An obstetrician's guide to perinatal psychiatry

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Abstract

Between 15 and 20% of pregnant women will have mental health difficulties so obstetricians need to be familiar with these conditions. Using case vignettes to illustrate specific examples, this article will review the epidemiology, the obstetrician's role, the psychiatrist's role and the basics of managing serious mental illnesses in pregnancy and post-partum including post-partum psychosis. Common psychotropic medications used in pregnancy and their indications will be considered, as well as the Mental Health Act and the Mental Capacity Act.

Keywords antipsychotics; Mental Capacity Act; Mental Health Act; mental health difficulties; mental illness; post-partum psychosis; selective serotonin reuptake inhibitors; tricyclic antidepressants

Introduction

Do obstetrics and psychiatry seem like polar opposites to you? Maybe you were relieved to finish your psychiatry in medical school? Or maybe you've had experience of a pregnant woman with a serious mental illness such as bipolar affective disorder? The aim of this article is to provide obstetric specialty registrars with the knowledge of psychiatry that is relevant to their clinical practice and post-graduate examinations. Areas covered will include case vignettes, serious mental illness in pregnancy and the post-partum period, which patients to refer to specialist perinatal psychiatry services, other mental health difficulties seen in pregnancy as well as post-partum psychosis.

Case 1

A 30 year old primip, married, professional, fully employed but off sick (due to hyperemesis gravidarum initially) presents for the third time to the antenatal ward as an emergency out of hours stating that she cannot breath. She is 28 weeks gestation and has been feeling like this since 22 weeks gestation, when her hyperemesis gravidarum stopped. She is accompanied by her family members who are very concerned for her. She is admitted again, fully examined, and investigations ordered. Respiratory rate varies between 16 and 20 breathes per minute. Oxygen saturations are normal. FBC reveals a mild anaemia for which she is already taking ferrous sulphate, other blood results are normal. VQ scan is normal and ECG is normal. Obstetrically she is fit for discharge, but she does not want to be discharged until her breathing is better. What are the possible diagnoses you are considering? How would you manage this situation?

Perhaps you have seen a case like this, or a similar situation where the patient is complicated to manage; you wonder about a possible mental health problem but the patient is insistent this is physical problem. This case vignette is similar to a referral to the Perinatal Psychiatry Team from our obstetric colleagues. The vignette demonstrates symptoms suggestive of an anxiety disorder. In such cases in late pregnancy, mental health may deteriorate further and a depressive episode develop.

Epidemiology of mental illnesses in pregnancy and post-partum

Mental illnesses are common with up to 27% of women conceiving whilst taking psychotropic medication. By far the most common mental health difficulties seen in antenatal clinics (ANC) are of mild conditions. Many women will have had their mental health difficulties managed in Primary Care. 10–15% of pregnant women will develop a mild anxiety disorder or mild depressive episode in the first trimester, which can be managed in primary care using psychosocial interventions. 5% of pregnant women will develop a depressive episode in the third trimester which if left untreated is likely to deteriorate in the post partum period. However, women with serious mental illnesses suffer relapses in pregnancy at the same incidence rates as non-pregnant women. Specialist Perinatal Psychiatry services are commissioned to manage women with serious mental illness in pregnancy and post-partum (up to 1 year post partum). This includes women with pre-existing conditions including schizophrenia, schizoaffective disorder, bipolar affective disorder and recurrent depression when episodes have been more severe as well as women who have had previous serious mental illness in the post-partum period, and those that develop moderate to severe illnesses in pregnancy or post-partum. Incidence rates of psychiatric illnesses increase in the post partum period. Epidemiological studies show that 15%–30% of women will experience an adjustment disorder in the post-partum period, most of which will be managed in Primary Care. In addition GPs will manage milder episodes of post-natal depression which occurs in up to 10% of women. Serious mental illness occurs in 3% of women post-partum including 2:1000 developing a post partum psychosis, 2:1000 births occurring in women with severe and enduring mental illness, with between 3% and 5% experiencing a severe depressive episode post-partum. Anxiety disorders including Obsessive Compulsive Disorder also deteriorate post-partum and may require secondary mental health services having previously been managed in primary care.

Obstetrician's role in identification of women who require referral to mental health services

The curriculum for the RCOG for maternal and fetal medicine states that all trainees in obstetrics need to develop clinical competencies in taking an appropriate history for women with psychiatric illness including past psychiatric history, drug history and risk factors. Identifying women with a past psychiatric history should also be done by midwives using the screening questions at

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the booking appointment. In addition, in the antenatal clinic the obstetrician will need to illicit questions about past psychiatric history, when relevant focussing on past diagnosis, whether the patient has been managed in primary or secondary care, whether the patient is currently open to mental health services and any medication taken at any point during pregnancy. Women who lack insight into their pre-existing serious mental illness may not be concordant with medication, but will usually attend antenatal appointments, so the obstetrician is able to ensure appropriate liaison with psychiatric services occurs. Regarding risk factors, in addition to identifying risk to self and risk to others, risk to the baby needs to be considered.

Case 2

A 25 year old woman of south Asian origin who was open to psychiatric services became pregnant. Her diagnosis is that of schizoaffective disorder, although when asked, she would usually deny any problems with her mental health. At conception, the patient was taking Sertraline (SSRI) and Flupentixol Decanoate (IM depot antipsychotic). Her psychiatric team changed her depot antipsychotic to oral haloperidol, as per guidelines, however, the patient was non-concordant with all oral medication. She had a past psychiatric history which included admissions under the Mental Health Act and ECT for dehydration due to severe self-neglect. She continued to see her midwife and attend antenatal clinic. The patient began to experience psychotic symptoms, depressive symptoms and began to neglect herself particularly from 28 weeks gestation onwards. As an obstetrician what are your concerns for this woman and her fetus? What would be the appropriate course of action you would need to take? What are her risks in the post-partum period?

As an obstetrician you need to ensure she is physically well enough to remain in the community. Assessing her level of dehydration clinically as well as Urea & Electrolytes would be vital, in addition to monitoring the growth of her fetus. Liaising with the psychiatric team involved to ensure they are fully informed regarding physical health, the health of the fetus and whether an intervention such as intra-venous fluids was required would be vital. In this particular case, a patient like this may deteriorate and need admission under the Mental Health Act to ensure appropriate treatment of her mental illness is able to be given.

Risk of relapse post-partum

Early identification of women at risk of serious mental illness and referral to appropriate psychiatric services for proactive management of the mental illness is key to reducing maternal mortality and morbidity. Suicide continues to be one of the leading indirect causes of maternal deaths. Women who have a diagnosis of bipolar affective disorder, even when they have been well for two years, have a 1:2 risk of relapse in the post-partum period. The current arrangement of psychiatric services is such that most people who are well are no longer under secondary care (even if their diagnosis is that of a severe and enduring mental illness); it is thus vital that the antenatal services identify these women and refer them, ideally to specialist psychiatric services. Women who have had a previous post-partum psychosis have a 1:2 risk of relapse post-partum and women who have had a previous episode of severe depression post-partum have a 1:2 to 1:3 risk of recurrence post-partum.

Case vignette 3

A married 31 year old doctor who had previously been diagnosed with bipolar disorder had become pregnant with a planned pregnancy. She had been well for 10 years on lithium so, in agreement with her psychiatrist, had reduced and stopped her lithium prior to conception. At her request, she saw a psychiatrist in the last trimester of pregnancy (her previous psychiatrist had retired). In the post-partum period, by nine weeks she had developed a severe depressive episode with psychotic symptoms that went untreated. By eleven weeks post-partum, due to her mental illness she committed infanticide and suicide. This case was reviewed as part of the Confidential Enquiry into Maternal Deaths and an independent repost was written regarding it which makes very thought-provoking reading. As doctors, this case reminds us anyone can suffer from a serious mental illness, which left untreated can have devastating consequences.

Post-partum psychosis

Post-partum psychosis is a topic some obstetricians may consider to be beyond their remit, given that the baby has been born. However, it should be noted that 50% of cases occur within seven days of delivery so some of these cases will present on the post-natal wards. Figure 1 shows the number of admissions to psychiatric wards due to psychosis, and clearly demonstrates the huge peak during the first few weeks post-partum.

As stated above, post-partum psychosis occurs in 2/1000 deliveries. It is a condition with a sudden onset, however, the clinical picture can fluctuate, making diagnosis more difficult. Symptoms may include hallucinations, delusions, disturbed behaviour, perplexity and fear. As the illness develops, women usually also develop affective symptoms of either depressed mood or elated mood. On the post-natal wards, these women are difficult to manage and need to be seen urgently by a psychiatrist. Admission of mother and baby will ideally be to a specialist psychiatric mother and baby unit, but given there are only seventeen of these in the country, at times the woman is admitted without her baby to a general adult psychiatric ward. This is far from ideal, will affect breast feeding, cause the mother distress and, if the mother and baby continue to be separated, it will affect the attachment of the baby to the mother. **A suspected case of post-partum psychosis requires immediate referral to psychiatric services** with a clear statement of the concern this might be post-partum psychosis along with all relevant obstetric details and current presentation. The woman would need to be kept in a safer environment such as a side room, and not left alone with her baby if there are concerns for the safety of the baby. Ideally, the woman will be one-to-one nursed until the psychiatrist arrives to assess her, and she may require sedation with medication such as Lorazepam or Haloperidol. Before administering medication, the obstetrician will need to seek advice from a psychiatrist. It should be noted that if Lorazepam is administered, the baby will not be allowed to breast feed for a certain period of time and any breast milk expressed during that time will need to be disposed of, to prevent the infant receiving Lorazepam.