Bipolar Disorder in the Perinatal Period

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Disclosures

- No conflicts of interest

What is bipolar disorder?

- Bipolar disorder is characterised by recurrent episodes of depression and mania or hypomania
- Often misdiagnosed or over-diagnosed
- Age of onset 12 to 30 years, with a peak in reproductive years
- Chronic disease, relapsing and remitting
- Elevated suicide risk
- Increased risk of relapse with discontinuation of maintenance medication

(Nierenberg et al., 2023)

Mania

- Distinct period of time with below symptoms:
- Symptoms:
  - Elevated (3 or more below symptoms) or irritable (4 or more) mood
  - Increased self esteem or grandiosity
  - Decreased need for sleep
  - Rapid speech
  - Racing thoughts or flight of ideas
  - Distractible
  - Increased goal-directed activity (such as cleaning, cooking)
  - Increased dangerous behavior (spending lots of money, using substances, high risk sexual behaviors)

Mania: Screening

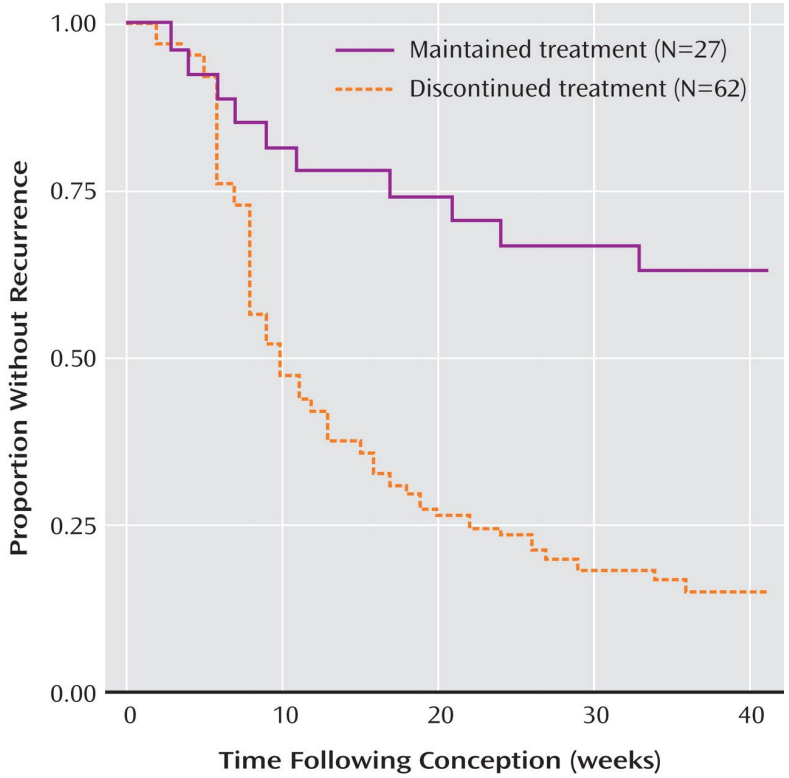
- Can utilize Mood Disorders Questionnaire (MDQ)
- Different from baseline
- Sustained over time
- Noticeable by others
- Decreased need for sleep – not feeling tired the next day
- In the absence of substances

Role of OB and Primary Care Provider

- Screen for mania prior to initiation of SSRI/SNRI
- If bipolar disorder is suspected or history of bipolar disorder -> Refer to psychiatry
- Discuss risks of untreated bipolar disorder vs risks of medications

Risk of relapse

- Very high risk of recurrence or relapse in pregnancy
- If treatment is stopped – 80% have recurrence
- Women who stop mood stabilizer spend 40% of pregnancy in mood episode vs 8.8% in women who continued treatment



(Viguera et al., 2000); (Viguera et al., 2007)

Risks during pregnancy

- Risks to maternal health
  - Poor prenatal care, increased substance use, risk of suicide, risk of postpartum psychosis
- Obstetric risks
  - C-section, IUGR, preeclampsia, placental abnormalities
- Risks to neonate
  - Low birth weight, adverse neurodevelopmental outcomes, small for gestational age, preterm birth

(Hutner et al., 2021)

General principles

- Use lowest **effective** dose
- Minimize polypharmacy as able
- Often the best medication is the one that patient tolerates and is effective at maintaining stable mood
- May need to increase dose as pregnancy progresses due to physiologic changes in pregnancy

(Hutner et al., 2021)

Lithium during pregnancy

- Increased risk of cardiac and overall congenital abnormalities – though absolute risk is lower than initially reported
  - Requires fetal echo at 20 weeks
- Other risks: preterm birth, higher birth weight, diabetes insipidus, hypothyroidism and neuromuscular complications
- Lithium is metabolized faster during pregnancy
  - Need to check lithium level monthly, then weekly in the last 4 weeks of pregnancy
  - Hold lithium during delivery
  - Restart pre-pregnancy dose after delivery
  - Re-check lithium level in the immediate postpartum and then 5 days postpartum

(Patorno et al., 2016); (Munk-Olsen et al., 2018); (Fornaro et al., 2019)

Lithium during lactation

- Can consider breastfeeding on lithium with close collaboration with pediatrician
- Requires vigilance from parents to monitor for lithium toxicity in the infant
- RID is variable and is readily transmitted through the breastmilk, limited adverse events
  - Elevations of thyroid-stimulating hormone, blood urea nitrogen and creatinine have been reported and were transient
  - No adverse developmental effects though data is limited

(Newmark et al., 2023)

Mood stabilizers during pregnancy and lactation

- Lamotrigine
  - Not associated with congenital malformations
  - Metabolized more rapidly due to increased estrogen levels effect on glucuronidation
  - Obtain pre-pregnancy level and monitor for mood changes
  - Excreted in breastmilk at high levels (RID 6-18%), though limited adverse events in infants
- Valproic acid
  - Associated with NTD, cardiac defects and neurodevelopmental adverse outcomes
  - Contraindicated in pregnancy
  - Discuss birth control with your reproductive aged patients on valproic acid!
  - RID < 5% so likely compatible with breastfeeding

(Pariente et al., 2017); (Nordmo et al., 2009); (Jentink et al., 2009)

Antipsychotics during pregnancy

- No increased risk of neurodevelopmental disorders
- Likely no increased risk for congenital malformations
- 2011 FDA label based upon small studies warning of extrapyramidal symptoms (EPS) and withdrawal syndrome (tremor, tone abnormality, feeding problems, somnolence, irritability)
  - Other confounding factors- mothers may be using drugs, may have severe illness
  - Usually do not require interventions

(Huybrechts et al 2016); (Wang et al., 2021); (Straub et al., 2022)

Antipsychotics during lactation

- Considered compatible with breastfeeding, most have RID < 10%
- Aripiprazole – partial agonist so may decrease prolactin and reduce supply
- Clozapine – contraindicated in breastfeeding due to risk of agranulocytosis

Bipolar disorder during pregnancy

- Plan for delivery
  - Collaborate with psychiatry and pediatrician
  - Discuss a plan for protecting sleep in the postpartum
    - Sleep deprivation can exacerbate mania/hypomania
    - Prescribe sleep - ensure support plan is in place to protect 5-6 hours of uninterrupted sleep
  - Discuss breastfeeding goals and how to protect sleep in this context
  - Identify support plan

Take away points

- Screen for and identify bipolar disorder
- Discuss risk of untreated illness vs risk of medications during pregnancy and breastfeeding in women with bipolar disorder
- Treatment of bipolar disorder during pregnancy and postpartum is extremely important
- Protect sleep as able in postpartum

Resources

- Massachusetts General Hospital (womensmentalhealth.org)
- Postpartum Support International
- Mother to baby (www.mothertobaby.org)
- National Curriculum for Reproductive Psychiatry
- Lactmed
- Reprotox
- InfantRisk

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