Peripartum Bipolar Disorder and Psychosis

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Definition peripartum=last month of pregnancy and first few weeks post delivery

Includes:

- Known bipolar illness-relapse
- First episode affective psychosis during pregnancy/postpartum
- Isolated peripartum psychosis
- (Schizophrenia spectrum disorders)

If untreated

- Unwanted, unplanned pregnancies for those known with bipolar illness
- Risk for physical wellbeing of mother, fetus/baby
- Distress for mother and family
- Disruption of maternal-infant bond
- Rare but tragic-maternal suicide, filicide
- Risks for negative child outcomes

Epidemiology

Prevalence of severe mental illness in pregnancy not well researched

Postpartum mood episodes with psychotic features:

- 1 in 500 to 1 in 1000 deliveries
- risk of recurrence following first episode=30% to 50% with each subsequent pregnancy
- 50%-80% chance of developing another episode **at any** point, usually within bipolar spectrum

Risk Factors

Patient:

- Personal history of bipolar disorder
  - 1 in 2 risk for mood episode peripartum/1 in 5 for severe recurrence
  - risk for relapse in pregnancy >with BPD than schizophrenia (even on medication)
- Prior episode of isolated peripartum psychosis
- Non-adherence
- Medication changes

Psychosocial:

- Depression with psychotic features peripartum not associated with stressful life events in comparison with non psychotic peripartum depression

Obstetric risk:

- Primiparity
  - Mechanism unclear; theories include increased psychological stress and/or less likely to have further children following a severe first episode

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Pathophysiology

- **Hormonal changes:**
  - no direct link
- **Immunological factors:**
  - postulated but needs further exploration
- **Sleep deprivation post partum:**
  - little evidence but sleep loss can trigger mania onset in those susceptible

Genetic factors:

- Family history of peripartum psychosis
- Family history of bipolar illness

Neuroimaging:

- few studies

Onset

- Rapid
- Intrapartum
- Postpartum-within 2 weeks of delivery

Clinical presentation

- Mania or depression, mixed mood + psychosis or non affective psychosis (<10%)
- Disorganized behaviour
- Obsessive thoughts, delusions, hallucinations- may be in relation to the infant, delusions may be mood incongruent
- Notable perplexity
- Marked fluctuations in intensity of symptoms
- Suicidality, homicidality-"altruistic homicide"
- Always enquire re thoughts of harm to self and/or infant/other children

Differential Diagnosis

Psychiatric:

- "Baby blues"
- Major depressive disorder
- Substance intoxication/withdrawal
- Substance induced disorders
- Schizophrenia spectrum disorders

Organic:

- Delirium
  - Pre-eclampsia
  - Infection
  - Postpartum haemorrhage
- Thyroid disease

Management

Psychiatric emergency

- Exclude medical cause /substance intoxication or withdrawal
- Collateral
- Manage risk to mother and child-?certify if:
  - suicidal ideation, aggression to others, delusions involving infant, risk of harm to baby/other children
  - deal to admit with baby-mother and baby unit
- Rapid tranquilization if indicated-haloperidol and lorazepam considered fairly safe
- Mobilize social support

Management

Psychiatric emergency

- Pharmacological interventions
  - If intrapartum onset-antipsychotics first choice
  - Postpartum-mood stabilizers may be considered even in the context of breastfeeding
  - **Start low, go slow**
  - **Lowest effective dose**

Management

Psychiatric emergency

- Non pharmacological interventions
  - ECT-beneficial in reducing medication load, quick response (suicidal, catatonic, not eating or drinking)
  - Psychoeducation
  - Psychotherapy
  - Family counselling
  - Ongoing social work intervention
  - Occupational therapy input

Prescribing in pregnancy

Mood stabilizers

Lithium

- Associated with cardiac anomalies with early fetal exposure
- Ideally switch to another agent pre-conception
- Avoid abrupt discontinuation-high risk of relapse
- If benefits outweigh risks may continue-preferably after 1st trimester
- Third trimester-change in plasma levels due to alterations in body fluid content; higher doses may be required with immediate return to pre-pregnancy levels after delivery
- Monitoring of levels regularly throughout pregnancy and following delivery NB*

Prescribing in pregnancy
Mood stabilizers

Case:

- 25 yr female
- G2 P0 M1
- 12 weeks pregnant
- Unplanned pregnancy but wanted
- Known with bipolar disorder type 1
- Two previous admissions to psychiatric facility due to mania with psychotic features
- Adherent to lithium
- How do you proceed?

Prescribing in pregnancy
Mood stabilizers

Anticonvulsants

- Valproate>carbamazepine-neural tube defects
- Should be avoided in women of child bearing age
- France recently banned use of valproate in pregnancy/women of child bearing age without contraceptive use for treatment of bipolar NOT epilepsy
- Lamotrogine-evidence suggests safer than above

Prescribing in pregnancy

Antipsychotics

- Typical antipsychotics-possible teratogenic affects but no clear evidence and risk likely extremely low
- Atypical antipsychotics-unlikely teratogenic, possible increased risk for gestational diabetes
- Depot preparations should be avoided
- Haloperidol, risperidone, olanzapine, quetiapine
- Clozapine-not contraindicated but theoretical risk of agranulocytosis in fetus/neonate

Prescribing in pregnancy

Antipsychotics

Case:

- 20 yr female
- G2 P1
- 8 weeks pregnant, unplanned
- Known with treatment resistant bipolar disorder since 16
- Stabilized on clozapine but defaulted due to pregnancy
- Currently manic + psychotic, ++ persecutory delusions, initiated on risperidone with admission
- Best treatment choice?

Prescribing in pregnancy
Antidepressants

- Most evidence supports safety of SSRIs
- ?Increased risk for preterm labour, neonatal respiratory distress, persistent pulmonary hypertension-evidence poor quality
- Paroxetine-associated with cardiac malformations

Prescribing in pregnancy

Sedatives

- Benzodiazepines
  - first trimester exposure-association with oral clefts
  - third trimester exposure-floppy baby

- Short acting agents e.g. lorazepam/promethazine-unlikely harmful

Breastfeeding

- All psychotropic agents excreted in breast milk
- Maternal mental health must be prioritized
- Avoid drugs with long half lives
- If on sedating medication advise mothers not to sleep with infant in bed
- **SSRIs**: good safety profile

Breastfeeding

- **Antipsychotics:**
  - avoid clozapine if possible
  - amisulpride contraindicated by manufacturers
  - no evidence to support the use of sulpiride for depression/anxiety

- **Mood stabilizers:**
  - valproate may be used but be aware possibility of neonatal hepatotoxicity + contraception use essential
  - lithium-may be considered but pump and dump + infant monitoring recommended

Pre-conception management

- Encourage planned pregnancy
- Include partners in discussions
- Counsel re risk of relapse
- Optimize physical and mental health-address diet, exercise, vitamins, substance use
- Routine lab investigations to exclude adverse affects e.g. metabolic screen

Pre-conception management

- Address medication-risk vs benefit of continuing current medication, discontinuing or switching agents
  - Risk of continuing-teratogenicity
  - Risk of discontinuing-relapse
  - Risk of switching-relapse but better to do so preconception than during pregnancy
- Once pregnant-liase with other disciplines involved

Prognostic factors

Good:

- Shorter duration of acute episode
- First onset affective psychosis **postpartum** as opposed to affective psychosis onset outside the postpartum period

Refer if

- First episode affective psychosis
- Danger to self/others
- Medication concerns

If known with bipolar illness + stable on treatment with fair safety profile in pregnancy no need to refer

References

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Thanks!

Any questions?