Treatment of bipolar disorder in pregnancy and post partum

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Abstract

Bipolar disorder tends to occur during reproductive years in women. It is a source of distress, disability, burden to relatives and caregivers, and death through suicide. Prevention and treatment is especially important for women in the reproductive age. Close psychiatric follow up and coordinated care with the obstetrician is needed.

Key words: bipolar disorder, pregnancy, postpartum period.

Introduction

Is pharmacotherapy in pregnancy ethical?

We should always weigh the benefit against potential risk or harm to the fetus.
There is now much evidence that untreated bipolar disorder presents many risks for the fetus and newly born.

The amount of suffering that is caused by the symptoms of untreated bipolar disorder and the possible preventive role of early treatment must be considered. Treatment with medication, psychotherapy and psychoeducation may reduce the suffering of patients and their families, prevent potential harm to the fetus and newborn, enable better bonding between the mother and the newborn and influence the course of the bipolar disorder in the future.

Risk and course of bipolar disorder during pregnancy

There are a few studies that support the view that pregnancy has a protective effect on the course of bipolar disorder (1), but the sample may not have been representative for broader groups of women with BPD (2). Other research and growing clinical evidence suggest that pregnancy does not protect against recurrences but is a time of substantial risk of relapse. The risk is higher after discontinuation of mood-stabilizing maintenance treatment (3,4). According to some data approximately half of women with bipolar disorder become symptomatic during pregnancy (5). To some extent the risk may be predicted by the past history of illness frequency and severity.

Risk and course of bipolar disorder during the postpartum period

The postpartum period has been consistently recognized as a high risk period for relapse with rates well above 50% (4,5). BPD is closely related to postpartum psychosis, the risk is 10-20% in women with BPD and 0.1- 0,2 % in the general population (6). Postpartum psychosis is a psychiatric emergency with a rapid onset within the first few days after delivery and a high risk of infanticide and suicide. Women with a history of postpartum psychosis have a risk as high as 90% in their subsequent pregnancies (7). Prophylactic treatment with mood stabilizer or atypical antipsychotics can reduce the risk by threefold to fivefold (7).

Treatment

Physicians caring for women with BPD face a clinical challenge: achieving the mental health and wellbeing of the mother with minimal risk to the fetus.

Pharmacotherapy

There is a 3-4% risk of malformations in the general population of newborns.
Each organ system seems to be vulnerable to teratogenic effects during a certain period of time, for example formation of the heart and great vessels takes place between week 5 and 10 of gestation.
Neural tube folding and closure occurs within the first 5-7 weeks of gestation (10).
Mood stabilisers: risk during pregnancy (from highest to lowest)

1. Valpoate (neural tube defects, spina bifida 2%, other potential severe adversities – overall 22% risk). If planning a pregnancy, the woman should be switched to another treatment. Folate, vitamin B12 and vitamin B6 are recommended prophylactically for women in childbearing age on valproate (9).
2. Carbamazepine (spina bifida 0.5%, other minor malformations and mild developmental delay compensated in the first years – overall 8% risk of serious adverse events) (9).
3. Lithium (20 fold higher risk of Epstein's malformation than in the general population – still a very low risk). Women with a moderate to high risk of relapse should continue the treatment and be carefully monitored with ultrasonography (10).
4. Lamotrigine (2% incidence of severe adverse events, about the same as the general population).
5. Atypical antipsychotics. No specific risk has been observed (8).
6. SSRI antidepressants. Little evidence of teratogenicity, with the exception of paroxetine with 1.5 to 2 fold increased risk of cardiac malformations with first trimester exposure (10).
7. Other potential treatments

ECT is sometimes recommended for severely depressed patients during pregnancy but the impact of a seizure on the fetus has not been systematically studied.
High dose folate treatment is widely recommended.
Risk of no treatment
Poor prenatal care.
Poor nutrition.
Increased use of alcohol or tobacco.
Stress and trouble with attachment and bonding.
High risk of hospitalization and more intense pharmacological treatment.

Psychoeducation

Women should be offered prepregnancy counselling. They should be informed of the potential risk of medication and risk of recurrent illness. Decisions about what is the best option ultimately rests with the informed patient.
Optimal clinical care of patients with BPD during pregnancy
Patients' informed choices about pharmacological treatment.
Close psychiatric follow up.
Coordinated care with the obstetrician.
Increased psychosocial support.
Initiation or continuation of a psychotherapeutic modality (CBT, group therapy, etc.).

Breastfeeding

All psychotropic medications can enter human breast milk. Most are found in the milk at very low levels and are probably clinically insignificant to the neonate.
The risk/benefit ratio of breastfeeding should be considered individually.

Valproate appears in breast milk in only 10% of the maternal blood levels, breastfeeding is not contraindicated (8).

Carbamazepine data are limited but it is considered probably to be safe (8).

Lithium reported adverse events include lethargy, hypotonia and ECG changes. Its use during lactation is discouraged (8).

Atypical antipsychotics. Olanzapine appears to be the safest. Quetiapine and ziprasidone are not recommended during breastfeeding (8).

GP Comment

What have I learned from this paper?

The content of this paper is basic and extremely important, both for general practitioners and patients. There is need for GPs to pay careful attention to the management of bipolar disorder in pregnancy. Close working between GPs, obstetricians, midwives and psychiatrists, using a joint management approach is essential in this situation and needs to be set out clearly in a local management pathway for the management of bipolar disorder during pregnancy.

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