Section: Psychiatry

Original Research Article

ASSESSMENT OF LONG-TERM OUTCOME OF POSTPARTUM PSYCHOSIS

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Abstract

Background: To assess long-term outcome of postpartum psychosis. **Materials and Methods:** One hundred ten women with a diagnosis of first-onset mania or psychosis during the postpartum period were classified into 2 groups. Group I (55) was non- postpartum recurrence group and group II (55) was no recurrence outside the postpartum period. Parameters such as education, marital status, parity type of disorder, length of initial hospital admission in days, lithium treatment during admission, antipsychotics treatment during admission etc. was recorded. **Result:** Education was primary seen in 25 and 29, high in 20 and 25 and degree in 10 and 6 in group I and II respectively. Marital status was married in 40 and 43 and not in relationship in 15 and 12. Parity was 1 seen in 34 and 28, 2 seen in 20 and 25, 3 seen in 1 and 2. Disorder was bipolar I disorder seen in 15 and 15, major depressive disorder in 12 and 10, anxiety/panic disorder in 10 and 12, brief psychotic disorder in 7 and 9, schizoaffective disorder in 4 and 5, mood disorder in 2 and 1 and cyclothymic disorder seen in 2 and 3 in group I and II respectively. The difference was non- significant (P> 0.05). Length of initial hospital admission was 56.2 days in group I and 54.7 days in group II. Lithium treatment during admission was seen in 47 and 46, antipsychotics treatment during admission was seen in 49 and 50, recurrence within 6 months after lithium stop was seen in 7 and 0, lithium treatment at follow-up was seen in 40 and 19 and antipsychotics treatment at follow-up was seen in 9 and 4 in group I and II respectively. The difference was significant (P< 0.05). **Conclusion:** No clinical predictors of a woman's risk of severe episodes outside the postpartum period were found. It was found that the majority of women with first-onset postpartum psychosis, the risk of illness was limited to the period after childbirth.

INTRODUCTION

Postpartum psychosis comprises of postpartum mania, psychosis, psychotic depression and a mixed affective state. It occurs shortly after childbirth. Postpartum psychosis is the most severe form of childbirth-related psychiatric disorders. An incidence of 0.3 to 0.6 per 1000 births has been reported. The clinical presentation in females with postpartum psychosis are mood fluctuations, insomnia and obsessive concerns about the baby, followed by severe mood symptoms, and sometimes disorganized behavior, delusions and hallucinations.[1,2]

The onset is typically sudden, and occurs within the first two weeks postpartum. Features such as a delirium-like waxing and waning of consciousness, disorganization and confusion, depersonalization, and bizarre delusions (often concerning the child or childbirth) has been recorded. Insomnia, anxiety, irritability, or mood fluctuation. While the psychotic symptoms are often the most dramatic manifestation, women also present with mood symptoms – mania (can be irritable or elevated), depressive symptoms, or mixed symptoms are other early warning symptoms.[3,4]

The postpartum period has been revealed as a time of particularly high risk of severe psychiatric disorders, implicating childbirth in the triggering of these episodes in contrast to before or during pregnancy. While more than 40% of women affected by postpartum psychosis have no history of severe psychiatric illness, the remainder present with a recurrence of a pre-existing psychiatric illness, predominantly of a psychotic or mood disorder. Evidence robustly indicates a strong and specific relationship with bipolar disorder, suggesting that in most cases, postpartum psychosis may be a manifestation of bipolar disorder in women vulnerable to the puerperal trigger. We

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performed this study to assess long-term outcome of postpartum psychosis.[5-7]

MATERIALS AND METHODS

After considering the utility of the study and obtaining approval from ethical review committee, we selected one hundred ten women with a diagnosis of first-onset mania or psychosis during the postpartum period. Patients' consent was obtained before starting the study.

Data such as name, age, etc. was recorded. Patients were diagnosed by a clinician using the Structured Clinical Interview for DSM. Patients were classified into 2 groups. Group I (55) was non- postpartum recurrence group and group II (55) was no recurrence outside the postpartum period.

Parameters such as education, marital status, parity type of disorder, length of initial hospital admission in days, lithium treatment during admission, antipsychotics treatment during admission etc. was recorded. The results were compiled and subjected for statistical analysis using Mann Whitney U test. P value less than 0.05 was set significant.

RESULTS

Education was primary seen in 25 and 29, high in 20 and 25 and degree in 10 and 6 in group I and II respectively. Marital status was married in 40 and 43 and not in relationship in 15 and 12. Parity was 1 seen in 34 and 28, 2 seen in 20 and 25, 3 seen in 1 and 2. Disorder was bipolar I disorder seen in 15 and 15, major depressive disorder in 12 and 10, anxiety/panic disorder in 10 and 12, brief psychotic disorder in 7 and 9, schizoaffective disorder in 4 and 5, mood disorder in 2 and 1 and cyclothymic disorder seen in 2 and 3 in group I and II respectively. The difference was non- significant (P> 0.05) [Table 1].

Table 1: Patients distribution

Parameters	Variables	Group I	Group II	P value
Education	Primary	25	29	0.18
	High	20	25	
	Degree	10	6	
Marital status	Married	40	43	0.72
	Not in relationship	15	12	
Parity	1	34	28	0.91
	2	20	25	
	3	1	2	
Disorder	Bipolar I Disorder	15	15	0.65
	Major Depressive Disorder	12	10	
	Anxiety/Panic Disorder	10	12	
	Brief Psychotic Disorder	7	9	
	Schizoaffective Disorder	4	5	
	Mood Disorder	2	1	
	Cyclothymic Disorder	2	3	

Table 2: Assessment of parameters

Parameters	Variables	Group I	Group II	P value
Length of initial hospital admission (days)		56.2	54.7	0.91
Lithium treatment during admission	Yes	47	46	0.05
	No	8	9	
Antipsychotics treatment during admission	Yes	49	50	0.04
	No	6	5	
Recurrence within 6 months after lithium stop	Yes	7	0	0.01
	No	48	55	
Lithium treatment at follow-up	Yes	40	19	0.02
	No	15	36	
Antipsychotics treatment at follow-up	Yes	9	4	0.03
	No	48	51	

Length of initial hospital admission was 56.2 days in group I and 54.7 days in group II. Lithium treatment during admission was seen in 47 and 46, antipsychotics treatment during admission was seen in 49 and 50, recurrence within 6 months after lithium stop was seen in 7 and 0, lithium treatment at follow-up was seen in 40 and 19 and antipsychotics treatment at follow-up was seen in 9 and 4 in group I and II respectively. The difference was significant (P< 0.05) [Table 2].

DISCUSSION

The high rate of recurrence of existing mood disorders in the postpartum period may, in part, be accounted for by medication factors. For example, women with bipolar disorder face difficult decisions regarding the use of psychotropic medication during the perinatal period, often in the absence of an established evidence base. Many subsequently choose to withdraw medication due to fears of teratogenic effects or because they have an intention

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to breastfeed. Postpartum psychosis provides a unique opportunity to investigate the aetiology and potential triggering factors of psychotic and mood disorders. In no other psychiatric condition are we able to predict as precisely the onset of the disorder, definable to within such a narrow timeframe in relation to a biological trigger. Similar to psychiatric disorders more generally, the aetiology of postpartum psychosis is likely to be explained by a complex interaction of biological, psychological and social factors. We performed this study to assess long-term outcome of postpartum psychosis.[8-11]

Our results showed that education was primary seen in 25 and 29, high in 20 and 25 and degree in 10 and 6 in group I and II respectively. Marital status was married in 40 and 43 and not in relationship in 15 and 12. Parity was 1 seen in 34 and 28, 2 seen in 20 and 25, 3 seen in 1 and 2. Disorder was bipolar I disorder seen in 15 and 15, major depressive disorder in 12 and 10, anxiety/panic disorder in 10 and 12, brief psychotic disorder in 7 and 9, schizoaffective disorder in 4 and 5, mood disorder in 2 and 1 and cyclothymic disorder seen in 2 and 3 in group I and II respectively. Rommel et al tested the outcome of postpartum psychosis and identified potential clinical markers of mood/psychotic episodes outside of the postpartum period in 106 women with a diagnosis of first-onset mania or psychosis during the postpartum period. Women were categorized into either (1) recurrence of non-postpartum mood/psychotic episodes or (2) mania/psychosis limited to the postpartum period. It was found that 2/3rd of the women did not have major psychiatric episodes outside of the postpartum period during follow-up. The overall recurrence rate of mood/psychotic episodes outside the postpartum period was~32%. Of these women, most transitioned to a bipolar disorder diagnosis. None of the women fulfilled diagnostic criteria for schizophrenia or schizophreniform disorder. No clinical markers significantly predicted recurrence outside of the postpartum period.[12,13]

Our results showed that length of initial hospital admission was 56.2 days in group I and 54.7 days in group II. Lithium treatment during admission was seen in 47 and 46, antipsychotics treatment during admission was seen in 49 and 50, recurrence within 6 months after lithium stop was seen in 7 and 0, lithium treatment at follow-up was seen in 40 and 19 and antipsychotics treatment at follow-up was seen in 9 and 4 in group I and II respectively. The diagnosis 'bipolar disorder' suggests a vulnerability to mood episodes at all times, not only during the postpartum period. Consequently, we believe a diagnosis of bipolar disorder should only be given following severe mood episodes outside of the postpartum period, either mania or depression. For women with vulnerability for episodes limited to the postpartum period, a distinct classification within the bipolar spectrum would be more accurate and reduce stigma.[14,15]

CONCLUSION

No clinical predictors of a woman's risk of severe episodes outside the postpartum period were found. It was found that the majority of women with first-onset postpartum psychosis, the risk of illness was limited to the period after childbirth.

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