PRECONCEPTION GUIDELINES – EPILEPSY

Around 25% of people with epilepsy are women of childbearing age. Many of these women will have well controlled epilepsy and not be in contact with secondary care so primary care has an essential role to play in preconception counselling. There are risks associated with epilepsy and its management in pregnancy but steps can be taken, especially prior to conception, to help to reduce these risks. Most women with epilepsy have normal healthy babies and risk of congenital malformations is low if she is not on any antiepileptic drugs (AEDs) in the preconception period. Women should be counselled on the risks of epilepsy during pregnancy, especially those on valproate (where a pregnancy prevention plan should be in place due to the high risk of congenital malformations).

Risks of epilepsy in pregnancy:

- The risk depends on the type, number and dose of AED
- Lamotrigine and carbamazepine have the least risk
- There is very little evidence for levetiracetam and phenytoin.
- Risks with AEDs
    - Neural tube defects
    - Congenital heart disorders
    - Urinary tract and skeletal abnormalities
    - Cleft palate (especially valproate and phenytoin)
- There is also a possible impact on long-term neurological development of babies born to mothers taking valproate
- If there are risk factors for inherited forms of epilepsy then refer for genetic counselling
- Two-thirds of women with epilepsy will not have seizure deterioration in pregnancy. Pregnant women who have experienced seizures in the year prior to conception require close monitoring for their epilepsy
- Women and girls with generalised tonic-clonic seizures should be informed that the foetus may be at relatively higher risk of harm during a seizure, although the absolute risk remains very low, and the level of risk may depend on seizure frequency.
- Women and girls should be reassured that there is no evidence that focal seizures, absence seizures and myoclonic seizures affect the pregnancy or developing foetus adversely unless they fall and sustain an injury

Reducing risk prior to conception:

- The importance of planning pregnancy should be discussed as well as the increased risk of combined oral contraceptive failure with enzyme-inducing AEDs (such as carbamazepine and phenytoin)
- Women considering pregnancy should start **folic acid 5mg** (prescription only dose) at least 3 months prior to conception until 12/40 gestation – this should be the case also for any woman taking AEDS for any other reason apart from epilepsy
- Aim for seizure freedom before conception and during pregnancy (particularly for women and girls with GTC seizures) but consider the risk of adverse effects of AEDs and use the lowest effective dose of each AED, avoiding polytherapy if possible
- Minimise exposure to valproate and poly treatment by changing medications prior to conception, as recommended by an epilepsy specialist
- Give women verbal and written information on antenatal screening, risks of self-discontinuation of AEDs and status epilepticus/SUDEP (sudden unexplained death in epilepsy), effects of seizures and AEDs on the foetus and pregnancy, breastfeeding and contraception
- Inform women of safety precautions to reduce risks of accidents and reduce anxiety
- NICE have a very useful document here

Refer to preconception clinic if:

- Taking more than 1 AED
- Taking valproate
- Not seizure free for the past 2 years

How to refer

- GPs can refer by completing the referral form (available on the GP website) and attaching this to an e-RS referral.

Any queries, please email the obstetric query email on huh-tr.obstetricquery@nhs.net or neurology advice and guidance on e-RS

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