HHS Public Access

Author manuscript

Am J Psychiatry. Author manuscript; available in PMC 2015 March 03.

Published in final edited form as:

Am J Psychiatry. 2014 March ; 171(3): 371. doi:10.1176/appi.ajp.2014.13111493r.

Response to Sharma and Sommerdyk

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To the Editor

As Drs. Sharma and Sommerdyk highlight, optimizing medication management in pregnant women with Bipolar Disorder (BD) is an area with urgent need for data to drive decision making. The objectives of the Treatment in Psychiatry publication were to combine a review of the data on the pharmacokinetic changes of LTG in pregnant women with epilepsy (WWE) with observations from our case series and generate recommendations for LTG dosing in pregnant women with Bipolar Disorder (1). These investigators raise an important point about whether women treated with LTG in pregnancy experience an increase in mood symptoms due to declining LTG concentrations. Serum level reductions of psychotropic medications due to dose decreases or non-adherence are associated with episode recurrence and symptom worsening. Data on LTG use in pregnant women with Bipolar Disorder are sparse; however, the literature on managing LTG in WWE is relevant for guidance about pharmacokinetic changes during gestation. WWE suffer increased seizure frequency associated with declining LTG levels in pregnancy. Similarly, if the bioavailability of LTG for maintenance treatment of Bipolar Disorder is not sustained in the pregnant woman, she is at risk for symptom worsening. As Sharma et al recommended, careful monitoring of symptoms is essential in the gravid woman taking LTG since pregnancy may increase clearance and lower levels (2). Establishing a baseline serum level at the patient's therapeutic dose of LTG and adjusting the dose to maintain the baseline level increases the likelihood of preventive efficacy.

As we discussed (1), an association between LTG serum levels and mania and depression scores was not found. In our naturalistic study from which the case series was derived, subjects' LTG doses were managed by their community-based physicians. Serum levels were checked during scheduled study protocol visits rather than at the time their physician observed a change in symptoms and changed the dose. A study designed to address these pharmacokinetic and pharmacodynamic questions for optimal management of LTG dosing and prevention of relapse is underway in our Center.

The author's disclosures accompany the original article.

Whether LTG prevents postpartum episodes remains to be investigated; however, continuing effective maintenance therapy prior to and during pregnancy is good clinical practice, and every woman with Bipolar Disorder requires close observation after birth regardless of medication status (3).

The predictors of episode recurrence during pregnancy may be related to the Bipolar Disorder variant rather than sample characteristics (tertiary care versus community psychiatric setting). In a large-scale screening study for postpartum depression in an obstetrical population, 22.6% of women with positive screens were diagnosed with Bipolar Disorder (4). The majority of these women were symptomatic during pregnancy, with episode onset either prior to pregnancy (38%) or during pregnancy (33%) and continuing through 4–6 weeks postpartum (5). Bergink et al. (6) reported that women with chronic Bipolar Disorder (such as the subjects in our case series) benefitted from continued lithium prophylaxis during pregnancy while those with a history limited to postpartum episodes remained well during gestation without medication but relapsed postpartum. In sum, pregnancy is a vulnerable time for episode recurrence in many women with Bipolar Disorder.

Acknowledgments

A Building Interdisciplinary Research Careers in Women's Health (BIRCWH) NIH K12 award through Northwestern University, received in September 2013 by Dr. Clark, supports this work.

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