Part 8. Bipolar Disorder in Different Situations

Relationship between postpartum mood disorders and bipolar disorder, based on a case report of a patient with postpartum psychosis.

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Abstract

Data from the literature indicate the existence of a close relationship between some postpartum mood disorders and bipolar disorder. Women with a diagnosed bipolar disorder are at very high risk for affective psychosis in the weeks following delivery. We describe a case of a 28 year old woman, who developed the first symptoms of the disorder a few days after the delivery. Her first episode was successfully controlled with pharmacological treatment; however, she subsequently had relapses requiring hospitalisation. This case emphasises the importance of early psychiatric intervention, effective pharmacological treatment and co-operation with the family to control and treat the disorder successfully from the onset and through following recurring episodes.

Key words: postpartum mood disorders, bipolar disorder, risk factors, treatment

Introduction

The perinatal period is a particularly difficult time for women. Females are at an approximately 22 times higher risk of having onset of a manic or psychotic episode in the first month after giving birth than at any other time in their lives (1). That special time is not only associated with major lifestyle and economic changes, together with possible fear about childbirth complications, but on a physiological level it is also linked with significant changes in hormone levels. At the time of labour the level of oestrogen and progesterone is 200 times higher than during pregnancy and shortly after labour this level immediately decreases (2). The decrease in the level of estradiol seems to be most relevant, due to the major role that eostrogens perform in neurotransmission (3,4,5). Many authors have emphasised the role of the neurobiological changes after delivery in the occurrence of disorders with immediate postpartum onset (6). The spectrum of postpartum mood disorders includes postpartum depression, postpartum psychosis, postpartum hypomania, and maternal blues. These disorders will be described in the order of decreasing frequency.

The most frequent disorder - maternal blues, also called "baby blues" is the mildest among childbirth-related disorders and is so common (40-60 % (7)) that some authors describe it as a physiological reaction to labour-related stress (8). The onset of maternal blues takes place 3-5 days postpartum and is manifested by dysphoria, emotional lability, irritability, anxiety and mood swings. It is self-restricting and resolves spontaneously after a few hours to a few days. Although the condition of maternal blues might seem to be irrelevant it is a proven risk factor for developing more serious postpartum depression or postpartum anxiety disorders (9).

Postpartum hypomania is the hardest postpartum disorder to diagnose since it seems difficult

to establish the border between the "normal" joy that a newborn baby brings to the mother and pathologically elevated mood (10). Occurrence within the first 3 days postpartum ranges from 9.6 to 20.4% (11). The main symptoms are irritability, psychomotor agitation, a sense of racing thoughts, distractibility and decreased need for sleep (12).

A clinical screening tool for postpartum hypomania is The 'Highs'Questionnaire which currently is the only screening test validated for diagnosing the postpartum disorders on the bipolar spectrum (12). Postpartum depression is defined as an episode of major depressive disorder that occurs within the first four (according to DSM-IV-TR) or six (according to ICD-10) weeks after labour (13). It affects approximately 10% of women. Patients develop typical depressive symptoms: low mood, feelings of guilt, misery, apathy, irritability, social isolation, anxiety and dys-somnia.

Postpartum psychosis is a rare disorder: 1-2/1000 women are affected (14). Postpartum psychosis is currently not considered to be a distinctive disease entity. Its nosological status is not unambiguously classified - neither DSM-IV nor ICD- 10 has a specific category for postpartum psychosis. It is a heterogeneous group of disorders. The patient can develop various mood disorders: depression, mania or switch from mania to depression within the same episode (15). Affective phenomenology coexisting with positive symptoms seems to be a hallmark of the disease and this combination is more often present in postpartum psychosis compared to non-postpartum psychosis (16). There is also a relatively low occurrence of symptoms specifically associated with schizophrenia, such as "Schneiderian first-rank symptoms" (17). Aside from mood disorders that represent a distinctive change from the patient's previous functioning, the other typical symptoms are: disorganized thinking, insomnia, mood fluctuation, cognitive impairment (disorientation, derealisation, and depersonalization) and positive symptoms – hallucinations (auditory, olfactory or tactile) and delusions (persecutory, of reference or bizarre, often involving the child). The common denominator of these heterogeneous disorders is their temporal relationship with the labour. The timescale within which the symptoms manifest varies between reports, usually occurring within the first weeks after delivery, mostly up to three days after giving birth (18-25). Postpartum psychosis is the most severe postpartum disorder as it can potentially endanger the life of both mother and child. The risk of suicide in affected women increases 70 times and there is a 4% risk of infanticide (26). There is also a high risk of recurrence (20-50% (27)). The overwhelming majority of patients experience a complete remission of psychotic symptoms within 3 months postpartum after treatment.

Case history

M.S. is a 28 year old woman who delivered a healthy baby girl in June 2008. She has been happily married since 2004 and has no prior psychiatric history. Her childhood was happy; she was raised in a full family and felt taken care of by her parents and older brother. She has a Master's Degree in Management and prior to this and to the onset of the disorder she was working as a store manager. She lives with her husband and mother-in-law. Her relatives describe her as sociable, quick-witted, well organized and full of energy.

The onset of her psychotic symptoms was 3 days after the delivery. Her family (husband and mother-in-law) noticed alarming symptoms: disorganized behaviour (e.g. in the middle of the night she was ironing with her iron unplugged), delusions of the child's death (she was celebrating mass over her baby's bed), she neglected the child and became irritable, timid and insomniac. Two weeks after the delivery she was admitted to the Psychiatric Center in Katowice-Szopienice. The diagnosis was F23.0 - Acute Polymorphic Psychotic Disorder without Symptoms of Schizophrenia. Treatment with risperidone and perazine resulted in full remission of the psychotic symptoms. Since July 2008 she was treated as an outpatient with a suspicion of bipolar disorder. In that period there were 8 exacerbations at monthly intervals in constant sequence: first insomnia, then anxiety, strange inadequate speech, disorganized behaviour and tearfulness. Between these exacerbations she had symptoms of hopelessness, apathy, anergy, and difficulty in thinking and planning. After the introduction of valproic acid, the exacerbations were less severe but between them significant somnolence occurred.

2nd hospitalization: Closed Ward - 13.02.2009 –18.03.2009.

On admission it was difficult to establish verbal contact with her, due to lack of spontaneity and excessively concrete speech. Her affect was poorly modulated and not matched to verbal content. She also had auditory hallucinations (baby crying), thought blocking, difficulty in abstract thinking and a sense of emptiness in her head. She did not have any of Schneider's first-rank symptoms. She denied delusions or suicidal thoughts/attempts. Neuroimaging and psychological evaluation were performed. Her treatment was modified. Quetiapine 200 mg was added to valproic acid 800 mg. The therapy resulted in partial improvement of her mental state activity, emotional reactivity and concentration.

3rd hospitalization: Day Care Ward - 26.05.2009 – 11.09.2009.

On admission she was fully orientated. Her mood and affect were normal but she had vivid emotional reactions. There were no psychotic symptoms, nor suicidal thoughts/attempts. On 2.07.2009 she accidentally took another patient's medications: clozapine 100 mg and diosminum (a naturally-occurring agent used for vascular protection). She also took her own medication: valproic acid 300 mg and Sertraline 50 mg. She lost consciousness and was immediately transferred for close observation and therapy to a closed ward. The patient was re-transferred to the daycare ward the next day, in a stable condition. Psychotherapeutic interventions (occupational therapy, music therapy, group therapy) and increasing dosage of medications (valproic acid 800 mg->1000 mg, sertraline 50 mg->100 mg, quetiapine 200 mg -> 400 mg) resulted in a slight improvement in her social functioning and mental condition.

4th hospitalization: Closed Ward - 28.09.2009 -22.01.2010.

She was admitted for modification of therapy. On admission: full orientation, mood and affect within normal limits, she denied hallucinations, delusions, or suicidal thoughts/attempts. Properly administered medications (quetiapine 400 mg, sertraline 100 mg, valproic acid 1000 mg) and psychotherapeutic interventions (occupational therapy, music therapy, group therapy) resulted in an improvement of her mental and social functioning.

5th hospitalization: Day Care Ward - 19.12.2011 - 2.04.2012.

The reason for admission was distressing peri-menstrual swings. Her husband stated that she tended to become extremely irritable and anxious, then hypoactive and somnolent. The patient stated that her mood made her unable to take good care of her child. She was still not working but she did not miss her job. Her treatment was modified. The valproic acid was increased from 800 mg to 1300 mg. Quetiapine was discontinued and fluoxetine 20 mg was introduced. She actively and eagerly participated in psychotherapeutic activities and motivated other patients. By the end of January she stated that she did not experience the mood swings to be as disturbing as usual, which was confirmed by her husband. Stabilization of her mood had been achieved and she was discharged earlier than planned due to the improvement.

Postpartum psychosis and bipolar disorder

Bipolar disorder is a heterogeneous disorder, very often coexisting with other disorders. Most (95%) of the respondents with bipolar disorder in the National Comorbidity Survey met criteria for 3 or more lifetime psychiatric disorders. In a Stanley Foundation Bipolar Treatment Outcome Network study of almost 300 patients, 65% met DSM-IV criteria for at least one comorbid Axis I disorder (28). There are data indicating the existence of a close relationship between some postpartum mood disorders and bipolar disorder. Women with a diagnosed bipolar disorder are at very high risk (25-50%) for affective psychosis in the weeks following delivery (29). When, in addition, a first-degree relative has a history of postpartum psychosis, the risk rises to 75% (30).

For many women (40-80%) with no prior history of psychiatric disease, postpartum psychosis is the incipient onset of a bipolar mood disorder (31). 72-80% of postpartum psychosis cases are due to

bipolar disorder or schizoaffective disorder (32). The studies have confirmed the strong connection between severe postpartum episodes and susceptibility for bipolar disorder on a genetic level (33). There is a hypothesis that bipolar disorder in the postpartum period is associated with immune activation postpartum (34).

In the present case report there were no serious negative consequences of the disorder, thanks to an almost immediate response from the family. It should be emphasized that single mothers and women that are unsupported by relatives are particularly at risk. Obstetricians, midwives and general practitioners should pay close attention to women with risk factors for developing the most serious of childbirth related disorders – postpartum psychosis. Furthermore, psychiatrists should be aware of the relationship when diagnosing women with psychiatric problems unrelated to childbirth with bipolar disorder.

GP Comment

What have I learned from this paper?

The postpartum period is a time of increased vulnerability to a number of medical conditions, especially those affecting mental health and it is important to support women and their families at this time. Postpartum problems like wound infections, mastitis, insomnia and feeding problems may have adverse effect on the mother and infant. Preconception and antenatal planning are essential in women with known mental health problems, but serious mental illness, including postpartum psychosis may occur de novo at this time and GPs, Midwives, Health Visitors and the Primary Healthcare team should be alert for women who do not appear to be coping or who appear unwell. Women who do not have effective family support may be at particular risk, because presentation to medical services and treatment are likely to be delayed. Hypomania can be difficult to differentiate from the normal joys of motherhood and mixed states can occur.

The Edinburgh Postnatal Depression Score is now routinely assessed at the 6 weeks postnatal GP check, and earlier by the Midwife and Health Visitor but there is a potential gap of medical assessment between the time of birth and the 6 week check, and calls for help during this time – often to the on-call or out of hours GP - must be taken seriously, but with care not to over-medicalise normality. Postpartum psychiatric disorder, particularly postpartum psychosis, increases the risk for subsequent psychiatric disorders, particularly bipolar disorder and if a woman develops postnatal depression and subsequent recurrent depression, bipolar disorder should be considered and further evaluation arranged.

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