

## Prescribing Habits for Pregnant Patients in a Sample of Psychiatry Residents at Ibn Nafis Psychiatric Hospital: A Descriptive Study

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### Abstract

### Original Research Article

Prescribing psychotropics for pregnant women is a delicate issue as most drugs cross the placenta. There are concerns about possible hazards to the growing fetus and balancing the risk of malformation against the risk of a psychiatric condition relapsing is a common dilemma. To minimize the risks associated with polypharmacy monotherapy is typically the preferred approach. This study aimed to explore the prescription habits of psychotropic medications to pregnant women by residents at IBN NAFIS University Psychiatric Center and review it in the light of literature. 25 residents took part. We found that for agitation, 93% of residents prescribed classic antipsychotics. For major depressive disorder, 81% of residents prescribed selective serotonin reuptake inhibitors (SSRIs). For anxiety disorders, 68% of the sample prescribed SSRIs. For manic episodes, 50% of residents prescribed lamotrigine, 12% prescribed olanzapine, 6% preferred sodium valproate, 6% prescribed classic antipsychotics. For psychotic disorders, the vast majority of residents prescribed classic antipsychotics (88%), while 6% of them prescribed Risperidone and the remaining 6% preferred the use of Olanzapine. For insomnia, the majority of residents in the sample preferred prescribing hydroxyzine (69%). Oxazepam is considered a first-line anxiolytic because it doesn't create active metabolites. Classic antipsychotics like haloperidol and chlorpromazine are commonly prescribed during pregnancy due to their proven efficacy and safety. Atypical antipsychotics like olanzapine risperidone quetiapine and clozapine are used, with olanzapine being a first-line treatment due to reassuring data on fetal side effects. Thymoregulators like lamotrigine can be used but caution is advised due to potential risks. Antidepressants like tricyclics and SSRIs are commonly prescribed with SSRIs being preferred for pregnant women. The study emphasizes the importance of taking into account the particulars of the drugs such as the possibility of breastfeeding and the existence or lack of active metabolites when making a treatment decision.

**Keywords:** Psychotropics, Pregnancy, Pregnant, Side Effects, Fetus, Prescription, Malformation Risk.

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## I. INTRODUCTION

In psychiatry prescription is an important part of patient care that needs to be justified. Since most drugs cross the placenta there are worries regarding possible hazards to the growing fetus. When balancing the risk of malformation against the risk of a psychiatric condition relapsing, a dilemma frequently emerges. As the possible risks of medication exposure during pregnancy must be carefully considered, it is imperative to treat with medications only when necessary. As it can help reduce the possible risks associated with polypharmacy, monotherapy is typically the preferred approach. To get the best result for the patient a mix of drugs might be required in some circumstances. Any treatment choice must be carefully considered taking the needs and circumstances of each patient into account as well as any potential risks or benefits.

## II. OBJECTIVES

To explore prescription habits of psychotropic medications to pregnant women by residents at IBN NAFIS University Psychiatric Center, and review the findings in the light of literature.

## III. MATERIELS AND METHODS

The present study is a transversal, descriptive study conducted at the University Psychiatric Centre Ibn Nafis. The data was collected using a questionnaire filled out by the 25 psychiatry residents who participated, and processed using Microsoft Excel 2019.

## IV. RESULTS

### 1. For Agitation:

93% of residents prescribed classic antipsychotics, while only 7% prescribe atypical

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antipsychotics. Additionally, 25% of residents prescribed benzodiazepines.

## 2. For Major Depressive Disorder

81% of residents prescribed Selective Serotonin Reuptake Inhibitors (SSRIs), with 68% prescribing sertraline and 12% prescribing fluoxetine, while 12% of residents prescribed tricyclics, and 7% prescribed other medications.

## 3. For Anxiety Disorders

68% of residents in our sample prescribe SSRIs for anxiety disorders in pregnant women, 6% prescribe tricyclic antidepressants while 26% prescribe other medications

## 4. For Manic Episodes:

50% of residents prescribe lamotrigine for mania in pregnant women, 12% prescribe olanzapine, 6% prefer sodium valproate, 6% prescribe classic antipsychotics and 26% prescribe other medications.

## 5. For Psychotic Disorders

The vast majority of residents prescribe classic antipsychotics for pregnant women (88%), while 6% of them prescribe Risperidone and the remaining 6% prefer the use of Olanzapine.

## 6. For Insomnia

The majority of residents in our sample prefer prescribing hydroxyzine for insomnia in pregnant women population (69%). 7% prescribe alprazolam, 7% prefer zolpidem, 6% use chlorpromazine and the remaining 10% use other types of medications.

# V. DISCUSSION

## 1. Generalities

The management of patients receiving antipsychotic treatment while being pregnant is a part of the general problem of chronic diseases and pregnancy [1]. The main dilemma in the psychiatric context is the fine balance between inducing malformation risk and stability of the mother.

## 2. Anxiolytics

Alprazolam was used by 6% of practitioners in our study compared to 69% who used hydroxyzine. Hydroxyzine is approved and permitted for use in breastfeeding [2]. Breastfeeding is not advised while using alprazolam which render it a second-line treatment.

Since it doesn't create active metabolites and doesn't increase the risk of metabolite accumulation, Oxazepam is considered a first-line anxiolytic [2].

The preferences and expertise of practitioners in treating anxiety disorders during pregnancy is reflected in the selection of these medications. They emphasize the significance of taking into account the particulars of the drugs such as the possibility of breastfeeding and the

existence or lack of active metabolites when making a treatment decision.

## 3. Classic Antipsychotics

88% of the residents in the study choose to treat pregnant patients with classic antipsychotics for psychotic disorders and 93% chose them for agitation management. The first-line treatments mentioned in the literature are haloperidol and chlorpromazine, and there is a wealth of comforting information about their use in expectant mothers [2]. This implies that medical professionals feel comfortable prescribing these drugs to expectant patients as there is a plethora of data proving their efficacy and safety in this demographic.

Levopromazine can be used as a second-line treatment because although there is not much available data, no concerning side effect was found.

The use of haloperidol and chlorpromazine in breastfeeding is possible but under close monitoring. [2]. These results underscore the significance of taking into account the unique attributes of each patient as well as the particular properties of the drugs when deciding on a course of treatment during pregnancy.

## 4. Atypical Antipsychotics

Results of the study showed that 6% of residents treated psychotic disorders with olanzapine and 12% used it to treat manic episodes in pregnant patients. 6% use risperidone to treat psychotic disorders in this population.

Olanzapine is considered as a first line treatment in the pregnant population as the available data on its side effects on fetuses are vastly reassuring, and it can be also taken while breastfeeding. Nevertheless, it should be noted that it carries the risk of metabolic problems like weight gain and gestational diabetes [2].

Risperidone is suitable as a second line treatment. The available data on its effects on fetuses is not abundant, but there is no concerning findings. We note that it can be used in the breastfeeding population under monitoring.

Quetiapine is considered as a third-line treatment, with breastfeeding being also possible. Clozapine may be considered if there is a benefit for the mother. Aripiprazole should be avoided in the first trimester, as there is evidence for risk of diaphragmatic hernia in rats [2].

## 5. Thymoregulators

In our study we found that Lamotrigine is used by 50% of residents, followed by olanzapine at 12% and valproate sodium at 6%.

Lamotrigine can be given as a first-line treatment as of the first trimester. It should be noted that

using it carries a risk of palatal fissure [2]. We note that it should be avoided in breastfeeding women.

The three main psychotropes with increased teratogenic risk relative to the general population are carbamazepine valproate and lithium (before the 50th day of pregnancy). Before nine weeks lithium should be avoided, afterwards it might be taken into consideration as a second-line treatment. Goiter hydramnios and cardiopathies are possible side effects with these medications [2].

The FDA states that if anticonvulsants are thought to be required for the mothers stability folic acid (5 mg/day) supplements should be taken for 2 months before conception and 1 month after [5].

### 6. Antidepressants

12% of residents in our study use tricyclics and 81% percent use selective serotonin reuptake inhibitors (SSRIs). Tricyclic imipraminic medications such as amitriptyline clomipramine and imipramine have numerous encouraging studies and overwhelmingly positive feedback [6].

SSRIs can be used if necessary, with a very slight increase (or even none) in the risk of cardiac malformations with paroxetine and fluoxetine [2-7]. Breastfeeding is possible with paroxetine and sertraline. In current practice, SSRIs are more prescribed than tricyclics for pregnant women. However, it is advised to start SSRIs after 12 weeks of pregnancy [8].

Venlafaxine can be given as a second-line treatment, but breastfeeding is discouraged, as there is limited data available on this antidepressant [8].

## VI. CONCLUSION

This work highlights the need of using monotherapy as the standard practice rule and only

prescribing psychotropics when absolutely necessary for pregnant patients. It is also necessary to monitor the mother and the growing fetus with obstetric surveillance. The pharmacological treatment should be optimized by psychotherapy if needed, as it can help reduce the reliance on medication and improve the overall treatment outcome for both the mother and the child.

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