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CASE REPORT: POSTPARTUM PSYCHOSIS

Obstetrics & Gynaecology

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ABSTRACT

Postpartum psychosis (PPP) is a severe psychiatric condition that presents within days to weeks after childbirth. It is a medical emergency requiring prompt recognition and management. We report a case of a 22-year-old primigravida who developed postpartum psychosis following an uneventful vaginal delivery. She presented with agitation, fearfulness, and delusional thoughts concerning her baby. Her symptoms worsened despite initial pharmacological management, necessitating inpatient psychiatric care. This case highlights the importance of early diagnosis and comprehensive treatment of postpartum psychosis to ensure the safety of both mother and infant.

KEYWORDS

INTRODUCTION

Postpartum psychosis is a rare but serious mental disorder affecting 1 to 2 per 1000 deliveries[1,7,4]. The onset is rapid, typically within the first two weeks postpartum. Risk factors include primiparity, sleep deprivation, perinatal loss, and a personal or family history of bipolar disorder. The disorder manifests with symptoms of mania, depression, delusions, hallucinations, and disorganized behavior, increasing the risk of suicide and infanticide. Early intervention with antipsychotic medications, mood stabilizers, and sometimes electroconvulsive therapy (ECT) is critical for patient recovery.

Case Presentation

A 22-year-old homemaker from Kedanur, with no prior psychiatric illness, presented with complaints of lower abdominal pain and backache at 38 weeks and 2 days of gestation. She had conceived spontaneously and had an uneventful antenatal period. She underwent spontaneous vaginal delivery of a healthy female baby weighing 2.5 kg. The intrapartum and immediate postpartum periods were uneventful.

On postpartum day 3 (PND-3), the patient became agitated, had reduced sleep, and expressed suspiciousness that people would take away her baby. Psychiatric evaluation noted restlessness, agitation, and decreased speech tone, with no evident delusions or hallucinations. A provisional diagnosis of acute stress reaction was made, and she was prescribed clonazepam.

By postpartum day 4 (PND-4), her symptoms worsened, with increased agitation, crying spells, and persistent restlessness. The differential diagnosis included acute stress reaction and postpartum psychosis, and she was started on olanzapine 2.5 mg.

On postpartum day 5 (PND-5), her behavior became increasingly erratic. She exhibited persistent fearfulness and attempted to take other babies from their cribs. A diagnosis of postpartum psychosis was confirmed, and she was transferred to the psychiatry ward for further management. Olanzapine was increased to 10 mg daily.

Hospital Course And Management

Despite medication, her symptoms persisted. She was discharged against medical advice but was readmitted after seven days due to extreme agitation. Injectable haloperidol (10 mg IV) and lorazepam (2 mg IV) were initiated, along with oral chlorpromazine (50 mg three times daily) and sodium valproate (500 mg twice daily). Due to hyperammonemia, valproate was later tapered down. No electroconvulsive therapy was required.

After stabilization on oral antipsychotics, the patient was discharged after 15 days with continued psychiatric follow-up. Breastfeeding was discontinued with the consent of her family.

DISCUSSION

1. Pathophysiology and Risk Factors[2,6]

Postpartum psychosis is a rare but severe psychiatric disorder, typically occurring within 2–4 weeks postpartum. While its exact cause remains unclear, hormonal fluctuations (estrogen, progesterone, and oxytocin), sleep deprivation, genetic predisposition, and immune system alterations are believed to contribute.

In this case, the patient was a primigravida with no prior psychiatric history. Primiparity, along with sleep deprivation and stress related to new motherhood, might have been contributing factors.

Studies suggest that the strongest risk factor for postpartum psychosis is a history of bipolar disorder or a family history of mood disorders. However, it can also occur de novo, as seen in this case.

2. Clinical Presentation and Diagnostic Challenges[1,6]

Postpartum psychosis manifests with a spectrum of symptoms, including:

- **Early signs:** Anxiety, insomnia, restlessness
- **Psychotic Symptoms:** Delusions (often related to the baby), hallucinations, paranoia
- **Mood symptoms:** Mania, depression, emotional lability
- **Cognitive Symptoms:** Disorientation, confusion

In this case, the early signs were agitation, fearfulness, and reduced sleep on postpartum day 3. These symptoms progressed to delusions about her baby being taken away and attempting to take other infants. The diagnosis was initially challenging, as acute stress reaction was suspected before postpartum psychosis was confirmed.

The differential diagnosis includes[1,5]:

- Postpartum depression (more gradual onset, lacks psychotic features)
- Acute stress reaction (short-lived, resolves with supportive care)
- Bipolar disorder with postpartum onset

3. Management Strategies And Challenges

Postpartum psychosis is a psychiatric emergency requiring prompt intervention to prevent self-harm, suicide, or infanticide.

Treatment Approaches[1,2,3,4]:

a. Pharmacotherapy:

- Antipsychotics (Olanzapine, Haloperidol) – Mainstay of treatment
- Mood stabilizers (Sodium Valproate, Lithium) – Used in cases with bipolar features

- Benzodiazepines (Lorazepam) – Adjunct for agitation and insomnia
- Avoid antidepressants unless there is a clear depressive episode, as they may induce mania

b. Electroconvulsive Therapy (ECT):
- Considered in severe cases (suicidality, catatonia, treatment resistance)
- This patient responded to oral and injectable antipsychotics, so ECT was not required.

c. Breastfeeding Considerations:
- Many psychotropic medications are excreted in breast milk. In this case, breastfeeding was discontinued to ensure medication safety.

d. Inpatient vs. Outpatient Management:
- Due to aggression, delusions, and behavioral disturbances, the patient required hospitalization.
- She was initially discharged against medical advice (DAMA) but required readmission due to symptom worsening.

4. Prognosis And Follow-up

Postpartum psychosis has a high recurrence risk (20–25%) in future pregnancies. In severe cases, up to 4% of mothers commit infanticide, and 5% die by suicide if untreated.

Long-term Considerations:
- Close psychiatric follow-up
- Risk counseling for future pregnancies
- Discussion of prophylactic treatment in subsequent pregnancies (e.g., Lithium postpartum)

This case highlights the importance of early recognition and the need for long-term psychiatric care to prevent relapse

CONCLUSION

This case underscores the need for heightened awareness and early intervention in postpartum psychosis. Prompt psychiatric evaluation and treatment are vital for preventing maternal and neonatal complications. Long-term follow-up is essential to monitor recurrence and ensure maternal well-being.

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