RCPE Maternal Medicine

28th April 2021

Epilepsy - the multidisciplinary approach - Dr Alastair Campbell & Ms Yvonne Leavy

Q. In the acute situation during pregnancy, what would you advise as the best way to control seizures? Does one have to consider delivery sometimes?

A. Ned to ensure the seizure is epilepsy related. Most will be short lasting and resolve but if in status (convulsive seizure >5 minutes) then follow the unit guideline. In Lothian 1st line agent for status is a benzodiazepine eg. Midazolam or lorazepam and then loading with an IV AED.

It is uncommon to have to consider deliver due to a seizure. Maternal stabilisation is the priority. However if after this there is evidence of fetal compromise then plans for birth may be needed. It is not usual to have to expedite birth due to seizure control

Q. How often do you see epilepsy presenting for the first time during pregnancy?

A. Most women present before pregnancy but some of the epilepsies can present in late teens/early twenties so it depends on the age of the mother.

Q. if a patient has increasing doses of AEDs requirements in pregnancy, how do we adjust the dose postnatal?

A. This plan is made by the Epilepsy team at the end of the pregnancy in collaboration with the obstetric/midwifery team and should be copied to the patient and the primary care team.

Q. If malformations are increased with increasing doses of AED, is it better to be on low doses of multiple drugs or a higher dose of one AED?

A. The evidence of use of multiple low dose AEDs in relation to teratogenic outcomes compared with high dose monotherapy is lacking. However, any combination which includes sodium valproate or topirmate is likely to have increased rates of MCMs and neurodevelopment problems. At present epilepsy practitioners aim for monotherapy in the most efficacious drug at the lowest does to control the epilepsy and reduce the risks of teratogenicity to the baby.

Q. Do you usually have a year prior to pregnancy to make AED changes and determine if these changes are effective? There is a high rate of unplanned pregnancy in UK, I don't know if WWE are different in this regard?

A. Yes we do because WWE have contact with health services from the point of diagnosis and it is the responsibility of all health professionals to begin preparing and educating women for pregnancy and giving simple preconceptual advice.

Headache - Dr Richard Davenport

Q. What was the reference for those very helpful migraine treatment guidelines?
A. Please see abstract and references Amundsen et al 2015

Q. Does migraine increase risk of CVA in pregnancy, is it worth aspirin prophylaxis?

A. No indication to use aspirin in pregnant migraneurs for stroke preventation

Q. Could you advise treatment options for severe migraines in pregnancy?
A. See above reference Amundsen et al 2015

Q. Any recommendations for analgesia in pregnancy?

A. Amundsen et al 2015

Responding to a pandemic - but it's not all COVID - Professor Cathy Nelson-Piercy

Q. PE and covid can often co-exist, with similar clinical features. Do you have any advice for considering co-existent PE in women with covid? Have you lowered your threshold for imaging to exclude/confirm PE?
A. We have a low threshold for performing CT scans in COVID women so if we were worried about a PE we would go for CT rather than a V/Q especially with a very abnormal CXR