1. What type of assessments should be performed when a patient presents for prenatal care and exposure to ACE inhibitors has occurred?

Response from Dr. Catalin Buhimschi:

*Patients who are treated with ACE inhibitors suffer from medical conditions that require increased antenatal surveillance (ie, diabetic nephropathy, hypertension). Given the spectrum of malformations associated with exposure to ACE inhibitors, we recommend a second-trimester ultrasound and a fetal echocardiogram at 20–22 weeks of gestation. If treatment with ACE inhibitors is the only option the mother has, then serial monitoring of the amniotic fluid and serial evaluation of the fetal well-being (ie, biophysical profile) are also recommended.*
2. Should all patients who are exposed to SSRIs during the first trimester or who take them during pregnancy be offered a detailed fetal anatomic ultrasound between 18–22 weeks and/or fetal echocardiography?

Response from Dr. Catalin Buhimschi:

*All patients exposed to any type of medication should be offered a detailed fetal anatomic ultrasound evaluation at 18–22 weeks of gestation. Based on published data, we believe that patients exposed to sertraline and paroxetine also should be offered a fetal echocardiogram at 20–22 weeks of gestation.*

3. Do you recommend prophylactic oral vitamin K supplementation during the last month of pregnancy to women treated with antiepileptic drugs to protect the child against severe postnatal bleeding due to a deficiency in vitamin K-dependent clotting factors?

Response from Dr. Catalin Buhimschi:

*The evidence in support of routine prophylactic administration of vitamin K to women exposed to epileptic therapy to prevent hemorrhagic diseases of the newborn is weak and a subject of powerful debate. Antenatal vitamin K can be prescribed on an individualized basis (ie, increase risk of premature birth).*
4. Levetiracetam (Keppra) is a newer antiepileptic agent that appears to be growing in popularity. What considerations are relevant to its use in pregnancy?

Response from Dr. Catalin Buhimschi:

*There are no adequate reports or well-controlled studies of Levetiracetam in pregnant women. It is generally well tolerated during pregnancy. Women who become or who are planning to become pregnant while taking Levetiracetam should supplement their folic acid intake. Once pregnant, dosage readjustments may be necessary and should be based on clinical symptoms. There are no adequate reports or well-controlled studies in human fetuses. It is still unknown whether Levetiracetam enters human breast milk. Therefore, there are no definite guidelines on whether lactation is safe or not.*

5. Should fetuses exposed to benzodiazepines at or near term, and thus at risk for prolonged CNS depression, deliver at a specialized nursery (Level IIB or III)?

Response from Dr. Catalin Buhimschi:

*Yes. Presence of a neonatal resuscitative team at the time of delivery of a neonate exposed to benzodiazepines near term is a good practice. The hospital should have a neonatal resuscitative team, as we would hope all hospitals doing obstetrics have. If not available at the planned facility, referral to an appropriate facility should be a consideration.*
6. You stated that most pregnancies exposed to “low” doses of methotrexate are not adversely affected. How do you define a “low” dose?

Response from Dr. Catalin Buhimschi:

We defined a low dose of methotrexate as 50 mg/m² given as a single dose early in pregnancy as part of medical treatment of ectopic pregnancy. This is in contrast to other medical conditions such as trophoblastic disease, rheumatoid arthritis, psoriasis, mycosis fungoides, or cancer that require higher and multiple doses of methotrexate. In our article, however, we made the medical community aware that even exposure to a single dose of methotrexate during the first trimester may result in an increased risk of internal and external malformations (craniofacial, axial skeletal, cardiopulmonary, and GI abnormalities) and developmental delay. Therefore, extreme caution should be exercised when methotrexate is recommended to women of reproductive age.

7. What effect do combination oral contraceptives have on the quality and duration of breastfeeding?

Response from Dr. Catalin Buhimschi:

The American College of Obstetricians and Gynecologists (Practice Bulletin No. 73, June 2006 - “Use of Hormonal Contraception in Women With Coexisting Medical Conditions”) states that: “A systematic review of randomized controlled trials concluded that existing data are of poor quality and insufficient to establish an effect of hormonal contraception on lactation. Use of combination hormonal contraceptives can be considered once milk flow is well established.”