Reference Number: UHBOBS046 **Version Number:4**	**Date of Next Review: November 2022** **Previous Trust/LHB Reference Number:**

Epilepsy in Pregnancy

Introduction and Aim

Provide guidance on the management of women with epilepsy in pregnancy, including pre-conceptual advice, antenatal care and intrapartum considerations.

Objectives

Care of women during pregnancy and childbirth with Epilepsy

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	
Approved by	*Maternity Professional Forum and Obstetrics & Gynaecology Quality & Safety*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*Pina Amin, Malisa Pierri, Rhian Evans*

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1		*2010*	Pina Amin
2		November 2013	Pina Amin
3		November 2016	Pina Amin, Malisa Pierri, Sarah Harries
4	6/12/2019	10/12/2019	Pina Amin, Malisa Pierri, Rhian Evans

Contents

1 Introduction

In order to enable informed decisions and choice, and to reduce misunderstandings, women with epilepsy and their partners, as appropriate, must be given accurate information and counselling about contraception, conception, pregnancy, caring for children and breastfeeding, and menopause. All healthcare professionals who treat, care for, or support women with epilepsy should be familiar with relevant information and the availability of counselling (NICE, 2004, RCOG GTG No: 68, 2016).

Back to Contents

2 Pre-conceptual Care

2.1 Contraceptive Advice

Women need good **contraceptive** advice to ensure that all pregnancies are planned. The following enzyme inducing drugs can affect the efficacy of the combined oral contraceptive pill (OCP):

Carbamazepine (Tegretol)
Oxcarbazepine (Trileptal)
Phenytoin (Epanutin)
Topiramate (Topamax)
Primidone (Mysoline)
Phenobarbital

There is some evidence that lamotrigine can interact with the OCP and caution should be used and advice sought where necessary.

It is recommended that women taking any of the above take at least 50 micrograms of oestrogen, which equates to two normal 30 microgram tablets. It is also recommended that women take their pills for three cycles consecutively with a shorter four-day break.

The progesterone implant is not recommended in women taking enzyme-inducing AEDs (NICE, 2004).

Women taking enzyme-inducing AEDs who choose to use depot injections of progesterone no longer need to shorten the injection interval (FSRH 2017) (Guilleband 7th Ed 2017).

If emergency contraception is required for women taking enzyme-inducing AEDs, the dose of levonorgestrel should be increased to two 1500 mcg tablets (3mg) taken together.(NICE 2017) (Guilleband 7th Ed 2017).

Back to Contents

2.2 Pre-conception counselling

All women taking anti-epileptic medication should receive pre-conceptual counselling to reduce the risks of teratogenicity. Wherever possibly, seizure freedom during pregnancy should be sought to reduce the risks to the mum and baby. The clinician should discuss with the woman the relative benefits and risks of adjusting medication to enable her to make an informed decision. Where appropriate, the woman's epilepsy specialist should be consulted.

Social issues such as driving should be considered. If medication is to be withdrawn it is recommended that the DVLA be notified.

Women have the option to stop antiepileptic medication for the first trimester if they have been seizure-free for more than two years. However this will need to be discussed with the patient's epilepsy specialist, and counselling should include discussion of risks regarding seizures and SUDEP (Sudden Unexplained Death in epilepsy).

Folic acid 5 mg once daily should be started as soon as contraception is stopped. Current advice is that all women should receive 5 mg folic acid for at least 3 months prior to conception.

In women with epilepsy, seizure frequency during pregnancy for most is the same as the 12 month period before pregnancy. However, epilepsy is the second commonest indirect cause of maternal death in the UK and seizures should be monitored and treated appropriately.

Back to Contents

2.3 Teratogenicity of anti-epileptic medication

All Epilepsy medications are teratogenic.

The risk for any one drug is 3–5%, i.e. 2 to 3 times the background risk. The risk is dose-dependent. For women taking two drugs, the risk is increased.

Sodium Valproate is banned in women of child bearing age unless actively engaged in the PREVENT programme. It is not used in women and girls of child bearing age due to high risk of Teratogenicity and cognitive delay, unless other drugs have failed.

2.4 Risk of Baby having epilepsy

Within certain types of epilepsy, the risk of a child developing epilepsy if either parent has the condition is increased (on average about 5%). This can increase up to 25% where both parents have a genetic epilepsy.

Back to Contents

3 Antenatal Management

Continue Folic acid throughout pregnancy at a dose of 5 mg.

If the patient is seizure-free, monitoring of plasma drug levels is not necessary.

Antenatal screening should include serum screening at 16 weeks if requested and a detailed anomaly scan at 18 to 20 weeks. Also consider a fetal echo if appropriate. All women with history of Epilepsy are offered a growth US at 32/40 at UHW. Due to resource implications and lack of robust evidence serial US for growth should not be offered routinely.

There is no need to change anticonvulsant therapy in pregnancy if the woman is well controlled. Phenobarbital and Sodium Valproate may be weaned or changed due to potential risk of neonatal withdrawal convulsions and teratogenicity.

Relatives or friends should be given instructions on seizure management and safety. Relatives or friends should be instructed on how to place the woman in the recovery position in the event of a seizure. Women should be advised to shower or bath in shallow water and not to bathe alone in the house or with the door locked.

Women should be informed regarding the need for neonatal requirement for intramuscular Vitamin K injection at birth during the antenatal period. (This should be documented in the green high-risk plan). The literature review emphasises the need for Vitamin K for the new born but does not recommend antenatal intake.

If there are any concerns regarding the medication or frequency of seizures refer to Epilepsy team as soon as possible.

Back to Contents

4 Induction of Labour (IOL) and Intrapartum care

Indications for IOL in women with Epilepsy are similar to those in women without Epilepsy. It is important to encourage women with Epilepsy to rest and obtain adequate sleep during the IOL process and continue to take epilepsy medications as prescribed.

The risk of seizures can increase around delivery due to sleep deprivation and tiredness.

Generally, women may be reassured that the risk of a tonic–clonic seizure during the labour and the 24 hours after birth is low (1–4%) (NICE, 2004).

Seizures may be controlled by intravenous lorazepam or buccal midazolam.

Women with Epilepsy have the same choices of Intrapartum analgesia, apart from Pethidine which should be avoided. Pethidine should be avoided in women with Epilepsy as excess Pethidine use can trigger seizures. Diamorphine IM 5mg (which equates of 100mg of Pethidine) should be offered instead of Pethidine. This dosage can be repeated 6-8 hourly as necessary.

Parents should be explained the benefits of administration of Vitamin K 1mg IM at birth to their babies.

Back to Contents

5 Post natal Management

5.1 Breastfeeding

Breastfeeding in all women with epilepsy is generally safe and should be encouraged, except in very rare circumstances. However, each mother needs to be advised that sleep deprivation can be a major trigger for seizures and be supported in the choice of feeding method that bests suits her and her family (NICE, 2004, RCOG GTG 2016).

The woman and her partner should receive advice regarding caring for the baby at home:

- Changing nappies on the floor, not bathing the baby when alone at home, not carrying the baby down the stairs. When carrying the baby up or down stairs, use a carrycot or a car seat where possible
- Share the care of a baby, especially at night to avoid sleep deprivation which can be a major trigger for seizures.
- Women should be advised when feeding a baby from a bottle or breast, to sit on the floor on a towel or a rug holding the baby. Surround with cushions or use a deep seated chair.
- Use a low chair where possible or ensure a high chair is secure.
- Prams and carrycots can be purchased with adaptive brakes, using pressure to take the brake off. These are recommended in parents with epilepsy.

Further information can be found at: Epilepsy Action www.epilepsy.org.uk

Back to Contents

6 References:

1. Handbook of obstetric medicine. Catherine Nelson Piercy. Ed.Dunitz2002
2. Medical disorders in pregnancy. Michael De Sweet, 2002
3. NICE guidance for Epilepsy, 2004
4. RCOG Green Top Guideline Number 68, 2016.

Back to Contents