

Management Issues for Women with Epilepsy

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Recommendations: Over 90% of Women with Epilepsy (WWE) can expect good pregnancy outcomes. A minority of WWE will experience a worsening of seizure control during pregnancy. A coordinated approach to the care of WWE, with contributions from a primary care provider, obstetrician, geneticist, and neurologist, is ideal. Interdisciplinary communication for counseling and management is crucial.

<p>For WWE During and After Pregnancy <i>There is strong evidence (class I) you should:</i></p> <ul style="list-style-type: none"> • Optimize therapy for WWE before conception. • Complete AED therapy changes at least six months before planned conception, if possible. • Do not change to an alternate AED during pregnancy for the sole purpose of reducing teratogenic risk. • Offer patients being treated with carbamazepine, divalproex sodium or valproic acid: <ul style="list-style-type: none"> ◦ Prenatal testing with alpha-fetoprotein levels at 14 to 16 weeks gestation. ◦ Level II (structural) ultrasound at 16 to 20 weeks gestation; and ◦ If appropriate, amniocentesis for amniotic fluid alpha-fetoprotein and acetylcholinesterase levels • Encourage breast-feeding for WWE; monitor the neonate for sedation or feeding difficulties. <p><i>There is evidence (class III) you should consider:</i></p> <ul style="list-style-type: none"> • Monitoring non-protein bound AED levels during pregnancy. For the stable patient, levels should be ascertained before conception, at the beginning of each trimester, and in the last month of pregnancy. Additional levels should be done when clinically indicated. • Monitoring AED levels through the eighth postpartum week. If AED dosage increases have been necessary during pregnancy, you will probably be able to reduce subsequent dosages to prepregnancy levels safely; this may be necessary to avoid toxicity. • Prescribing 10 mg per day of vitamin K in the last month of pregnancy for WWE taking enzyme-inducing AEDs. 	<p>For WWE During Reproductive Years <i>There is strong evidence (class I) you should:</i></p> <ul style="list-style-type: none"> • Choose the antiepileptic drug (AED) most appropriate for seizure type; goal should be monotherapy. • Counsel patients entering reproductive years about the decreased effectiveness of hormonal contraception with enzyme-inducing AEDs. • Begin folic acid supplementation with at least 0.4 mg/day; continue through pregnancy. <p><i>There is evidence (class III) you should:</i></p> <ul style="list-style-type: none"> • Recommend a formulation containing 50 ug of ethinyl estradiol or mestranol if your patient's preferred method of birth controls hormonal contraception and treatment involves an enzyme-inducing AED. The risk of contraceptive failure in this setting should be discussed with the patient and discussion documented. • Counsel WWE on the following issues: <ul style="list-style-type: none"> ◦ Folic acid supplementation ◦ Teratogenic potential of AEDs ◦ Possible change in seizure frequency during pregnancy ◦ Importance of medication compliance and AED level monitoring during pregnancy ◦ Inheritance risks for seizures ◦ Vitamin K supplementation last month of pregnancy ◦ Pros/cons of breast feeding
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Definitions for Classification of Evidence

Class I: Evidence provided by one or more well-designed randomized, controlled, clinical trials.

Class II: Evidence provided by well-designed observational, clinical studies with concurrent controls.

Class III: Evidence provided by expert opinion, case series, case reports and studies with historical controls.