

# Pregnancy in the severely mentally ill patient as an opportunity for global coordination of care

Rocio Acera Pozzi, MD, MSS; Lynn M. Yee, MD, MPH; Kara Brown, MD; Kara E. Driscoll, MD; Priya V. Rajan, MD

Although obstetricians commonly care for pregnant patients with psychiatric disorders, little has been written about the implications of managing a pregnancy during a prolonged psychiatric hospitalization for severe mental illness. Multidisciplinary care may optimize obstetric and psychiatric outcomes. We describe a severely mentally ill patient at 27 weeks' gestation (G1P0) who was admitted after a suicide attempt. She exhibited intermittently worsening depression and anxiety throughout a 2-month inpatient psychiatric hospitalization, during which her psychiatric and obstetric providers collaborated regarding her care. We review recommendations for antepartum and intrapartum treatment of the acutely suicidal and severely mentally ill patient and, in particular, the evidence that a multidisciplinary coordinated approach to planning can maximize patient physical and mental health and facilitate preparedness for delivery.

**Key words:** depression, multidisciplinary approach, pregnancy

Obstetricians regularly care for pregnant women with mental illness; such care largely unfolds without complications. Although major depression affects 3.1-4.9% of women during pregnancy, they rarely require prolonged psychiatric hospitalization.<sup>1</sup> Care for pregnant patients with severe mental illness can be complicated by concerns regarding the appropriate treatment of symptoms relative to risks of exposure during pregnancy. For providers who are not familiar with the treatment of severe mental illness during the

perinatal period, this can lead to deviations from obstetric and psychiatric standards of care. To illustrate the issues that arise in such cases, we describe a pregnant woman with longstanding severe mental illness who presented after intentional overdose. We review potential challenges to caring for severely mentally ill women during pregnancy and offer an example of a patient-centered multidisciplinary approach. We will not review psychotropic medication use during pregnancy, which has been addressed in detail elsewhere.<sup>2</sup>

## A third-trimester suicide attempt

This married 37-year-old Hispanic woman (G1P0) had a complicated psychiatric history that was significant for recurrent major depressive disorder and obsessive compulsive disorder (OCD) that resulted in multiple suicide attempts and psychiatric hospitalizations. Before her unplanned pregnancy, she had 4 years of stability on a regimen of paroxetine and lamotrigine. Her medical comorbidities included obesity and likely chronic hypertension. After consultation with her psychiatrist, the patient elected to discontinue her psychotropic medications once pregnancy was diagnosed. She consulted with maternal-fetal

medicine (MFM) providers at 12 weeks' gestation to discuss medication use, potential implications of pregnancy on her mental illness, and options for pregnancy management. She was counseled that the continuation of psychotropic medications during pregnancy is recommended in cases of severe, recurrent depression. Medication use for pregnant women with such severe mental illness is recommended because of the high risk of relapse with medication discontinuation, with corresponding maternal and fetal risks.<sup>3-6</sup> Nevertheless, the patient elected to forego reinitiation of psychiatric medications until 24 weeks of gestation, when she agreed to resume them for worsening symptoms of OCD and depression. In the interim, she had had 2 psychiatric hospitalizations that were triggered, in part, by typical symptoms of pregnancy such as weight gain and fetal movement.

At 27 weeks 2 days' gestation, the patient was transferred from a local hospital to our intensive care unit after an intentional overdose. She had been found unconscious by her husband after she had ingested a combination of quetiapine, paroxetine, fluoxetine and clonazepam. Once stabilized, she was transferred to the labor and delivery (L&D) unit for obstetric monitoring. She reported feeling "tired of the pregnancy," was acutely anxious, worried she was a burden to family, and wondered whether she could care for a baby. On L&D, bedside ultrasound showed an appropriately grown fetus. Initial biophysical profile was 2 of 10, which was suspected to be a transient response to her overdose. Fetal status became reassuring during the period of observation. Because the psychiatry service had determined that the patient lacked the capacity to provide informed consent after the overdose, her husband consented for potential emergency cesarean delivery in the event fetal status had not improved. At this time,

From the Division of Maternal-Fetal Medicine, Departments of Obstetrics and Gynecology (Drs Acera Pozzi, Yee, and Rajan) and of Psychiatry and Behavioral Sciences (Drs Brown and Driscoll), Northwestern University Feinberg School of Medicine, Chicago, IL.

Received May 27, 2013; revised July 24, 2013; accepted July 29, 2013.

The authors report no conflict of interest.

Reprints: Lynn M. Yee, MD, MPH, Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, 250 East Superior St., Suite 05-2175, Chicago, IL 60611. [lynn.yee@northwestern.edu](mailto:lynn.yee@northwestern.edu).

0002-9378/\$36.00

© 2014 Mosby, Inc. All rights reserved.

<http://dx.doi.org/10.1016/j.ajog.2013.07.029>

she did not have an advanced directive but designated her husband as her medical proxy.

### Antepartum planning

After obstetric stabilization, the patient was transferred to the inpatient psychiatric unit where she stayed for the next 2 months. Her obstetric care was transferred from her private obstetrician to the MFM service. Once care was assumed by the MFM service, she had a consistent care team throughout her antepartum admission. Initially, she was treated with a combination of fluoxetine, quetiapine, lorazepam, and haloperidol for acute symptoms of depression and OCD. During the hospitalization, she experienced 2 acute setbacks with suicidal behaviors that necessitated one-to-one supervision for safety. Treatment with electroconvulsive therapy was proposed, but the patient declined. She was then restarted on her prepregnancy regimen of paroxetine and lamotrigine in conjunction with quetiapine. After the change in medications, she improved and transitioned from ambivalence to increased bonding with her fetus and motivation to participate in treatment. During this period of improvement, she reconfirmed her medical proxy. She signed a power of attorney for health care form that formally designated her husband as her primary surrogate decision-maker in the event of her incapacity. She included advanced directives regarding her wishes in the event of need for life-sustaining care.

At 31 weeks' gestation, she was diagnosed with gestational diabetes mellitus (GDM) and started on medical nutritional therapy. The GDM diagnosis was made late because of both the patient's receipt of betamethasone on initial presentation and the initial focus on her psychiatric needs. A hemoglobin A1c test that was performed at the time of her diagnostic oral glucose tolerance test was 5.8%. She had persistent hyperglycemia, despite dietary therapy. Although insulin was the preferred agent, she was started on the oral hypoglycemic medication glyburide because of OCD-related needle intolerance. On this regimen, she achieved

adequate glycemic control. The patient was counseled about options for delivery mode and postpartum contraception. At our institution, cesarean delivery on maternal request is not presented typically to women as a preferable choice, but it is considered on an individual basis. This patient expressed her desire for a vaginal delivery and a long-acting reversible contraception method.

### Multidisciplinary coordination of care

A multidisciplinary meeting for collaborative management was organized at 32 weeks' gestation and included members of the MFM, L&D nursing, psychiatry, social work, pediatrics, anesthesiology, hospital administration, and medical ethics teams. Some of these teams initially suggested a planned cesarean delivery might be better for the patient because of her difficulty coping in unpredictable circumstances and her obsessive fear of contamination. Weighing the maternal and fetal benefits of vaginal delivery against the patient's mental illness, the group arrived at the consensus that a trial of labor was preferable in the absence of obstetric indications for cesarean delivery. Because the patient achieved sufficient psychiatric stability to be involved in decisions about her care, her preference for vaginal delivery and subsequent intrauterine contraception carried significant weight. Contingency plans were developed for the management of emergent obstetric events on the psychiatric unit. Induction of labor was planned for 39 weeks' gestation because of her GDM. Although Department of Child and Family Services involvement is not mandatory for all mentally ill patients, this patient's severe mental illness and high risk for self-harm warranted consultation with the Department of Child and Family Services to ensure newborn infant safety. A care plan was developed and distributed.

One aspect of the plan involved repeated exposures to typical aspects of L&D. Nonstress tests, which were performed for fetal surveillance because of GDM, increased her comfort with the obstetrics unit and fetal monitoring. She met with anesthesiologists to address

her fear of needle contamination; they demonstrated the materials and sterile technique that would be used to provide labor analgesia. The obstetrics team educated her about the evolving pregnancy and labor symptoms.

At 33 weeks 2 days' gestation, her blood pressure became mildly elevated, and a 24-hour urine collection revealed 336 mg of protein. Mild preeclampsia was suspected. Because she was psychiatrically stable, she was transferred to the obstetrics antepartum unit with constant psychiatric supervision for safety. At 34 weeks 5 days' gestation, she experienced worsening transaminitis and severe hypertension; repeat urine collection contained 525 mg of protein. A decision was made to proceed with delivery for severe preeclampsia.

Key points of the labor plan included (1) a psychiatric nurse to be present in the labor room, (2) an early combined spinal-epidural to minimize pain and avoid pain-induced anxiety, (3) intrapartum telemetry because of Q-T interval prolongation that had recently normalized, (4) premedication with lorazepam before epidural placement to prevent worsening anxiety, (5) parenteral haloperidol (5 mg), lorazepam (2 mg), and benztropine (1 mg) available for acute psychiatric symptoms, and (6) efforts to avoid mechanical restraints (if needed, a left-sided restraint was planned because patients are supine in a 4-point restraint, which could result in inferior vena cava compression by the gravid uterus).

### Delivery and recovery

At the time of decision for delivery, the fetus was found to be in a transverse presentation. She consented to an external cephalic version, which was unsuccessful. She subsequently underwent an uncomplicated low transverse cesarean delivery under spinal anesthesia that resulted in delivery of a 2645 g male neonate with Apgar scores of 7 and 9 at 1 and 5 minutes, respectively. A ParaGard intrauterine device (IUD; Teva Women's Health Inc, Sellersville, PA) was placed after delivery of the placenta. She tolerated delivery without worsening of psychiatric symptoms and recovered without postoperative complications.

Download English Version:

<https://daneshyari.com/en/article/3433519>

Download Persian Version:

<https://daneshyari.com/article/3433519>

[Daneshyari.com](https://daneshyari.com)