The Need for Increased Surveillance During the Post-Partum Period: A Case Report

Elliott Baker, MS[1] Sriram Ramaswamy, MD[1]

1 Creighton University School of Medicine, Psychiatry Department, Omaha, NE

INTRODUCTION

Post-partum psychosis (PPP) is a rare but devastating complication following pregnancy. It is usually observed in women that already have been diagnosed with a mood disorder, most often bipolar disorder. PPP occurs in around 0.1% to 0.2% of women in the peripartum period[1]. Screening for current mental health issues, history of psychiatric treatment, and family history of mental issues is paramount during pregnancy in order to accurately gage problems during the post-partum period. Positive screening necessitates education and monitoring in the weeks following childbirth. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not define PPP as a unique disorder, but rather classifies patients with PPP based on a primary mood disorder with an additional specifier of "peripartum" and "with psychotic features" if the onset of psychotic features occurs within the first four weeks of delivery[2]. There is a paucity of data on PPP occurring after the DSM-5's four-week timeframe definition, even though, physiologic changes following pregnancy occur up to 6 months[3]. This may be due to post-partum depression and PPP being labeled major depressive disorder (with or without psychotic features). This case illustrates the complex nature of post-partum mood symptom onset, duration, and escalating severity into psychosis.

CASE PRESENTATION

A 29 y.o. female with history of depression, anxiety, and substance abuse was admitted with paranoia, agoraphobia, auditory/visual hallucinations , psychomotor retardation, and low mood. Three months prior to admission, she presented to the ER with depression and suicidal ideation; she was admitted for one day and then discharged. Contributing factors leading to this case report's admission included discontinuation of psychiatric medications prior to the death of her 6-month-old child. Upon admission, drug screen was negative and physical exam was unremarkable. She required inpatient treatment in the special care unit for twenty days. During this time, she exhibited paranoia, poor oral intake, and isolative behavior. These symptoms necessitated discussion of facility transfer for IV fluids and ECT treatment. She ultimately stayed, and her symptoms improved with increasing dosages of Olanzapine, Clonazepam, and Sertraline. She was discharged on Olanzapine 30mg, Sertraline 150mg, Clonazepam 1.5mg, and Trazadone 50mg.

DISCUSSION

The DSM-5 definition of PPP may not be inclusive enough and lead to missed cases of PPP due to lack of screening and monitoring in the post-partum period. The standard post-partum clinic visit usually occurs within the first 6 weeks following childbirth[4]. However, new mood symptoms secondary to childbirth may still present within a year, and a systemic review found major depressive disorder and minor depression to peak highest at 2 and 6 months post-partum[5,6] These mood symptoms may quickly spiral into psychosis in susceptible patients like this case. Additionally, increased monitoring, such as telemedicine, may have been able to prevent this episode of PPP or limit the severity of her psychotic symptoms. Decreasing the severity of a psychotic episode is critical because risk factors like duration of untreated psychosis, insidious mode of onset, severity of negative symptoms are associated with worse future patient outcomes[7]. Thus, monitoring known psychiatric patients in the post-partum period can allow for better clinical outcomes for both mother and child. Post-partum mood disorders are associated with poor mother-infant interactions that lead to higher incidences of infant crying, sleep issues, hostility towards the child, and decreased breast feeding[8]. Access to care is always a major hurdle in both psychiatry and obstetrics. Telehealth is one avenue to monitor post-partum psychiatric patients. It is patient friendly and has a low barrier access to care that is greatly beneficial to mothers and their newborns.

REFERENCES

1. Balaram K, Marwaha R. Postpartum Blues. [Updated 2020 Mar 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554546/
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th, ed. American Psychiatric Publishing, 2013. DSM-V
3. Chauhan G, Tadi P. Physiology, Postpartum Changes. [Updated 2020 Mar 15]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555904/
4. Acog.org. 2020. *Optimizing Postpartum Care*. [online] Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care> [Accessed 24 September 2020].
5. Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M. Postpartum depression risk factors: A narrative review. *J Educ Health Promot*. 2017;6:60. Published 2017 Aug 9. doi:10.4103/jehp.jehp_9_16
6. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106:1071–83.
7. Suvisaari J, Mantere O, Keinänen J, et al. Is It Possible to Predict the Future in First-Episode Psychosis?. Front Psychiatry. 2018;9:580. Published 2018 Nov 13. doi:10.3389/fpsyt.2018.00580
8. Martins C, Gaffan EA. Effects of early maternal depression on patterns of infant-mother attachment: a meta-analytic investigation. J Child Psychol Psychiatry. 2000;41:737–46.