Use of Psychotropics in Bipolar Disorder with Pregnancy: A Case Report

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INTRODUCTION

- Use of psychotropics in a pregnant woman is a complex topic.
- No single consensus on the use of antipsychotics, mood stabilizers, and benzodiazepines in pregnancy.
- Various guidelines are available on the safe and effective use of these medications in pregnancy.
- Use should be tailored to the individual patient profile.

AIM

- To look for various psychotropics options available for use in pregnancy associated with a psychiatric disorder.
- To rationalize the use of psychotropics if the benefits of treatment outweigh the risks posed to the mother and the fetus.

METHOD

- Direct patient care.
- EPIC chart review for gathering information on pertinent labs and imaging studies.

CASE REPORT

- AB, a 30-year-old, single, African-American female with a psychiatric history of Bipolar Disorder, currently six weeks pregnant, unemployed, Supportive Housing resident.
- Brought in by the EMS to our hospital ER from a hotel lobby due to erratic behavior.
- Diagnosis of Bipolar I disorder, current episode manic, with psychotic features, severe was made and admitted to the inpatient psychiatric unit.
- Recently treated at other facility with Haloperidol 5 mg PO BID and Clonazepam 0.5 mg PO TID.
- Started on Haloperidol 5 mg PO BID, Clonazepam 1 mg PO BID, Folic acid 2 mg PO daily, Prenatal Vitamin one tablet daily at our facility.
- Obstetrics was periodically consulted for the ultrasound, well being of the fetus, and the safe use of psychotropics in pregnancy.
- Strict endocrinological surveillance (HbA1C, glycemia, cholesterol, triglycerides serum levels, bodyweight gain) was maintained.
- Haloperidol titrated up to 10 mg PO BID and Lurasidone 40 mg PO BID was added
- Clonazepam titrated down to 0.5 mg PO BID during the hospital course.
- Significantly improved clinical symptoms noted and discharged to her Supportive Housing after giving IM Haloperidol Decanoate 150 mg for better medication compliance, and with appropriate follow-up appointments.

CONCLUSION

- Antipsychotic therapy should be considered mandatory in pregnant patients with psychotic features.
- Privilege the choice to continue the previous therapy if known, as pregnancy is not the best period to experiment with new drugs' effectiveness.
- Provide strict gynecological surveillance during therapy with antipsychotics.
- Provide strict endocrinological surveillance during treatment with antipsychotics.
- For bipolar patients who plan to or do become pregnant, maintenance pharmacotherapy rather than no treatment is recommended.
- Lurasidone is classified as a Pregnancy Category B agent, and the use is recommended during pregnancy if the maternal benefit justifies the fetal risk.
- Benzodiazepine exposure during first-trimester of pregnancy may carry a small risk of cleft lip and palate.

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