FLAME LECTURE: 135

TOOHEY / BURNS 8.10.15

Learning Objectives

- Identify risk factors for postpartum psychosis
- Differentiate between postpartum psychosis and depression
- Describe treatment options for postpartum psychosis
- Prerequisites:
  - NONE
- See also – for closely related topics
  - FLAME LECTURE 41 – Psychotic Disorders in Pregnancy
  - FLAME LECTURE 134 – Postpartum Depression

Introduction

- Psychosis is characterized by the presence of **perceptual disturbances** (hallucinations), **delusional thinking**, or **disordered thought**
- Postpartum period is time when women are most likely to experience psychosis
- Postpartum psychosis occurs in 1-2 out of every 1000 postpartum women
  - Abrupt onset of manic or psychotic symptoms within 4 weeks of delivery
  - Patients usually experience insomnia, restlessness, irritability, and affective instability as well as hallucinations and/or delusions
    - Delusions and disorganized thoughts often regard baby (often harming baby)
  - Increased psychosocial stress both during and after the pregnancy increase the risk for postpartum psychosis
  - Postpartum psychosis is often associated with an underlying untreated bipolar disorder
    - 70% of women suffering from bipolar disorder experience a relapse during pregnancy
    - 50-80% of women suffering from bipolar disorder will relapse in the postpartum period in the form of postpartum psychosis
    - When due to underlying bipolar disorder, symptoms often present earlier, within a couple days of delivery

Introduction

- Differential diagnosis:
  - Postpartum depression (See **FLAME LEC 134: Postpartum Depression**)
  - Psychotic depression (depression with psychotic features)
    - Often presents as late-onset PP psychosis, preceded by months of PP depression
  - Schizophrenia / Schizoaffective disorder / Bipolar Disorder
    - 75% of women with PP psychosis diagnosed with bipolar or schizoaffective disorder
    - 12% of women with PP psychosis diagnosed with schizophrenia
  - Brief Psychotic Disorder
    - Psychotic symptoms (delusions, hallucinations, disorganized thought or behavior) that last 1day – 1 month
    - Can often be a transient response to a life stressor and therefore can be associated with birth
    - 50-80% recovery rate
  - Hyperthyroidism
  - Substance abuse
- Diagnosis: DSM-V doesn't recognize "post-partum psychosis." Instead, woman would be diagnosed with **MDD w/ psychotic features** or **Bipolar Disorder w/ psychotic features**, both with '**post-partum onset**'

Risk Factors[1]

- History of postpartum psychosis
- History of bipolar disorder
- Recently discontinued lithium/mood stabilizers
- Family history of post partum psychosis
- Women with PP psychosis more likely to be primagravid
- No differences found between PP psychosis and general population in terms of:
  - Delivery method/complications
  - Lactation
  - Neonatal risk factors

Clinical Consequences

- Postpartum psychosis is a **psychiatric emergency requiring hospitalization**
  - Women are at high risk for suicide (5%)
  - Infanticide rarer occurrence (4%) but still increased risk from general population
    - Despite few women committing infanticide, a significant portion will have infanticidal ideation and delusions about harming the baby so this should be monitored closely
- Recurrent psychosis: women with a previous episode of post-partum psychosis have a:
  - 70% risk of recurrent postpartum psychosis with the next pregnancy[3]
  - 60% risk of developing psychotic episode unrelated to pregnancy[4]
  - 50% risk of post-partum depression with the next pregnancy

Treatment

- Antipsychotic therapy to relieve psychosis and agitation
  - Unlike pregnancy, where atypical antipsychotics are less advisable, **olanzapine** and **risperidone** are recommended as initial treatment for PP psychosis
  - **Haloperidol** also is advisable in post-partum women
- Sleep deprivation/insomnia should also be treated immediately to avoid psychotic episode
  - Can be treated acutely w/ benzodiazepine (i.e. **lorazepam**)
- **Electroconvulsive Therapy**: particularly good for rapid reduction in harm
  - One retrospective study found that postpartum women are more responsive than non-postpartum women with psychosis (however postpartum women have better response to treatment in general)[5]
  - ECT also has minimal effect on breast-feeding

Postpartum Psychosis & Breastfeeding

- Women with mild or moderate disease should be allowed to breastfeed, under monitoring
- However, risks of infant safety from maternal harm should be weighed before allowing breastfeeding

Treatment – *medications*[2]

Antipsychotic Medications			
Generic Name	Brand Name	Pregnancy Risk Category	Lactation Risk Category
Typical Antipsychotics			
Chlorpromazine	Thorazine	C	L3
Fluphenazine	Prolixin	C	L3
Haloperidol	Haldol	C	L2
Loxapine	Loxitane	C	L4
Perphenazine	Trilafon	C	N/A
Pimozide	Orap	C	L4
Thioridazine	Mellaril	C	L4
Thiothixene	Navane	C	L4
Trifluoperazine	Stelazine	C	N/A
Atypical Antipsychotics			
Aripiprazole	Abilify	C	L3
Clozapine	Clozaril	B	L3
Olanzapine	Zyprexa	C	L2
Quetiapine	Seroquel	C	L4
Risperidone	Risperdal	C	L3
Ziprasidone	Geodon	C	L4

IMPORTANT LINKS / REFERENCES

- ACOG Practice Bulletin 92, April 2008 (“Use of Psychiatric Medications during Pregnancy and Lactation”)

1. UpToDate.com
2. Viguera, et al *Am J of Psychiatry* (164) Dec 2007
3. Videbech et al *Acta Psychiatr Scand*. 1995
4. Reed et al *J Affect Disord*. 1999