CERPO
Centro de Referencia Perinatal Oriente
Facultad de Medicina, Universidad de Chile

Seminario n°134: Otros trastornos psiquiátricos y Embarazo

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MAPA DE LA RUTA:

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TRASTORNOS PSIQUIÁTRICOS Y EMBARAZO

- Introducción
- Esquizofrenia
- Trastorno afectivo bipolar
- Psicosis post parto
- Consumo de sustancias en Chile
- Conclusiones

Introducción

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- **Los trastornos psiquiátricos en el embarazo pueden alterar el desarrollo de apego.**
- **Implicancia a largo plazo para el bienestar de la mujer, el RN, su familia y la sociedad**
- **Puede culminar en suicidio o infanticidio**
- **El uso de antipsicóticos que no producen hiperprolactinemia, ha aumentado la fertilidad en el grupo de pacientes bajo control**

CLINICAL PSYCHOLOGY REVIEW

Intimate partner violence during pregnancy and perinatal mental disorders in low and lower middle income countries: A systematic review of literature, 1990–2017

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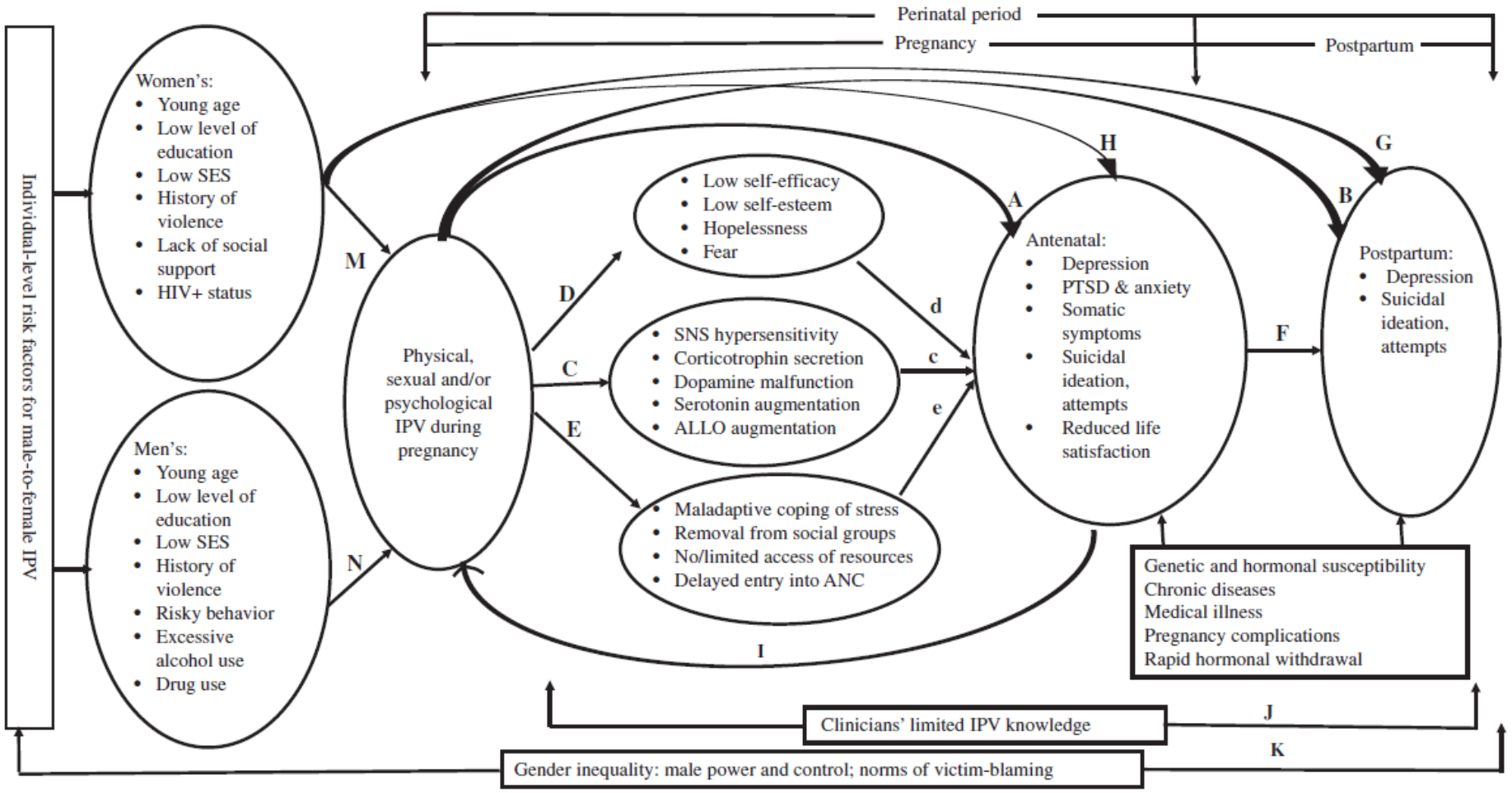

Fig. 1. Causal pathways linking IPV during pregnancy and perinatal mental disorders. Notes: SNS = Sympathetic Nervous System; ALLO = Allopregnanolone, a cholesterol-derived neuroactive steroid.

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	IPV in 6/12-months prior to pregnancy		IPV during pregnancy		Lifetime IPV	
	Authors, year	AOR (95% CI)	Authors, year	AOR/RR (95% CI)	Authors, year	AOR (95% CI)
Depression	IPV Type: Physical					
	–	–	Mahenge et al. (2013)	3.76 (2.25–6.29) (moderate physical IPV)	–	–
	–	–		1.74 (1.14–2.67) (severe physical IPV)	–	–
	–	–	Nasreen et al. (2011)	1.69 (1.02–2.80)	–	–
	–	–	Varma et al. (2007)	victimized/not victimized = 10.6/3.6	–	–
	IPV Type: Sexual					
	–	–	Mahenge et al. (2013)	3.20 (2.21–4.63)	–	–
	IPV Type: Physical and sexual IPV					
	–	–	Mahenge et al. (2013)	2.76 (1.71–4.47)	–	–
	IPV Type: Physical or sexual IPV					
	–	–	Mahenge et al. (2013)	3.31 (2.39–4.59)	Stewart et al. (2014a)	18.5 (4.98–68.6)
	–	–	–	–	Stewart et al. (2014b)	19.0 (5.76–62.7)
CMD	IPV Type: Physical					
	–	–	Hanlon et al. (2009)	6.3 (1.7–23.4)	–	–
	–	–	Fisher, Tran, Biggs et al. (2013a)	4.1 (1.1–15.8)	Fisher, Tran, Biggs et al. (2013a)	1.7 (1.0–2.7)
	IPV Type: Psychological					
	Karmaliani et al. (2009)	4.0 (2.8–5.8)	–	–	Fisher, Tran, Biggs et al. (2013a)	2.5 (1.4–4.5)
	IPV Type: Sexual					
	–	–	–	–	Fisher, Tran, Biggs et al. (2013a)	14.3 (3.3–62.7)
	IPV Type: Physical or sexual IPV					
	Karmaliani et al. (2009)	9.3 (6.1–14.0)	–	–	–	–
	IPV Type: Physical, sexual or psychological					
	Fisher, Tran, Duc Tran, et al. (2013)	2.1 (1.5–2.9)	–	–	Patel et al. (2002b)	1.9 (1.4–2.7)
	–	–	–	–	Abdelhai and Mosleh (2015)	3.3 (1.3–8.3)
Anxiety	IPV Type: Physical					
	–	–	Mahenge et al. (2013)	4.57 (2.73–7.65) (moderate physical IPV)	–	
	–	–		1.90 (1.22–2.96) (severe physical IPV)	–	–
	–	–	Nasreen et al. (2011)	β, *p*: 1.61, 0.02	–	–
	IPV Type: Sexual					
	–	–	Mahenge et al. (2013)	3.49 (2.39–5.10)	–	–
	IPV Type: Physical and sexual IPV					
	–	–	Mahenge et al. (2013)	3.06 (1.87–5.00)	–	–
	IPV Type: Physical or sexual IPV					
	–	–	Mahenge et al. (2013)	3.98 (2.85–5.57)	–	–
PTSD	IPV Type: Physical					
	–	–	Mahenge et al. (2013)	4.57 (2.73–7.65) (moderate physical IPV)	–	–
	–	–		1.44 (0.68–3.05). (severe physical IPV)	–	–
	–	–	Varma et al. (2007)	19.7 vs. 17.0, < 0.05	–	–
	IPV Type: Sexual					
	–	–	Mahenge et al. (2013)	2.25 (1.27–3.98)	–	–
			Varma et al. (2007)	19.9 vs. 17.1, ns		
	IPV Type: Physical and sexual IPV					
	–	–	Mahenge et al. (2013)	2.70 (1.40–5.19)	–	–
	IPV Type: Physical or sexual IPV					
	–	–	Mahenge et al. (2013)	2.94 (1.71–5.06)	–	–

(continued on next page)

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	IPV in 6/12-months prior to pregnancy		IPV during pregnancy		Lifetime IPV	
	Authors, year	AOR (95% CI)	Authors, year	AOR/RR (95% CI)	Authors, year	AOR (95% CI)
Suicidal ideation	IPV Type: Psychological					
	Asad et al. (2010)	5.66 (2.10–15.26) (> 1 act/wk. vs. < 1 act/mo)	-	-	-	-
		n.s. (1 act/wk.-1 act/mo vs. < 1 act/mo	-	-	-	-
	IPV Type: Physical or sexual IPV					
	Asad et al. (2010)	4.90 (1.94–12.39) (> 1 act/wk. vs. < 1 act/mo	-	-	-	-
		2.61 (1.13–6.04) (1 act/wk. − 1 act/mo vs. < 1 act/mo)	-	-	-	-
	IPV Type: Physical, sexual or psychological					
	-	-			Supraja et al. (2016)	Not significant

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Summary findings on associations of postnatal mental disorder with IPV by type, n = 24, 1990–2017.

	IPV in 6/12-months prior to pregnancy	IPV during pregnancy	IPV during postpartum	Lifetime IPV	IPV in 6/12-months prior to pregnancy		IPV during pregnancy	IPV during postpartum
	Authors, year	AOR (95% CI)	Authors, year	AOR/RR (95% CI)	Authors, year	AOR/RR (95% CI)	Authors, year	AOR (95% CI)
Depression	IPV Type: Physical							
	-	-	Islam et al. (2017)	1.79 (1.25–3.43)	Kabir et al. (2014)	2.8 (1.7–4.64)	Gausia et al. (2009)	1.00 (0.3–3.9)[!]
	-	-	Rogathi et al. (2017)	2.15 (1.13–4.11).	-	-	Budhathoki et al. (2012)	1.53 (0.41–5.75)[!,a]
	-	-			-	-	Budhathoki et al. (2012)	1.36 (0.37–5.05)[!,a]
	-	-			-	-	Budhathoki et al. (2012)	0.35 (0.04–2.98)[!,a]
	IPV Type: Sexual							
	-	-	Islam et al. (2017)	2.25 (1.14–4.45)			-	-
	-	-	Rogathi et al. (2017)	1.98 (1.22–3.23)	Kabir et al. (2014)	1.1 (0.1–1.6)[!]	-	-
	IPV Type: Psychological							
			Islam et al. (2017)	6.92 (1.71–28.04)	Kabir et al. (2014)	1.1 (0.9–1.2)[!]	Fisher et al. (2007)	β, p-value: 0.27, 0.02
	-	-	Rogathi et al. (2017)	1.46 (0.92–2.30). N.S.	-	-	-	-
	IPV Type: Physical, seuxual or psychological IPV							
	Husain et al. (2006)	0.6 (0.2–1.7)[!]	Shamu et al. (2016)	7.04 (3.68–13.44) (5 + IPV acts)	-	-	DØRheim Ho-Yen et al. (2007)	3.20 (0.9–11.6)[!]
	-	-		2.53 (1.31–4.88) (1–4 IPV acts)	-	-	Patel et al. (2002)	1.9 (1.2–2.8) If girl infant
	-	-	Rogathi et al. (2017)	2.51 (1.67–3.76)	-	-	Patel et al. (2002)	1.7 (0.8–3.5)[!] If boy infant
CMD	IPV Type: Physical							
	-	-	-	-	-	-	Fisher, Tran, Biggs et al. (2013)	2.6 (1.5–4.5)
	IPV Type: Sexual							
	-	-	-	-	-	-	Fisher, Tran, Biggs et al. (2013)	3.9 (1.8–8.7)
	IPV Type: Psychological							
	-	-	-	-	-	-	Fisher, Tran, Biggs et al. (2013)	3.1 (1.8–5.8)
	One Type of IPV							
	-	-	-	-	Fisher, Tran, Biggs et al. (2013)	5.0 (1.6–15.7)	-	-
	2–3 types of IPV							
	-	-	-	-	Fisher, Tran, Biggs et al. (2013)	10.1 (2.8–37.3)	-	-
Suicide	IPV Type: Physical, sexual or psychological							
	-	-	Shamu et al. (2016)	2.21 (1.18–4.12) (5 + IPV acts vs. 0)	-	-	-	-
	-	-		1.26 (0.67–2.37) (1–4 IPV acts vs. 0)	-	-		-
CMD	Disoders in the perinatal period							
	IPV Type: Physical, seuxual or psychological IPV							
	Fisher et al. (2010)	9.3 (6.1–14.0)	-	-	-	-	-	-
	Tran et al. (2012)	β, p: 0.26, 0.02	-	-	-	-	-	-

Perinatal mental health 2

Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period

Ian Jones, Prabha S Chandra, Paola Dazzan, Louise M Howard Lancet 2014; 384: 1789–99

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Esquizofrenia

- **Evidencia no muestra mayor recaída durante embarazo**
- **La prescripción de antipsicóticos podría ser menor durante el 2°y3er trimestre, pero no se debe discontinuar tratamiento.**

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Trastorno afectivo bipolar

- Embarazo podría ser factor protector tanto de debut como de descompensación.
- 8% de los casos perinatales debutan durante el embarazo
- 50% recaída post parto, 20% psicosis puerperal

- SUSPENDER TRATAMIENTO?

  - En episodios de psicosis puerperal, el embarazo no constituye mayor riesgo, no obstante, en episodios no relacionados con la maternidad, el embarazo es más riesgoso

Perinatal mental health 2

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Ian Jones, Prabha S Chandra, Paola Dazzan, Louise M Howard

Lancet 2014; 384: 1789–99

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Trastorno afectivo bipolar

Panel 2: Preconception advice for women with severe mental illness

All women with a severe mental illness in their reproductive years should be able to access advice with regard to pregnancy and parenting, ideally, from a perinatal specialist. A checklist of issues to consider would include the following criteria:

Planning for motherhood
A large proportion are unplanned and discussion of plans for a family and advice with regards to contraception should be routine with all women of childbearing potential.

Potential effects on illness
For each woman, her individual risk of a relapse or recurrence should be discussed. This discussion will include the severity and nature of previous episodes, severity of current episode or time since last episode, and family history of episodes in relation to childbirth.

Optimisation of physical and mental health
Preconception is an ideal time to address a range of issues key to a healthy pregnancy. These issues will include smoking, obesity, diet, drug and alcohol use, domestic violence, folate and vitamins, and physical exercise. In addition, optimisation of management of mental health is needed to ensure women enter pregnancy as well as possible. In pregnancy, specific tests are required such as assessment of gestational diabetes and consideration should be given to referral for specialised ultrasound.

Medication
The risks and benefits of all options should be discussed, including continuation of current medication regime, stopping of one or all drugs, and switching of medication. Issues to consider in the risk–benefit analysis include evidence of efficacy in this woman for each drug; previous response to change in medications or dose reduction; what alternative treatment options have been explored; and past history of teratogenicity (eg, neural tube defects). Options for restarting of medication later in pregnancy or in the post partum can be discussed.

Genetic risk
Women and their partners might have concerns about passing a susceptibility to severe mental illness to their children and these concerns can be addressed or the woman referred for further genetic counselling.

Liaison with other services
All professionals involved in looking after a woman through pregnancy and the post-partum should be informed about the history of severe mental illness. Professionals include—obstetricians, midwives, mental health services, social services, general practitioners, and health visitors.

Tratamiento TAB

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- Teratogenicidad Antipsicóticos
- Litio:
  - Anomalía de Ebstein
- ECT
  - 3% complicaciones fetales
  - 5% complicaciones obstétricas

Psychopharmacotherapy in Pregnancy and Breastfeeding

Salvatore Giovanni Vitale, MD,* Antonio Simone Laganà, MD,* Maria Rosaria Anna Muscatello, MD, PhD,† Valentina Lucia La Rosa, PsyD,‡ Veronica Currò, MD,§ Gianluca Pandolfo, MD, PhD,‖ Rocco Antonio Zoccali, MD, PhD,¶ and Antonio Bruno, MD, PhD,‖

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Volume 71, Number 12
OBSTETRICAL AND GYNECOLOGICAL SURVEY

- Tratamiento por equipo multidisciplinario disminuye significativamente el riesgo de deterioro y recaídas
- Tratamiento no farmacológico sin eficacia demostrada

ORIGINAL ARTICLE

Recent status of pregnant women with mental disorders at a Japanese perinatal center

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Department of Obstetrics and Gynecology, Japanese Red Cross Katsushika Maternity Hospital, Tokyo, Japan

THE JOURNAL OF MATERNAL-FETAL & NEONATAL MEDICINE, 2017
https://doi.org/10.1080/14767058.2017.1336761

Offspring outcomes after prenatal interventions for common mental disorders: a meta-analysis

Marlies E. Brouwer[1,2], Alishia D. Williams[1,6], Sam E. van Grinsven[1], Pim Cuijpers[3], Mijke P. Lambregtse-van den Berg[4], Huibert Burger[5] and Claudi L. H. Bockting[2]

Brouwer *et al. BMC Medicine*
https://doi.org/10.1186/s12916-018-1192-6

Psychopharmacological prescribing practices in pregnancy for women with severe mental illness: A multicentre study

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Table 3 Prescription drugs use by primary diagnosis and hospital ($N = 535$).

	Schizophrenia/psychosis ($n = 154$)			Bipolar disorders ($n = 218$)			Non-psychotic SMI ($n = 163$)		
	Mercy ($n = 29$)	KEMH ($n = 125$)	OR[a] [95% CI]	Mercy ($n = 39$)	KEMH ($n = 179$)	OR[a] [95% CI]	Mercy ($n = 54$)	KEMH ($n = 109$)	OR[a] [95% CI]
	n (%)	*n* (%)		*n* (%)	*n* (%)		*n* (%)	*n* (%)	
No medication	**1 (3.4%)**	**16 (12.8%)**	**4.11 [0.52, 32.33]**	**8 (20.5)**	**20 (11.2%)**	**0.49 [0.20, 1.21]**	**27 (50.0%)**	**16 (14.7%)**	**0.17[c] [0.08, 0.37]**
Atypical antipsychotics	**25 (86.2%)**	**98 (79.7%)**	**0.51 [0.19, 1.81]**	**15 (38.5%)**	**118 (65.9%)**	**3.01[c] [1.51, 6.33]**	**13 (24.1%)**	**38 (34.9%)**	**1.69 [0.81, 3.53]**
Quetiapine	7 (24.1%)	33 (26.4%)	1.13 [0.44, 2.88]	6 (15.4%)	95 (53.1%)	6.22[c] [2.48, 15.58]	7 (13.0%)	28 (25.7%)	2.32[0.94, 5.73]
Olanzapine	6 (20.7%)	43 (34.4%)	2.01[0.76, 5.31]	7 (17.9%)	24 (13.4%)	0.71[0.28, 1.78]	5 (9.3%)	12 (11.0%)	1.21[0.40, 3.64]
Clozapine	4 (13.8%)	8 (6.4%)	0.43[0.12, 1.53]	0 (0%)	1 (0.6%)	-	0 (0%)	0 (0%)	-
Risperidone	2 (6.9%)	18 (14.4%)	[b]	0 (0%)	4 (2.2%)	-	0 (0%)	1 (0.9%)	-
Aripiprazole	7 (24.1%)	12 (9.6%)	.33[c][0.12, 0.94]	2 (5.1%)	4 (2.2%)	[b]	0 (0%)	1 (0.9%)	-
Ziprasidone	1 (3.4%)	1 (0.8%)	[b]	0 (0%)	0 (0%)	-	1 (1.9%)	0 (0%)	-
Asenapine	0 (0%)	1 (0.8%)	-	0 (0%)	1 (0.6%)	-	0 (0%)	0 (0%)	-
Typical antipsychotics	**3 (10.3%)**	**21 (16.8%)**	**1.75[0.49, 6.32]**	**0 (0%)**	**4 (2.2%)**	-	**1 (1.9%)**	**0 (0%)**	-
Typical antipsychotics - low potency	0 (0%)	7 (5.6%)	-	0 (0%)	3 (1.7%)	-	1 (1.9%)	0 (0%)	-
Typical antipsychotics - high potency	3 (10.3%)	20 (16.0%)	1.65[0.46, 5.98]	0 (0%)	3 (1.7%)	-	0 (0%)	0 (0%)	-
Mood stabilizers and antiepileptics	**2 (6.9%)**	**6 (4.8%)**	**0.68 [0.13, 3.56]**	**20 (51.3%)**	**80 (44.7%)**	**0.78 [0.38, 1.54]**	**5 (9.3%)**	**9 (8.3%)**	**0.88 [0.28, 2.77]**
Lithium	2 (6.9%)	1 (0.8%)	[b]	11 (28.2%)	32 (17.9%)	0.55[0.25, 1.23]	2 (3.7%)	2 (1.8%)	[b]
Sodium valproate	0 (0%)	2 (1.6%)	-	2 (5.1%)	11 (6.1%)	[b]	1 (1.9%)	3 (2.8%)	[b]
Carbamazepine	0 (0%)	2 (1.6%)	-	1 (2.6%)	6 (3.4%)	[b]	0 (0%)	1 (0.9%)	-
Lamotrigine	1 (3.4%)	1 (0.8%)	[b]	8 (20.5%)	35 (19.6%)	0.94[0.40, 2.23]	2 (3.7%)	1 (0.9%)	[b]
Gabapentin	0 (0%)	0 (0%)	-	1 (2.6%)	0 (0%)	-	0 (0%)	2 (1.8%)	-
Other antiepileptics	0 (0%)	0 (0%)	-	0 (0%)	1 (0.6%)	-	0 (0%)	0 (0%)	-
Antidepressants	**3 (10.3%)**	**39 (31.2%)**	**3.93[c][1.12, 13.77]**	**13 (33.3%)**	**94 (52.5%)**	**2.21[c][1.07, 4.58]**	**16 (29.6%)**	**18 (74.3%)**	**6.87[c][3.33, 14.19]**
SSRI	3 (10.3%)	21 (16.8%)	1.75 [0.49, 6.32]	7 (17.9%)	58 (32.4%)	2.19[0.91, 5.26]	13 (24.1%)	45 (41.3%)	2.22[c][1.07, 4.61]
SNRI	0 (0%)	16 (12.8%)	-	5 (12.8)	35 (19.6%)	1.65[0.60, 4.53]	2 (3.7%)	37 (33.9%)	13.36[c][3.08, 57.93]
Mirtazapine	0 (0%)	5 (4.0%)	-	1 (2.6%)	15 (8.4%)	[b]	1 (1.9%)	20 (18.3%)	[b]
Tricyclic antidepressants	0 (0%)	2 (1.6%)	-	0 (0%)	2 (1.1%)	-	0 (0%)	2 (1.8%)	[b]
Other antidepressants	0 (0%)	1 (1.8%)	-	0 (0%)	3 (1.7%)	-	0 (0%)	3 (2.8%)	-
Sedatives	**0 (0%)**	**14 (11.2%)**	**-**	**0 (0%)**	**12 (11.2%)**	**-**	**1 (1.9%)**	**24 (22.0%)**	[b]
Psychostimulants	**0 (0%)**	**1 (0.8%)**	**-**	**0 (0%)**	**10 (5.6%)**	**-**	**0 (0%)**	**4 (3.7%)**	**-**
Other	**0 (0%)**	**0 (0%)**	**-**	**0 (0%)**	**1 (0.6%)**	**-**	**0 (0%)**	**2 (1.8%)**	**-**

Note. Non-psychotic SMI group comprises diagnoses of major depressive disorder, obsessive compulsive disorder, post-traumatic stress disorder, panic disorder, anorexia and bulimia nervosa, adjustment disorder.
–Binary regression not conducted due to one or both cells being constant.
[a] Within each Primary Diagnosis group, the odds ratio (OR) that a KEMH woman (0), versus a Mercy Hospital woman (1), will be using an agent belonging to the prescription drug class at any point during pregnancy.
[b] OR unstable and not reported: large standard error due to small cell count.
[c] $p < .05$.

Psychopharmacological prescribing practices in pregnancy for women with severe mental illness: A multicentre study

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Table 2 Psychotropic prescribing in antenatal women across pregnancy, first trimester and third trimester by primary diagnosis and hospital ($N = 535$).

	Schizophrenia/psychosis			Bipolar disorders			Non-psychotic SMI		
	Mercy ($n = 29$)	KEMH ($n = 125$)	Total ($n = 154$)	Mercy ($n = 39$)	KEMH ($n = 179$)	Total ($n = 218$)	Mercy ($n = 54$)	KEMH ($n = 109$)	Total ($n = 163$)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Across pregnancy									
None	1 (3.4%)	15 (12.0%)	16 (10.4%)	10 (25.6%)	22 (12.3%)	32 (14.7%)	29 (53.7%)	15 (13.8%)	44 (27.0%)
One	20 (69.0%)	48 (38.4%)	68 (44.2%)	13 (33.3%)	41 (22.9%)	54 (24.8%)	17 (31.5%)	34 (31.2%)	51 (31.3%)
Two	7 (24.1%)	41 (32.8%)	48 (31.2%)	10 (25.6%)	55 (30.7%)	65 (29.8%)	5 (9.3%)	38 (34.9%)	43 (26.4%)
Three	1 (3.4%)	14 (11.2%)	15 (9.7%)	6 (15.4%)	46 (25.7%)	52 (23.9%)	3 (5.6%)	19 (17.4%)	22 (13.5%)
Four	0 (0%)	7 (5.6%)	7 (4.5%)	0 (0%)	13 (7.2%)	12 (5.5%)	0 (0%)	2 (1.8%)	2 (1.2%)
Five	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.05%)	0 (0%)	1 (0.9%)	1 (0.6%)
Six	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1.1%)	2 (0.9%)	0 (0%)	0 (0%)	0 (0%)
First trimester									
None	1 (3.4%)	17 (13.6%)	18 (11.7%)	10 (25.6%)	22 (12.3%)	32 (14.7%)	29 (53.7%)	16 (14.7%)	45 (27.6%)
One	20 (69.0%)	50 (40.0%)	70 (45.5)	13 (33.3%)	47 (26.3%)	60 (27.5%)	17 (31.5%)	35 (32.1%)	52 (31.9%)
Two	7 (24.1%)	40 (32%)	47 (30.5%)	10 (25.6%)	51 (28.5%)	61 (28.0%)	5 (9.3%)	37 (33.9%)	42 (25.8%)
Three	1 (3.4%)	12 (9.6%)	13 (8.4%)	6 (15.4%)	44 (24.6%)	50 (22.9%)	3 (5.6%)	18 (16.5%)	21 (12.9%)
Four	0 (0%)	6 (4.7%)	6 (3.9%)	0 (0%)	14 (7.8%)	14 (6.4%)	0 (0%)	3 (2.8%)	3 (1.8%)
Five	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Six	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.6%)	1 (0.5%)	0 (0%)	0 (0%)	0 (0%)
Third trimester									
None	1 (3.4%)	26 (20.8%)	27 (17.5%)	10 (25.6%)	34 (19.0%)	44 (20.2%)	29 (53.7%)	23 (27.1%)	52 (31.9%)
One	20 (69.0%)	51 (40.8%)	71 (46.1%)	13 (33.3%)	58 (32.4%)	71 (32.6%)	17 (31.5%)	38 (34.9%)	55 (33.7%)
Two	7 (24.1%)	35 (28.0%)	42 (27.3%)	10 (25.6%)	50 (27.9%)	60 (27.5%)	5 (9.3%)	39 (35.8%)	44 (27.0%)
Three	1 (3.4%)	11 (8.8%)	12 (7.8%)	6 (15.4%)	30 (16.8%)	36 (16.5%)	3 (5.6%)	7 (6.4%)	10 (6.1%)
Four	0 (0%)	2 (1.6%)	2 (1.3%)	0 (0%)	5 (2.8%)	5 (2.3%)	0 (0%)	1 (0.9%)	1 (0.6%)
Five	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.9%)	1 (0.6%)
Six	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1.1%)	2 (0.9%)	0 (0%)	0 (0%)	0 (0%)

Note. Non-psychotic SMI group comprises diagnoses of major depressive disorder, obsessive compulsive disorder, post-traumatic stress disorder, panic disorder, anorexia and bulimia nervosa, adjustment disorder.

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General principles of prescribing in the perinatal period:

- It should not be assumed that it is always better to avoid psychotropic drugs
- Use the lowest effective dose
- Use the drug which is effective for women and has the lowest known risk to mother and fetus
- Prescribe the least number of drugs as possible
- Document all decisions
- Ensure that the mother and partner or family are as involved as possible in all decisions

In discussions about drugs include:

- Woman's level of distress from untreated symptoms
- Severity of previous episodes, previous response to treatment and the woman's preference
- Potential effects of an untreated mental disorder on the fetus or infant (and the need for prompt treatment)
- Risks of relapse or discontinuation symptoms from stopping drug abruptly
- Background risk of fetal abnormalities for pregnant women without a mental disorder
- Uncertainty with regards to possible increased risk of harm associated with drug treatments during pregnancy and the postnatal period; include the risk in overdose
- The possibility that stopping a drug with known risk during pregnancy might not remove the associated risk
- Absolute and relative risks should be discussed using natural frequencies and common denominators (eg, 20 in 100 and 25 in 100, not 1 in 5 and 1 in 4)

Where possible, written material (preferably individualised) should be provided to explain the risks

Pre-pregnancy

Discuss the possibility of pregnancy (including unplanned)

Avoid using contraindicated drugs eg, valproate unless only effective drug; women should be made fully aware of their risks

Carefully review need for drugs; choose drugs most likely to achieve clinical stability and of low risk (note risk of relapse with stopping or changing drug)

Consider discontinuation of treatment (potentially switching to psychological treatment) if the woman is well and at low risk of relapse

During pregnancy

Where possible use non-drug treatments

Use lowest effective dose of drug if needed; avoid changing drug regimen and use drugs with the largest up-to-date evidence of safety for the mother or fetus, taking previous response into account

Titrate doses as pregnancy progresses and drug handling is changed

Be aware of potential problems with individual drugs around the time of delivery—inform the obstetric team of psychotropic use and possible complications (including neonatal adaptation symptoms in infants)

Postnatal and breastfeeding

In each case, weigh up the benefits of breastfeeding to the mother and infant against the risk of drug exposure in the infant (which is much lower than in utero); usually inappropriate to withhold treatment to allow breastfeeding when mother is at high risk of relapse; treatment of maternal illness is the highest priority

Where possible, suitable treatment options should be used for women who wish to breastfeed rather than recommending avoidance of breastfeeding

Where a mother had taken a particular drug during pregnancy, continuation with the drug while breastfeeding will usually be appropriate to minimise withdrawal symptoms in the infant

Infants should be monitored for any adverse effects of the drugs used, for example feeding patterns and growth and development; premature infants and infants with renal, hepatic, cardiac, or neurological impairment are at high risk of exposure to drugs

Time of pregnancy

Figure 2: Guidelines to prescribe in the perinatal period

Perinatal mental health 2

Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period

Ian Jones, Prabha S Chandra, Paola Dazzan, Louise M Howard Lancet 2014; 384: 1789–99

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Psicosis puerperal

- Delirio y alucinaciones
- Se manifiesta principalmente las primeras 2 semanas post parto
- 50% 1-3 días

- 50% sin antecedentes de severidad
- Ingresos psiquiátricos 1-2/1000 RNV
- 50% de nuevo episodio en embarazos futuros
- 50% de episodio si antecedente familiar en TAB

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5)

Episodes of bipolar disorder, depressive disorders and brief psychotic disorders with onset in pregnancy or within 4 weeks of delivery can be flagged with a peripartum-onset specifier (termed postpartum-onset specifier for brief psychotic disorders).

The International Classification of Diseases (ICD–10)

A category of mental and behavioural disorders associated with the puerperium, not elsewhere classified for episodes with onset within 6 weeks of delivery, but the instruction is that this diagnosis should only be used when episodes do not meet the criteria for other diagnoses. ICD–11 is in development and whether any changes will be made to the classification of perinatal episodes is not known.

Psicosis puerperal

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- Factores de riesgo:
  - PRIMIPARIDAD
  - CAMBIOS EN MEDICACIÓN
  - ANTECEDENTE DE TAB
  - ANTECEDENTE EPISODIO POST PARTO SEVERO

- La suspensión del tratamiento tiene un riesgo de recaída 2,9 veces mayor en las embarazadas que en la población general (70% v/s 24%)

- Alteración de la función monocito-macrófago supondría una disregulación del setpoint inmunoneuroendocrino

Psicosis puerperal

- TAC CEREBRAL:
  - Mayor área ventricular izquierda
  - Mayor relación ventrículo/cerebro
  - Mayor volumen de cisterna cerebelar

Drogas en Chile

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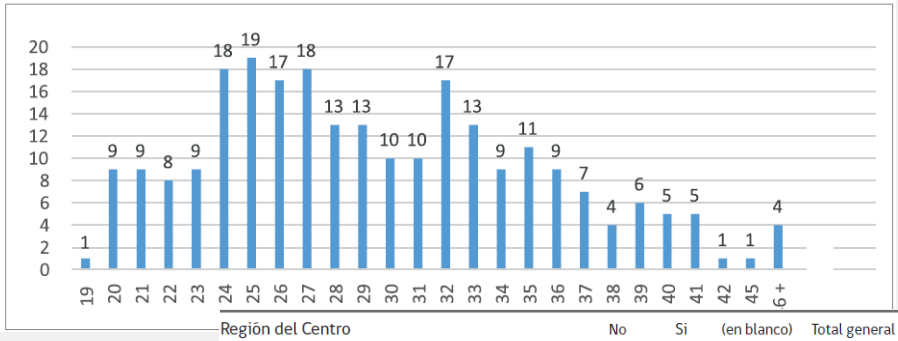
- Teratogenicidad, neurodesarrollo
- Ambiente intrauterino estresante
- Compromiso del eje HH-S
- Función placentaria
- Programación

Edad de las mujeres que ingresan embarazadas



Región del Centro	No	Si	(en blanco)	Total general	Porcentaje de embarazadas
ANTOFAGASTA	212	14		226	6,2
ARICA Y PARINACOTA	126	7	6	139	5,0
ATACAMA	156	5		161	3,1
AYSÈN DEL GENERAL CARLOS IBÃÑEZ DEL CAMPO	60	1		61	1,6
COQUIMBO	171	8	1	180	4,4
ARAUCANÌA	157	2		159	1,3
LOS LAGOS	153	2		155	1,3
LOS RIOS	116	7		123	5,7
MAGALLANES Y LA ANTÃRTICA CHILENA	56		1	57	0,0
TARAPACÁ	134	3	1	138	2,2
VALPARAÌSO	406	28		434	6,5
BÌO-BÌO	314	17		331	5,1
LIBERTADOR GENERAL BERNARDO O´HIGGINS	262	12		274	4,4
MAULE	280	13	1	294	4,4
METROPOLITANA	2535	127	11	2673	4,8
Total general	5138	246	21	5405	4,6

Tratamiento. Documentos técnicos. Mujeres y tratamiento de Alcohol y otras Drogas. Embarazo, puerperio y Lactancia. SENDA 2016. Chile.

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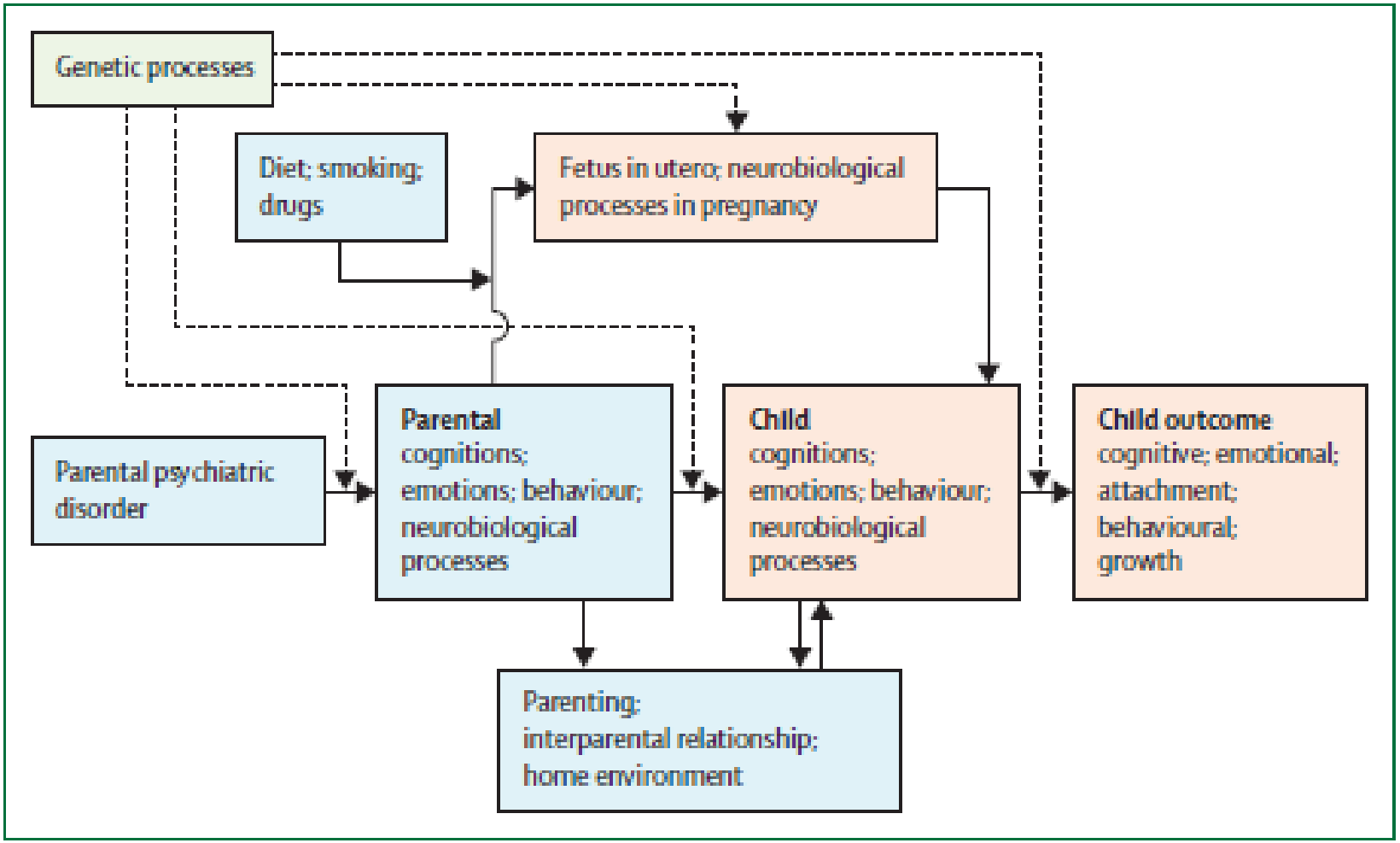

Figure: Possible mechanisms underlying the association of parental psychiatric disorders and child outcomes
Dotted lines show genetic processes. Solid lines show interactions. Orange colours refer to the child. Blue colours refer to the parents. Green represents genetic processes. Figure is based on figure 1 from Stein and Harold.[9]

Conclusiones

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Key messages

- Severe mental illness in the perinatal period occurs as a continuation of chronic psychotic illness or a new onset, often shortly after childbirth (post-partum psychosis), and these episodes can result in substantial distress and have long-term implications for the wellbeing of the woman, her family, and wider society
- Childbirth is a powerful trigger of mania and psychosis, and episodes at this time cause substantial morbidity and mortality, with suicide a leading cause of maternal death
- Pregnancy should be an important consideration in the treatment of all women with severe mental illness in their reproductive years, and careful counselling of the woman and her partner to acknowledge the many areas of uncertainty is crucial to optimal care
- Individualised risk–benefit analyses are needed when psychotropic drugs are regarded for use in the perinatal period, and the risk of untreated illness for the mother and fetus or infant should be taken into account
- Further research is essential to help understand more about the triggering of psychotic episodes by pregnancy and childbirth, enable better prediction of women at risk, and develop improved treatments for women who become unwell at this time

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Seminario n°134: Otros trastornos psiquiátricos y Embarazo

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