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LETTER/CARTA AO EDITOR

Lithium Prescription in Peripartum Period
Prescrição de Lítio no Peri-Parto

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Dear Editor,

The interest in perinatal mental health has increased significantly in recent years.[1] Since bipolar disorder (BD) is a serious condition with adverse maternal and neonatal outcomes, prophylactic treatment should be considered. Lithium is regarded as the first-line option in the maintenance treatment of patients with BD.[2-4]

Fetal lithium exposure during the first trimester is associated with an increased risk of cardiac malformations in a dose-dependent manner, however the magnitude of this effect is small (one additional case per 100 live births with early maternal exposure).[3] Additional information about the obstetric, neonatal and child outcomes was reviewed by Poels and colleagues.[5]

Guidelines about its prescription in the peripartum period have lack of specific recommendations, with some diverging.[2,5] For instance, the Dutch guideline advocates lithium prescription as first-line treatment in pregnant women with BD.[5]

The Portuguese Health Authority[4] argues that lithium should be avoided during pregnancy unless it is essential (2012). In women whose risk-benefit profile favors its prescription, changes in lithium pharmacokinetics are expected in each trimester and after delivery.[5,6] Due to the increased risk of lithium intoxication in the third trimester and in the postpartum period,[2] dose adjustment and a close monitorization of plasma lithium levels are needed. The national norm recommends weekly monitorization in thirty-six or more weeks pregnant women and on the first day after the delivery.[4] Poels *et al* advocate that lithium levels should also be determined on the day before the delivery.[5] According to the Portuguese norm, lithium should be discontinued around the delivery and it should be restarted a few days later, but additional information is not given. Doubts regarding the safety of this intervention arise since it is known that one in five women with pre-existing BD has a severe postnatal mental illness,[1] and that lithium abrupt discontinuation is associated with recurrence and relapses.[6] Also, it is now known that the lithium exposure risk during pregnancy is low,[3,6] particularly in low doses and after the first trimester.[2]

A recent systematic review and meta-analysis[6] added new information about the use of lithium in the days immediately preceding delivery, and it is recommended to reach the lowest therapeutic range. However, in an observational study, Molenaar *et al* (2020) neither recommend the dose reduction strategy nor its interruption before delivery.[2] Therefore, lithium dosage should be determined on an individual basis, considering different factors, such as previous response, tolerability, hydroelectrolytic balance, and potential interacting drugs (for instance, non-steroidal anti-inflammatory drugs).[5]

Another concern that is not included in the national norm is related to the introduction of lithium as a prophylactic strategy in bipolar women who were not medicated during pregnancy. For Poels *et al*, those with a previous BD diagnosis require prophylaxis with a higher lithium target during the first month postpartum.[5]

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Some authors do not recommend breastfeeding in infants whose mothers are taking lithium.[5] However, according to Lactmed, a database about drugs and lactation, lithium prescription is not an absolute contraindication to breastfeeding.[7]

Taking into account the high prevalence of psychiatric diseases during pregnancy and in the postpartum period and the recent evidence about the safety and efficacy of pharmacological interventions, the elaboration of a national norm about perinatal psychopharmacology is of greater importance. Also, the authors believe that the Portuguese norm about the maintenance treatment of bipolar patients should be reviewed and updated.

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