



MENSTRUAL PSYCHOSIS: A CASE REPORT OF EPISODIC PSYCHOSIS WITH A TEMPORAL CORRELATION TO THE MENSTRUAL CYCLES

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ABSTRACT

Introduction: Transient psychosis with a temporal correlation to menstrual cycles, known as menstrual psychosis, has been acknowledged in psychiatric literature for over a century, yet remains under-recognized in modern practice.⁽¹⁾ **Case Report:** This case report details a 40-year-old female with a 12-year history of psychotic episodes linked to her menstrual cycle. Each episode is marked by sudden onset of irritability, mood lability, impulsivity, increased talkativeness, delusions of infidelity, and decreased need for sleep, typically starting on days 1-3 of her menstrual cycle and lasting for about 10 days. These symptoms remit spontaneously between episodes, allowing the patient to return to her baseline functioning. Despite having regular menstrual cycles without significant premenstrual symptoms, she presented with acute psychotic features during her menstrual period. Upon presentation, thorough physical and biochemical evaluations, including hormonal assays and MRI, were conducted and found to be within normal limits. **Treatment and Outcome:** The patient was treated with olanzapine, which led to significant symptom improvement over a month. **Conclusion:** This case underscores the importance of recognizing menstrual psychosis as a distinct diagnostic entity due to its unique temporal pattern and treatment implications. Further research is warranted to explore its biological underpinnings and to develop standardized treatment guidelines.

KEYWORDS :

INTRODUCTION

Transient psychosis with a temporal correlation to menstrual cycles has been studied since time immemorial with Kraepelin himself acknowledging a possible association as early as the beginning of the 20th century⁽¹⁾. However, the entity largely seems to have gone under the radar of modern-day psychiatry.

A review of the literature revealed that in most cases the onset of symptoms is centred around menarche and after childbirth with symptoms appearing before or during the onset of menstruation with complete intermenstrual recovery. Here, we present the case of a 40-year-old female who presented to the OPD with a 12-year history of transient psychosis with a temporal correlation to her menstrual periods.

Case Report

A 40-year-old female, with no known comorbidities, belonging to a middle-class family, hailing from a rural background, was brought to the OPD with complaints of an episodic illness for the past 12 years. Information about the episodes was collected from the patient, her husband, and her daughter, and the information was substantiated by videos of the patient that the husband had shot on his phone during the prior episode.

According to the informants, each episode of the illness is characterized by a sudden onset of irritability, impulsivity, lability of mood, increased talkativeness, delusions of infidelity, and a decreased need for sleep. The episodes were also marked by verbal and physical assault which involved the patient hurling household property at her family members.

The symptoms are always acute in onset, commencing on Day 1 – Day 3 of the menstrual cycle every month and lasting for about 10 days. This is followed by spontaneous and complete remission and a return to her usual level of functioning.

The patient reports having regular 30-day menstrual cycles

with normal flow and without significant premenstrual symptoms since she achieved menarche at the age of 14. She is married for the past 20 years with a daughter aged 17. There is no prior history of endocrine dysfunction or mood disturbances in the intermenstrual period or any relevant family history. Premorbidly, the patient was well-adjusted to life.

The patient presented to the OPD one day after the onset of the current episode and on the 3rd day of her menstrual cycle. The patient had previously on 2 separate occasions sought treatment for her condition but did not consume any medication for fear of adverse effects. The nature of the medications prescribed or any previous diagnosis was not available.

A detailed physical examination was done and routine biochemical investigations including Complete Blood Count, Thyroid Function Test, Renal Function Test, Liver Function Test, and Serum Electrolytes were done and were found to be within normal limits. MRI Brain was found to be normal. Her serum FSH, LH, Oestrogen, and Progesterone levels were measured during the follicular phase of the menstrual cycle and were found to be unrevealing. She was followed up regularly in the OPD throughout the current episode as the family members refused in-patient care. During the first interview (Day 3 of menstruation) the patient was irritable with increased tone and volume of speech, elevated mood, and delusion of infidelity (that her husband was being unfaithful to her). Screening for anxiety and depression was done and was found to be negative and her symptoms were rated using the Brief Psychiatric Rating Scale (BPRS). A second MSE was performed and screening for anxiety and depression was done on Day 17 of the cycle which was unremarkable.

Treatment

Based on the symptoms, its duration and temporal correlation to the menstrual cycles we suspect this to be a case of

menstrual psychosis. After due discussion with the patient and the family members, the patient was started on Tab Olanzapine 5mg; the patient was closely followed up over the next week and the dose was up-titrated to 10mg. The patient was closely followed up on an OP basis for the next month.

Treatment Outcome

Her symptoms showed marked improvement during the following month (July 2024) with >50% reduction in her BPRS score. The patient was advised to continue on the same medication with once a week follow-up.

We intend to monitor the patient regularly on an outpatient basis and observe for relapse of symptoms.

CONCLUSION

The authors feel that a diagnosis of “menstrual psychosis” as a distinct nomological entity is of great importance owing to the differences in prognosis when compared to psychosis as in schizophrenia. A review of the literature documents the rates of menstrual psychosis anywhere from 1 in 1000 to 29 in 1000 in psychiatric inpatients further underlining the need for it to exist as a distinct code-able entity⁽²⁾. Further studies are warranted regarding the biological correlates, especially the genetic nature of the condition particularly given the plethora of case reports citing the presence of a similar illness in a first-degree relative^(3,4). Further studies are also needed to assess and compare treatment outcomes and to formulate a guideline for the management of menstrual psychosis.

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