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Case Report Open Access

Recognition of Postpartum Psychosis; Obstetricians, Gps, Midwives, Community Psychiatric Nurses and Psychiatrists Working Together

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Abstract

Psychiatric illness remains one of the leading causes for indirect maternal deaths in the United Kingdom. CMACE Report 2006-2008 reported 13 maternal deaths attributed to psychiatric illness compared to 18 deaths in the previous triennial report. This significant improvement highlights the importance of early recognition, appropriate referrals and multidisciplinary approach for dealing with Psychiatric illness during pregnancy and puerperium.

Puerperal Psychoses or Postpartum Psychosis is characterized by sudden onset and rapid deterioration. Therefore, early recognition should be an essential skill for Obstetricians and midwives working together with Psychiatrists; Understanding the incidence, risk factors and symptoms are integral in early recognition of the disorder, and consequently patients receiving the proper treatment.

Keywords: CMACE; Maternal death; Psychiatric illness; Postpartum psychosis; Risk factors; Symptoms; Early recognition; Obstetricians; Midwives

Case Report

A 32 years old mother, gave birth to her first baby two weeks ago, she believes that she is the mother of God, her partner reported that she is more agitated and acting in an aggressive behavior, her partner is worried about her and the baby.

Another 25 years old lady, delivered a healthy baby after an unplanned pregnancy, soon after her delivery, her family reported that her speech can be disorganized and she appears to be responding to external stimuli by talking to someone when no one is in her room. This is out of her character and is causing her significant distress.

The above are clinical examples similar to real cases of a disorder called Postpartum Psychosis. It is a term that covers a group of mental illnesses with the sudden onset of psychotic symptoms following childbirth.

The incidence is less than 1/1000 deliveries [1] and hence significantly affects thousands of women in the UK every year. The onset is usually abrupt and usually starts within the first 2-3 weeks after delivery.

There is an uncertainty about aetiology, but it occurs more in first time mothers and in unwanted or unplanned pregnancy as in the above cases. Possible links to menstrual disorders have been suggested as well as specific heritable factor [2-4]. There is evidence of linkage to chromosome sixteen [5].

Some patients have typical manic symptoms, such as euphoria, over activity, decreased sleep, flight of ideas, disinhibition, irritability, aggression. Delusions are usually grandiose or religious. The above first case shows a combination of a grandiosity and religious delusion believing that she is the mother of GOD; others have severe depression with delusions, Hallucinations, or transient swings into hypomania. In severe cases mutism and stupor can occur.

Some can switch from mania to depression (or vice versa) within the same episode. Atypical features include perplexity, confusion, emotions like extreme fear and ecstasy, catatonia or rapid changes of mental state with transient delusional ideas; these are so striking that some authors have regarded them as a distinct, specific disease, but they are the defining features of acute polymorphic (cycloid) psychoses, and are seen in other contexts (for example, menstrual psychosis) and in men.

Without treatment, psychosis can last longer; but with specialist treatment the symptoms usually resolve within a few weeks. However mothers who suffer a puerperal episode are liable to other manic depressive disorder or acute polymorphic episodes, some of which occur after other children are born, some during pregnancy or after an abortion, and some unrelated to childbearing. Puerperal recurrences occur after at least 20% of subsequent deliveries or over 50% if depressive episodes are included [6].

Obstetricians, midwives and GPs are in an ideal situation to recognize the symptoms by careful clinical examination and performing a risk assessment with particular care of the risk on the patient, baby and others involved with the patient. Information obtained from the family will be very helpful in recognition of the disorder. Consequently an urgent referral should be arranged for a Psychiatrist or Community mental health team for assessment and treatment. The location of treatment could be an issue: hospitalization can be disruptive to the family, and it is possible based on the risk assessment to treat cases at home, where the sufferer can maintain her role as a mother and build up her relationship with the newborn.

This requires the presence of competent adults such as the baby's maternal grandmother, and /or a supportive partner and frequent visits by professional staff [7]. If hospital admission is necessary, there are advantages in conjoint mother and baby admission.

Suicide is rare, and infanticide extremely rare, during these episodes. Infanticide after childbirth is usually due to profound postpartum

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depression (melancholic filicide) when it is often accompanied by suicide [8].

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