysis if other interventions have been unsuccessful  
• NRT may present some risk to the foetus but this may be less harmful to the foetus than smoking during pregnancy  
• Do not offer varenicline or bupropion to pregnant or breastfeeding women |
References


Pregnancy and Breastfeeding Recommendations for special groups in the
    • Maudsley Prescribing Guidelines 12th eds
    • Bazire’s Psychotropic Drug Directory 2016


UKMI Q&A 394.1. Are atypical antipsychotics safe during breast feeding?. Published 25th February 2014, updated 7th March 2016 · https://www.sps.nhs.uk/articles/are-atypical-antipsychotics-safe-during-breast-feeding/


