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Case report

Postpartum Bipolar Disorder II: A Case Report

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SUMMARY

Introduction. The postpartum period is considered a period of increased risk of developing bipolar affective disorder (BDII) type II. According to the available data, postpartum BDII is a highly neglected area of observation, with negative consequences for mothers, offspring, and the family as a whole.
Case report. The paper describes the case of a patient with symptoms of a depressive episode of atypical features following childbirth. The patient had one mild postpartum depression episode and multiple previously detected hypomania-like episodes. Postpartum depression and bipolar affective disorder were detected in the family history. Escitalopram 20 mg in combination with Lamotrigine 200 mg was prescribed. There were no detected side effects to the prescribed therapeutic dose, and there have been no relapses so far.
Conclusion. During pregnancy and postpartum, women should be screened for BDII. Based on the experience from the presented case, the combination of escitalopram and lamotrigine has shown promising results and complies with all recommended BDII treatment guidelines.

Keywords: **postpartum, bipolar affective disorder type II, escitalopram, lamotrigine**

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BIPOLAR SPECTRUM DISORDER

According to the generally accepted criteria of the Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM-5), the term bipolar spectrum disorder (BSD) refers to a group of affective disorders, including bipolar disorder I (BDI), bipolar disorder II (BDII), and bipolar disorder not otherwise specified (BDNOS), characterized by chronic remitting and relapsing episodes of depression, hypomania, and mania (1). In order to be diagnosed, both BDI and BDII must have a history of at least one or more episodes of elevated mood not caused by some medical condition or substance use. Therefore, BDI is characterized by recurrent episodes of mania and depression, BDII by recurrent episodes of depression and hypomania, and BDNOS is characterized by manic and depressive symptoms in which clinical presentation does not meet the DSM-5 criteria (1).

BSD is a severe mental illness, with a total prevalence of 11% and a twelve-month prevalence of 1.8 % (1). A lifetime prevalence for BDI is 1.0%, 1.1% for BDII, and 2.4% for BDNOS (1, 2). The observed pronounced differences in prevalence raise the question of a possible lack of uniformity in the detection method, but also obvious ambiguities regarding the generally accepted diagnostic criteria. In terms of frequency by sex, BDII is more common in women (2).

As for the BSD symptoms, the most common include experiences of mood swings with associated impulsivity, risk-taking behaviors, and social conflicts (3). All the above symptoms fall within the BDI diagnostic criteria, so according to literature beyond BDI, experts believe that BDII seems to be often underdiagnosed or misdiagnosed as a major depressive disorder (MDR) (3). This is inevitably related to the fact that depressive episodes in BSD are more frequent and last longer than manic or hypomanic episodes (3). BDII women, compared with MDR women, are at higher risk for postpartum recurrence; BDII women are up to 50% more likely than those with MDR to develop postpartum depression and more likely to be hospitalized for the first time in early postpartum (1, 3).

BIPOLARITY IN THE POSTPARTUM PERIOD - SCREENING AND DETECTION

The term "postpartum" refers to a period that starts at the fourth stage of labor and lasts up to 6 weeks, and as such, it is classified in the DSM-5 nomenclature (1). The International Classification of Diseases (ICD11) accepts "postpartum" as a spectrum of affective mental disorders in the form of depressive episodes with or without psychotic symptomatology (4). The first couple of months following childbirth are particularly vulnerable to new-onset mental disorders, particularly BDII (1,3). In the acute stage, bipolar and unipolar postpartum depression are sometimes clinically indistinguishable.

The recommended mental health screening tools for women in the peripartum period in Serbia are based on the recommendations of the Canadian Network for Mood and Anxiety Treatments and the International Society for Bipolar Disorders Guidelines (2009). They recommend the application of the Edinburgh Postnatal Depression Scale (EPDS) (a 10-item, self-report scale, standardized and validated in Serbia) and Patient Health Questionnaire (PHQ-910; a 9-item, also self-report validated in Serbia), although these do not include strategies to differentiate unipolar from bipolar depression (5).

The use of a self-applied Mood Disorder Questionnaire (MDQ) and Hypomania Checklist-32 (HCL-32) is also recommended in clinical studies for BSD. MDQ is a brief self-report screen for BD; it includes 13 questions about manic symptoms, their timing, and the degree of impairment and takes approximately 5 minutes to complete (6). HCL-32 is a sensitive, useful, and valid tool in screening for BDII in patients with a previous history of hypomanic episodes (7).

POSTPARTUM BIPOLAR DEPRESSION

Studies have shown that up to 20% of BSD women experience postpartum depression, and more than 50% of women with postpartum depression have a lifetime diagnosis of BSD (1, 3). The generally accepted guideline for suspecting bipolar depression includes a family history of BSD, atypical depressive symptoms, mood instability induced by

antidepressants, and sustained improvement in mood by combining antidepressants with mood stabilizers or atypical neuroleptics (3).

Distinguishing between bipolar and unipolar depression is important in psychiatric evaluation. Valuable clues include subsyndromal elevated mood during pregnancy and after delivery, specifically in women with past mood disorders, atypical depressive symptoms, elevated mood and behavior in response to an antidepressant, mixed depression, behavioral agitation, disorganized thought and behavior, psychosis in the context of postpartum depression, and previously mentioned, family history of BSD (3).

POSTPARTUM HYPOMANIA

Postpartum hypomania is a highly neglected area of observation that occurs commonly in the early postpartum period. Various studies report rates of up to 20% (1, 3). It refers to an abnormal emotional response to childbirth and includes symptoms of thrill, increased goal-directed activity, flight of thoughts, reduced need for sleep, distractibility, irritability, and excessive talking (3,8). Postpartum hypomania, unfortunately, is not recognized by DSM-5 classification as a postpartum-onset specifier (1).

The symptoms like elated or irritable moods are often reminiscent of baby blues. Still, the onset of postpartum hypomania is on postpartum day 1, immediately following delivery, rather than day 3 or 4, as in the baby blues (8). Symptoms of baby blues like dysphoria, tearfulness, labile mood, insomnia, irritability, and anxiety occur in up to 90% of women in the few days after delivery and usually remit by the second week postpartum (8). Postpartum hypomania can cause several significant functional impairments in professional and social functioning and can be an episode of subsequent postpartum bipolar depression (3).

CONSEQUENCES OF UNDERDIAGNOSIS OR MISDIAGNOSIS IN BSD

Patients with underdiagnosed or misdiagnosed BSD face delay of appropriate therapy. In the case of misdiagnosing BSD as MDR, the use of antidepressants carries the risk of precipitating an episode of mania, rapid cycling, or a mixed episode and thus poses a greater risk for suicide and hospitalization (3, 9).

The consequences of inadequate diagnosis and treatment of mood disorders during peripartum are harmful to the mother, her offspring, and the whole family. Studies found cognitive and developmental delay, as well as behavioral problems later on in children, disruption of marital relations, impairment in social functioning, poor quality of life, and decreased self-esteem in women (3, 9, 10).

TREATMENT AND PREVENTION OPTIONS FOR BIPOLARITY IN POSTPARTUM

During pregnancy and postpartum, the goals must be to minimize infant exposure while optimizing maternal mental health. Inadequately treated BSD during pregnancy is associated with poor birth outcomes, preterm birth and being small for gestational age, low birth weight, intrauterine growth retardation and distress, and unfavorable neurodevelopmental outcomes. In the case of women with effective therapeutic adherence pre-pregnancy, the particular therapy should be the first choice in postpartum.

In case of detected postpartum depressive symptoms, the guidelines recommend the use of cognitive-behavioral, interpersonal, and/or supportive psychotherapy, and if required by the intensity and length of symptoms and consequent disability, the use of pharmacotherapy (3, 11). Antidepressants are commonly used in the management of depression, with close monitoring for cycle acceleration or mood switching to hypomania/mania if there is a reason to suspect bipolar depression. Lithium, lamotrigine, carbamazepine, and second-generation antipsychotics (aripiprazole, asenapine, lurasidone, olanzapine, immediate-release and extended-release quetiapine, risperidone, and ziprasidone) are indicated by the Food and Drug Administration for treating BSD (3).

For acute and prophylactic treatment of bipolar depression, treatment options include lithium, lamotrigine, lithium plus an antidepressant, or the combination of an antidepressant plus second-generation antipsychotics (3, 11). All listed pharmacotherapeutic options are transmitted through breast milk, so it is important to encourage women to consider feeding formula. For those who opt to con-

tinue breastfeeding, some studies consider carbamazepine and quetiapine to be safe when breastfeeding (3, 11, 12). Lithium and carbamazepine are recommended to prevent manic and depressive episodes, lamotrigine to prevent depressive episodes, and second-generation antipsychotics for acute mania (3). Valproic acid is an effective mood stabilizer but should be avoided during pregnancy because of the risk of birth defects and neurodevelopmental delays (3, 11, 12).

BSD women who discontinue their treatment during pregnancy have a high risk of postpartum recurrence in the first trimester (3). Therefore, the recommendation is to apply assessment with the EPDS, PHQ-9, MDQ, and HCL-32 at each office visit during pregnancy and after delivery.

HISTORY AND OBSERVATIONAL ASSESSMENT

Mrs. P. is a 35-year-old married mother of two, a 6-year-old girl and a 5-month-old boy. She first sought help three weeks after giving birth to the second child and after a few months of combining supportive psychotherapy and taking antidepressants on her own. She stated that she "stopped breastfeeding both children on her initiative due to the nature of her job." She had also been uncompliant and self-treated with monotherapy antidepressants or a combination of antidepressant and benzodiazepine, mainly sertraline and escitalopram, in combination with diazepam, the therapy taken by her mother. She described two isolated periods of depressive postpartum changes with a clear pathological impact on the activity and general functionality after both births, of longer duration and pronounced intensity after the second and in a milder form after the first, with multiple previously detected hypomania-like episodes.

She reported to a psychiatrist because of the "period when she is depressed" and the "short, just a couple of hours or maybe a day" period when she had a "burst of energy" and "feels important," with increased motivation and impulsivity, without a drop in functionality. Dominant complaints included lethargy, decreased functionality, passivity, a strong sense of guilt, low self-esteem, inability to initiate activities, poor organization of daily responsibilities, loss of satisfaction, hypersomnia, psychomotor retardation, and anxiety.

She tearfully, openly, and cooperatively approached the topic in a conversation, demonstrating slow and poor verbalizations with good introspective potential, adequate understanding of speech content, and the ability to perceive inner experiences. Nonverbal and facial expressions were adequate. She was aware of her changes in behavior and experience, denied current suicidality, but confirmed the existence of suicidal thoughts (without intentions and plans with a clear identification of protective factors) in the past period.

In the family functioning domain, the primary family was identified as one of the etiological factors of unstable functioning. In the primary family, there had been a chronicity of unstable structure, disturbed borders, contradictory messages, and inappropriate atmosphere for adequate development and formation of personality. She was the oldest of three children, with possible elements of sibling-focused parentification. Unstable, conflict-ridden relationships between parents had led to constant patterns of trivialization between parents and children, pathological symbioses that further destabilized the development of the subject's personality and adversely affected the normal patterns of acquisition, learning, and appropriate ways of controlling and expressing emotions.

A positive family history of postpartum depression in the mother and bipolar disorder in the father was reported. No one in her family had been admitted for inpatient psychiatric care or psychiatric admission, with a tendency to self-medicate. There is also a family history, however, of substance use disorder (mother, sisters, maternal grandmother, both paternal grandparents) and alcohol (father).

In the social relations domain, no important pathological determinants were detected, and the appropriate circle of friends and the ability to develop social relations were recorded. Subject to current restrictions in the field of social participation, she reported social withdrawal during mood disorders, but also the impossibility of complete adaptation and integration in the new environment.

Psychological exploration showed excellent intellectual capacity, currently reduced efficiency due to the registered depressive episode, recorded structural defects, and a tendency to experience intense moods with recurrent periods of depression and apathy, which are often interspersed with attacks of anger, anxiety or euphoria. The dominant determinant of this personality profile is non-

uniform affect, which was observed in unstable and labile mood, but also difficulty maintaining a clear sense of identity and the manifestation of cognitive-affective ambivalence. This profile indicates a clear period of elation, increased self-esteem, excessive activity, non-selective enthusiasm, excessive planning of unrealistic goals, impulsivity, and irritability, but also a period of behavioral apathy, low self-esteem, preoccupation with guilt, and loss of interest.

Mrs. P reported a history of using marijuana two to three times a year 15 years before "to take the edge off and help me to sleep." She denied drinking alcohol or using drugs at the moment, having a history of psychotic symptoms, suicide attempts, or psychiatric inpatient admission. Deviations were not observed in blood count, biochemical parameters, sex hormone, and thyroid hormone analyses. In her medical history, she denied other diseases of importance. She was allergic to penicillin (urticaria).

Of the self-assessment scales, EPDS, MDQ, HCL-32, Beck Depression Scale (BDS), and Beck Anxiety Inventory (BAI) were applied. Applying appropriate scales of assessment provided insight into the altering character of mood and activity, which indicated the existence of BDII, currently in a moderate depressive episode with moderate anxiety and the dominance of atypical depressive symptoms.

MANAGEMENT AND OUTCOME

When considering pharmacotherapeutic treatment options, we took into account the fact that this was a young woman who took care of her weight, who was not breastfeeding her second child, and had had positive experiences with the use of antidepressants, selective serotonin reuptake inhibitors (SSRI), with atypical depressive symptoms and dominant hypersomnia, and was not planning further family expansion.

We have already mentioned that antidepressant use as monotherapy for bipolar depression is controversial, and if used, it should only be in combination with a mood stabilizer or atypical antipsychotic (3, 11, 12). Lamotrigine has a mood-stabilizing effect and indication for bipolar depression treatment. It has a low side effect profile but should be administered with caution as it may cause life-threatening skin conditions (3, 11, 12). However, as lamotrigine has not shown robust efficacy in treating bipolar depression, and low mood is among the primary complaints in our patient, adjunctive SSRI treatment is required (3, 11, 12).

We started with the gradual inclusion of escitalopram to 20 mg a day to improve the depressive symptomatology. We added an initiated daily dose of 25 mg lamotrigine, with incremental increases of 25 mg daily every two weeks to the therapeutic 200 mg dose, to stabilize and prevent the switch into a hypomanic episode. The patient satisfactorily accepted the treatment plan and adhered to the prescribed regimen. There have been no side or unwanted events. She has not had a recurrence of a manic/hypomanic/mixed episode in the last six months. She is now seen in follow-ups every three months.

CONCLUSION

Postpartum period is an exceptionally vulnerable period for the onset or exacerbation of BSD, particularly BDII. Bipolar depression is often diagnosed as MDD. By recognizing hypomania early, we may be able to better treat and possibly prevent postpartum BDII and further BSD. Screening instruments are needed to detect, treat, and prevent postpartum BDII. Given the prevalence of BSD and the potentially severe consequences of its misdiagnosis, women should be screened for BSD, particularly BDII, during pregnancy and postpartum. Early identification, formal risk assessment, and close follow-up with appropriate treatment during that period can improve women's mental health. Treatment options for postpartum BDII have largely been based on data on BSD management outside postpartum, therefore, definitive recommendations cannot be made. Based on the experience from the presented case, the combination of SSRI, escitalopram, and mood stabilizer, lamotrigine, has given promising results and is in line with all the recommended BSD treatment guidelines. BDII deserves greater attention, awareness raising, and further research regarding risk factors, screening, and therapy options.

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Postporođajni bipolarni afektivni poremećaj tip II: prikaz slučaja

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SAŽETAK

Uvod. Period nakon porođaja smatra se periodom u kojem je rizik od nastanka bipolarnog afektivnog poremećaja tipa II (engl. *bipolar affective disorder type II* – BDII) povećan. Postporođajni BDII je, prema nama dostupnim podacima, izuzetno zanemarena oblast posmatranja, iako negativno utiče na majku, potomstvo i porodicu kao celinu.
Prikaz slučaja. Opisuje se slučaj pacijentkinje sa simptomima depresivne epizode atipičnih karakteristika nakon porođaja. Pacijentkinja je do sada imala jednu blagu postporođajnu depresivnu epizodu i više prethodno detektovanih epizoda sličnih hipomaniji. U porodičnoj istoriji otkriveni su postporođajna depresija i bipolarni afektivni poremećaj. Propisan je escitalopram od 20 mg na dan u kombinaciji sa lamotriginom od 200 mg na dan. Nisu zabeleženi ni ozbiljni ni neželjeni efekti propisane terapijske doze; takođe, dosad nije bilo recidiva.
Zaključak. U toku trudnoće i nakon porođaja žene treba da budu podvrgnute skriningu na BDII. Predstavljeni slučaj je pokazao da je kombinacija escitaloprama i lamotrigina, usklađena sa svim preporučenim smernicama za lečenje BDII, dala dobre rezultate.

***Ključne reči: post partum*, bipolarni afektivni poremećaj tip II, escitalopram, lamotrigin**