

Case Report

Antidepressant Use and Postpartum Psychosis

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Abstract

Background: Both the use of, and withdrawal from antidepressants has been linked to the development of mania in patients with major depressive disorder or bipolar disorder.

Case Presentation: I describe two cases of postpartum psychosis in primiparous women to highlight the potential risks associated with the use of antidepressants during and after pregnancy

Conclusion: Recommendations regarding the perinatal use of these drugs in women with a bipolar diathesis are discussed (German J Psychiatry 2011; 14: 51-54).

Keywords: Antidepressants, Mania, Mental Health, Psychiatry, Postpartum Psychosis

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Introduction

Depression is a common clinical problem during and after pregnancy with studies reporting that approximately 13 percent of pregnant women and new mothers have symptoms of depression (Gaynes et al., 2005; O'Hara & Swain, 1996). Due in part to the increased awareness of perinatal depression and the deleterious effect of untreated depression on the mother and her offspring, there has been a steady increase in the use of antidepressants during pregnancy in recent years (Cooper et al., 2007; Andrade et al., 2008). For example, the use of antidepressant medications increased from 5.7 percent of pregnancies in 1999 to 13.4 percent of pregnancies in 2003 (Cooper et al., 2007). While antidepressants are clearly indicated and are effective in women with major depressive disorder, their use can lead to the development of mania, mixed episodes and rapid cycling in women with a bipolar diathesis (Ghaemi et al., 2004). This is particularly the case in the postpartum period which is normally a high risk period for the onset of mood

episodes or cycle acceleration in women with bipolar disorder (Sharma, 2006).

Rarely, symptoms of mood elevation, hypomania and mania have been reported following the abrupt discontinuation of antidepressants in patients with major depressive disorder or bipolar disorder (Goldstein et al., 1999; Ali & Milev, 2003; Haddad & Anderson, 2007). Andrade critically reviewed the literature on the subject and noted that the symptoms begin shortly after the discontinuation of an antidepressant drug but within two weeks of the withdrawal (Andrade, 2004). A reduction in the antidepressant dose can also lead to emergence of manic symptoms. There are no confounding factors, such as the simultaneous discontinuation of mood stabilizers and patients can develop symptoms in spite of the concomitant use of mood stabilizers. The symptoms are usually transient but patients may relapse into depression. In some patients there is abatement of symptoms with reinstatement of antidepressants while others may require the use of mood stabilizers or neuroleptics. The clinical profile of the syndrome differs from previously experienced symptoms of hypomania or mania. Antidepressant-withdrawal mania

should be distinguished from mania occurring as part of the patient's expected course of the illness (Andrade, 2004; Goldstein et al., 1999). The other differential diagnosis is that of mania preceding the antidepressant withdrawal in which case patients discontinue antidepressant medication due to illness-related poor judgment (Andrade, 2004).

There is anecdotal evidence that the antidepressant-withdrawal mania in the context of major depressive disorder is more likely to occur in women than in men (Ali & Milev, 2003). Since women are at a greatly increased risk of developing manic and psychotic episodes in the postpartum period (Chaudron & Pies, 2003; Sit et al., 2006; Valdimarsdóttir et al., 2009), distinguishing antidepressant-withdrawal mania and antidepressant-induced mania from the childbirth-related manic and psychotic episodes can be extremely challenging. This is particularly problematic in primiparous women who are normally at a greatly increased risk of postpartum psychosis than multiparous women (Kendell et al., 1987; Valdimarsdóttir et al., 2009). In this paper, two cases of antidepressant-linked postpartum psychosis are described. In Case 1, the abrupt discontinuation of an antidepressant and in Case 2, the use of an antidepressant likely played a causal role in the onset of postpartum psychosis.

Case Presentation 1

Mrs A is a 31-year-old primiparous woman who was hospitalized for treatment of pre-eclampsia a couple of weeks prior to the expected day of confinement. There was no family history of a mood disorder but she had been taking paroxetine for treatment of depression. Prior to the initiation of paroxetine three years earlier, she had a fairly significant episode of depression during which she had atypical symptoms including hypersomnia, increased appetite and psychomotor retardation. There was a favourable response to paroxetine 20 mg daily but the dose had to be increased gradually due to repeated loss of antidepressant response.

Due to concerns regarding her physical health she did not receive paroxetine 60 mg for at least four days prior to delivery. Soon after delivering a healthy male child by caesarean section she was noted to have euphoria, pressured speech, increased level of activity, and perceptual disturbance in the form of auditory and visual hallucinations. She appeared perplexed and required increasingly less amount of sleep. The psychotic and manic symptoms improved two days after the reintroduction of paroxetine 60 mg and initiation of lorazepam 0.5 mg daily prn. But the manic symptoms reappeared soon after paroxetine was tapered off over a 3-week period. A trial of olanzapine 5 mg daily was commenced but she was unable to tolerate it due to excessive drowsiness. The manic symptoms resolved gradually on olanzapine 2.5 mg she quickly became depressed and was treated with lamotrigine 175 mg daily. She has been asymptomatic for six months on lamotrigine monotherapy.

Case Presentation 2

Mrs K is a 23-year-old lady with no personal or family history of psychiatric illness who became acutely depressed two weeks after delivering a healthy male child. In addition to the usual symptoms of depression including sad mood, anhedonia, reduced appetite, insomnia, lack of energy, and inability to concentrate, she had obsessive concerns regarding the safety of the newborn. She consulted her family physician who diagnosed her with postpartum depression and prescribed citalopram 20 mg daily. Within a week she developed catatonic symptoms including mutism and had thoughts of suicide and infanticide. She was hospitalized on an involuntary basis and diagnosed with postpartum psychosis. Citalopram was substituted with bupropion 300 mg daily without benefit and she had successive trials of risperidone 4 mg, olanzapine 10 mg and quetiapine 325 mg in combination with bupropion.

As her condition continued to deteriorate, a trial of electroconvulsive therapy was considered but the patient refused to consent to the treatment. At the recommendation of this author, bupropion was gradually discontinued and treatment continued with quetiapine 325 mg daily. There was a marked improvement in her condition and the patient was discharged home within a few weeks. Following the resolution of psychosis, she admitted to having had racing thoughts.

She was able to return to her job and has been working on a full-time basis for over two years. As her mood remained stable, quetiapine was gradually discontinued as she wanted a medication-free pregnancy. She is currently pregnant and is not on any psychotropic medication. She is aware of the high risk of postpartum relapse and is agreeable to reinitiation of quetiapine at delivery, or earlier for prophylactic or acute treatment purposes.

Discussion

Antidepressant-withdrawal mania is not a common occurrence. Goldstein and colleagues who conducted the only prospective study on the subject reported that 8.2% of bipolar patients developed the syndrome during an antidepressant taper despite the adequate concurrent trials of mood stabilizers (Goldstein et al., 1999). The rarity of the description of the syndrome in the literature may be due to episode misattribution and/or the protective effect of mood stabilizing drugs (Andrade, 2004).

In Case 1, there were various risk factors of postpartum psychosis including primiparity, emergency caesarean section (Kendell et al., 1987), and possible sleep disruption (Edwards et al., 2000) secondary to pre-eclampsia (Sharma & Mazmanian, 2003) that may have played a causative role. However, the symptom abatement upon the reinitiation of the antidepressant suggests that the abrupt discontinuation of the antidepressant was likely the main trigger for the

Table 1: Recommendations about the perinatal use of antidepressants in women with a bipolar diathesis

During pregnancy	
1.	Antidepressants should generally be avoided during pregnancy and the postpartum period in women with a bipolar diathesis.
2.	Decisions about whether to continue with antidepressant among expectant mothers with bipolar disorder should be made after a careful review of current mental state, type of the disorder (e.g. Bipolar I or Bipolar II Disorder), elimination half-life of the drug*, expected date of confinement, social support, and concomitant psychotropic drugs.
3.	Reinitiation of antidepressant should be avoided among women with a history of Bipolar I Disorder or postpartum psychosis who discontinue the antidepressant abruptly near delivery.
4.	Physicians should be aware of potential problems including the development of mania and postpartum psychosis associated with the abrupt withdrawal of antidepressant near delivery.
5.	Pregnant women who abruptly stop their antidepressant near delivery should be followed up closely in regards to emergence of (hypo) manic or psychotic symptoms.
6.	Use of a sedating neuroleptic such as olanzapine or quetiapine, or a mood stabilizer may be necessary to manage treatment-emergent mania.
After parturition	
1.	Before initiating antidepressant, screen all patients diagnosed with postpartum depression for evidence of bipolar disorder.
2.	Antidepressants should be used with caution in antidepressant-naïve women who experience their first depressive episode in the postpartum period.
3.	Caution also needs to be exercised while using antidepressants in women who have mixed depressions (major depressive episodes accompanied by subsyndromal manic or hypomanic symptoms).
4.	Antidepressant should be tapered if the patient develops postpartum psychosis, and treatment should be carried out with initiation/optimization of a mood stabilizer alone or in combination with a neuroleptic.

* It may not be advisable to discontinue drugs with short half-lives immediately before delivery.

psychotic episode (Goldstein et al., 1999; Andrade, 2004; Ali & Milev, 2003).

In Case 2, the antidepressant trial was justified because there were no clues to the bipolar nature of her postpartum depression. Her condition clearly deteriorated following the initiation of the antidepressant; she developed psychotic symptoms and began to have thoughts of suicide and infanticide. Due to the apparent absence of clear manic symptoms, she was thought to have a DSM-IV diagnosis of major depressive disorder with psychotic features with postpartum onset. However, following the resolution of catatonic fea-

tures she had symptoms such as racing thoughts and agitation that would suggest a bipolar diathesis. Interestingly, the response to quetiapine was poor when it was used in combination with an antidepressant but she quickly recovered following the discontinuation of the antidepressant.

Could postpartum psychosis have been prevented in these two cases? In Case 1, although there was no history of manic symptoms prior to the initiation of an antidepressant, there were some symptoms suggestive of a bipolar diathesis including the atypical symptoms (hypersomnia, increased appetite, and psychomotor retardation), the repeated loss of antidepressant response, and an early age of illness onset. In Case 2, the antidepressant trial was unavoidable given the serious nature of postpartum depression; however the antidepressant should have been tapered earlier due to a clear evidence of illness worsening on the antidepressant. The 'non-classic' presentation of postpartum psychosis may have contributed to the prolongation of antidepressant treatment. For example, the usual symptoms of a bipolar diathesis such as pressured speech, elation, agitation and mood lability were not readily discernable.

Due to its association with maternal suicide (Sit et al., 2006) and infanticide (Parry, 1995), postpartum psychosis requires prompt medical intervention and hospitalization. Drug therapy for postpartum psychosis is generally dictated by the same treatment principles as for a manic/mixed episode. However, there may be confusion about treatment of patients in whom the bipolar nature of the episode may not be readily evident. These are the individuals for whom the literature does not provide clear treatment suggestions. For example, what should be the role of antidepressants in patients who have a depressive type postpartum psychosis? In Case 2, for example there was preponderance of depressive symptoms initially and the bipolar characteristics of the episode became evident only upon the resolution of psychotic symptoms.

Despite the apparent depressive nature of postpartum psychosis, this case is supportive of the research evidence linking postpartum psychosis to bipolar disorder. Thus antidepressants should be avoided in favour of mood stabilizers and neuroleptics even when there is no clear evidence of concurrent manic symptoms. Based on a review of the literature and the two cases presented her, suggestions are made in Table 1 regarding the use of antidepressants during and after pregnancy.

Breastfeeding and medication use: Among selective serotonin reuptake inhibitors sertraline or paroxetine and among tricyclic antidepressants nortriptyline or imipramine have been recommended as first line agents during breastfeeding (Lanza di Scalea & Wisner, 2009). Both carbamazepine and valproic acid are generally considered compatible with breastfeeding. Lamotrigine should be used with caution due to concerns about skin rash and higher-than-expected drug levels, even though only 60% of the drug is transferred to the breast milk (Liporace et al., 2004). Due to concerns lithium may be secreted in high levels in breast milk or infants may not clear it efficiently, breastfeeding while taking lithium has been discouraged (Chaudron & Jefferson, 2000). However in light of recent data on its safety, lithium should be considered carefully in selected woman (Viguera et al.,

2007). The data on the safety of the atypical antipsychotics during lactation is limited however there is preliminary evidence support the use of quetiapine (Gentile, 2008).

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