One-Year Outcome After Preconception Consultation in Women With Bipolar Disorder

To the Editor: The pharmacologic management of bipolar disorder in women who wish to conceive poses a difficult dilemma for the patient, her partner, and the clinician.[1] If psychotropic medication is discontinued, the patient is as likely to develop a recurrence during pregnancy as a nonpregnant woman,[2,3] and immediately after childbirth she is more likely to become ill than remain well.[3] However, continuation of several drugs used in bipolar disorder carries the risk of congenital or developmental anomalies in the offspring. This concerns foremost valproate,[4] but also carbamazepine,[5] lithium,[6] and possibly lamotrigine.[7]

Psychiatrists specializing in perinatal disorders increasingly receive referrals for preconception consultation. Typically, the psychiatric and medication histories are carefully reviewed, and a medication plan is discussed with the patient and her partner and integrated into an overall relapse prevention plan. However, it is unknown what effect this intervention has on maternal mental health. In this uncontrolled retrospective evaluation, we examined maternal outcome in terms of treatment decisions made and symptoms experienced in the 12 months after preconception consultation in a specialist perinatal psychiatry service.

Method. Included in this study were women with a *DSM-IV* diagnosis of bipolar disorder or a single hypomanic/mixed affective episode without depression who attended the Perinatal Psychiatry Clinic in Manchester, England, for preconception advice during the period December 2001 to December 2007. Data on patient characteristics, psychiatric history, and symptoms and treatments in the 1-year follow-up period were extracted from hospital and family practice records. A recurrence was defined as any mood episode that fulfilled *DSM-IV* criteria. In line with national (United Kingdom) guidelines, the study was assessed by the Manchester Institutional Review Board (IRB) as a service evaluation rather than research and not needing IRB approval or patient consent. The project was registered with the Department for Research and Development of the Manchester Mental Health and Social Care Trust as a service evaluation.

Results. Thirty-two women (mean age = 34.0 years, SD = 4.9; bipolar I disorder: 24/32 [75.0%], bipolar II disorder: n = 6/32 [18.8%], single past episode: n = 2/32 [6.3%]; mean age at first treatment = 20.8 years, SD = 4.5; previous hospitalization: 30/32 [93.8%]; median number of past hospitalizations = 2, range 0–10) were included. Taking into account illness severity, adverse medication effects on the child, and patient preference, the clinic recommended to continue the same medication in 9 cases (28.1%), to stop medication treatment in 4 cases (12.5%), and to switch to different agents in 19 cases (59.4%). The main reasons for stopping or switching medication were teratogenicity (n = 16/23, 69.6%) and antipsychotic-induced hyperprolactinemia (n = 4/23, 17.4%). The most common recommendation was to stop treatment with an antiepileptic drug or replace it with an antipsychotic (n = 13/23, 56.5%). Recommendations for pharmacologic management were followed by the referring clinician in the majority of cases (preconception period: 27/32, 84.4%; pregnancy: 12/15, 80.0%). Recommendations for a change in psychosocial management were made in 9/32 (28.1%) cases and followed in 7/9 (77.8%) cases.

One of the 15 women who became pregnant in the follow-up period delivered within that time and was excluded from further outcome analysis. In 5 cases, incomplete follow-up information was available. Of the remaining 26 patients, 5 (19.2%) developed a *DSM-IV* episode (depression: n = 2, hypomania: n = 1, mixed affective: n = 2), mostly in the first 6 months after the preconception consultation (n = 4), and were treated as outpatients. In all of these cases, pharmacologic recommendations had been followed, but in only 1 of them had the medication been stopped. Psychosocial recommendations had been implemented in 2 of 3 cases.

This is the first published report of maternal outcome after preconception consultation in women with bipolar disorder. Pharmacologic recommendations were followed by the referring clinician in most cases. Although the choice of psychotropic medication is limited in bipolar women planning a pregnancy, adjustments in treatment did not seem to be followed by illness destabilization.

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