

Exposure to Prescribed Medication during pregnancy

Background:

- Refer also to Maternal mental health protocol (MP014)
- Women are prescribed medication during pregnancy for a variety of reasons e.g.:
 - Conditions arising in pregnancy (symphysis pubis dysfunction, pyelonephritis)
 - Treatment for mental health conditions (depression, anxiety, ODC, bipolar disorder)
 - Chronic long-term illness (fibromyalgia, endometriosis)
- Mothers with moderate to severe mental health problems or previous significant perinatal mental health illness, or bipolar disorder will usually have been seen by the PMHT Perinatal Mental Health Team (contact: tel:0300 304 0097, spnt.perinatalreferrals@nhs.net).
- There will be a birth plan, which should include discussion about breast feeding.
- Mothers with less severe/longstanding or stable mental health problems may be on medicine prescribed by their GP. Information provided is more variable.
- There is also an antenatal '*maternal medicine*' to which mothers can be referred using the email address uhsussex.smmc@nhs.net – plans from this clinic can be found in maternity badger under specialist review.

Use of codeine in pregnancy

- For painful conditions arising in pregnancy, codeine is safe to use during pregnancy and usually the first choice if straightforward measures are not effective.
- The prescriber should raise the possibility that this medication may result in withdrawal symptoms in the baby if taken regularly during the last few weeks of pregnancy. If only taken intermittently, or has been stopped before the last couple of weeks, then neonatal withdrawal is unlikely.
- If there is a need for this medication to be continued after delivery, and a mother wishes to breast feed, an alternative medication will be required. Make sure mother is aware. Seek specialist advice
- If newborn infants develop withdrawal symptoms, this usually occurs within 24 hrs.
- Occurrence after 36 hours is unlikely, and discharge is safe at 48 hours.

Medication for maternal mental health conditions

Most mothers will already have carefully considered the risks and benefits of taking medication in pregnancy, and a plan should have been made for delivery and the early newborn period which will normally have included breast feeding. However there is often considerable misinformation and sometimes conflicting views and advice.

General principles:

- Maternal/infant separation and prolonged hospital admission should be avoided
- The mother's notes should be read carefully
- If the newborn baby has any signs or symptoms it should not be assumed that these are 'just due to medication'. Take a careful history including non-prescribed medication.
- Seek further information/advice if you have any concerns that the maternal medication might affect the baby, then seek senior advice and discuss any concerns with her treating clinician.
- If you have any concern about the mother's health/well-being, have a low threshold for contacting the specialist nurse/psychiatric liaison team
- Seek the mother's permission to share information and share communication with all relevant professionals

Assessment of baby

- Look for symptoms of poor feeding, lethargy, irritability.
- Consider other possible causes: e.g. sepsis hypoglycaemia, polycythaemia
- Admission to neonatal unit (with maternal baby separation) is only according to clinical need.
- Repeated reassurance is important providing there are no specific concerns.
- Most babies can be safely discharged after 24 hours

SSRI treatment – neonatal adaptation post-birth

- It is not uncommon for these infants to develop some disturbances of muscle tone or increased jitteriness during the first 48-72 hours after delivery.
- Maternal reassurance is important. Avoid the use of the word '*withdrawal*' as this is not a helpful description (use '*adaptation*').
- Use of 'scoring charts' is not helpful, and they are not validated in this area.
- PPHN is reported as a potential complication. Our experience is that incidence reported in the literature (2-3/1000) is likely to be an overestimate due to reporting bias. This can be excluded by the oxygen saturation screening - so check this has been completed and the result is normal.
- Assessment – see above. Following assessment, then reassurance can be provided.
- The symptoms almost always settle spontaneously without treatment
- It is usually safe to breast feed with these medications- as the relative infant dose is <10%.

Multiple maternal medications:

- Situation may be more complicated and it is likely that the perinatal mental health team will be involved. Seek specialist advice.

Sources of information regarding breastfeeding:

- Textbooks: (Neonatal consultant office)
Briggs et al,
Schaefer et al (tends to give a more nuanced balanced approach)
- BUMPS – Best Use of Medicines in Pregnancy (excellent balanced patient information leaflets) www.medicinesinpregnancy.org
- BSUH Drugs information service (contact via pharmacy)
- Local prescribing guide: produced by the PMHT:
www.sussexpartnership.nhs.uk/sites/default/files/documents/perinatal_prescribing_-_jan_18_update_-_final_-_0218.pdf
- UK Specialist Pharmacy Service (SPS): www.sps.nhs.uk enter the name of medicine in search box, then click on the specific medicine in the list scroll down to lactation safety information
- Articles discussing safety in lactation for groups of drugs or specific clinical problems: www.sps.nhs.uk/?s=&cat%5B0%5D=266&cat%5B1%5D=3008
- LactMed database – National Library of medicine, USA
www.ncbi.nlm.nih.gov/books/NBK501922/