Treatment of Peripartum Bipolar Disorder

Crystal T. Clark, MD, MSc*, Katherine L. Wisner, MD, MS

KEYWORDS

• Bipolar disorder • Pregnancy • Lithium • Lamotrigine • Carbamazepine
• Antipsychotics • Light therapy • MDQ

KEY POINTS

- Women with bipolar disorder are vulnerable to episode recurrence during pregnancy and they have an increased risk for postpartum depression and psychosis.
- Pharmacotherapy is the mainstay of treatment for bipolar disorder and the benefits of medication management during pregnancy and lactation often justify the risks.
- Monthly therapeutic drug monitoring with dose adjustment is recommended for patients taking lithium and lamotrigine during pregnancy.
- Bright light therapy is an effective adjunct to treat bipolar depression.

INTRODUCTION

Bipolar disorder (BD) is characterized by chronic remitting and relapsing episodes of depression, hypomania, and mania. The lifetime prevalence is 4.4% (including all subtypes) of the United States population.[1] Men and women have a similar incidence of BD, but women are more likely to have depressive episodes, precipitous changes between depression and hypomania/mania (ie, rapid cycling), and episodes of both depressive and manic symptoms (ie, mixed states).[2] With an average age of onset at 18 years, women are affected throughout their reproductive years and pregnancy is a vulnerable time for episode recurrence. The mainstay of treatment for BD is pharmacotherapy and the goal is prevention of symptoms of BD during pregnancy and postpartum.

Compared with women with major depressive disorder, those with BD are at a greater risk for mood worsening immediately postpartum and are 50% more likely than those with major depression to have postpartum depression.[3] Women with BD are seven times more likely to be hospitalized for a first-time mood episode early

Disclosure Statement: The authors have no conflicts to disclose.
Department of Psychiatry and Behavioral Sciences, Northwestern University Feinberg School of Medicine, 676 St. Clair Street, Chicago, IL 60611, USA
* Corresponding author.
E-mail address: crystal.clark@northwestern.edu

Obstet Gynecol Clin N Am 45 (2018) 403–417
https://doi.org/10.1016/j.ogc.2018.05.002
obgyn.theclinics.com

postpartum.[4] Mental illness in the perinatal period increases the risk for suicide, a leading cause of maternal death.[5,6] With a 25% to 50% increased risk for psychosis—a 100-fold increase over the rate in the general population—women with BD are particularly vulnerable to severe postpartum mood worsening.[3] Clinicians must be able to distinguish between unipolar and bipolar depressive episodes to provide appropriate clinical management.

Optimizing pregnancy and postpartum outcomes for women with BD requires early identification, symptom monitoring, and effective treatment. This review focuses on the risk of untreated perinatal BD and treatment options. We discuss:

1. Screening for perinatal BD,
2. The risks of illness exposure,
3. The risks of pharmacotherapy during pregnancy and breastfeeding,
4. Effective dosing across childbearing, and
5. Nondrug treatments including bright light therapy and electroconvulsive therapy.

PATIENT EVALUATION OVERVIEW

Although manic and hypomanic episodes are diagnostic of BD, most episodes in the perinatal period are depressive. Acute episodes of bipolar and unipolar depression are clinically indistinguishable. The differentiation is based on the occurrence of previous manic or hypomanic episodes, which define bipolar 1 and bipolar 2 disorder, respectively. The distinction is important in the postpartum period, which confers a high risk for both recurrent and new onset BD. Manic and hypomanic episodes are distinguished by an elevated or irritable mood and increased energy that is present most of every day for four (hypomania) or seven (mania) consecutive days.[6] Patients must also have at least three or four (if an irritable mood is present) additional symptoms present including grandiosity, sleeping less than usual or not at all, rapid and verbose speech, racing thoughts, difficulty focusing, impulsive behavior, and/or increased goal directed activity at home or at work.[6] The onset of mood symptoms and the change in energy must not be attributable to the use of a substance or a medical comorbidity to meet criterion for BD. A personal history of postpartum depression, postpartum psychosis, or a family history of a first-degree relative with BD increases the risk for illness onset during the perinatal period. Ideally, during a preconception appointment, clinicians will inquire about diagnoses of mental illness, treatment with psychotropic medications, and/or family psychiatric history to guide the discussion of pregnancy management.

The US Preventive Services Task Force recommends depression screening for pregnant and postpartum women, but it does not mention strategies to differentiate unipolar from bipolar depression.[7] In a study by Wisner and colleagues[8] of 10,000 postpartum women in an urban obstetric setting, 22.6% of women with a positive depression screen (score of $\geq$10 on the Edinburgh Postnatal Depression Scale [EPDS]) were diagnosed with BD with a research diagnostic examination. None of the commonly used depression screens, such as the EPDS[9] (a 10-item, self-report scale, translated into 36 languages) and Patient Health Questionnaire (PHQ-9[10]; a 9-item, self-report instrument that has been validated in perinatal clinics) distinguish bipolar from unipolar depression.

The Mood Disorder Questionnaire (MDQ)[11] is a brief self-report screen for BD that takes approximately 5 minutes to complete. The MDQ includes 13 symptoms, the timing of symptoms, and the degree of impairment. A positive screen includes endorsement of seven symptoms occurring at the same time with moderate or serious impairment. Similar to the findings of Wisner and colleagues,[8] Merrill and