ISSN: 2475-5435

Case Report

International Journal of Psychiatry

Use of Psychotropics in Bipolar Disorder with Pregnancy: A Case Report

Shivendra Shekhar[1]* and Sandip Sheth[2]

[1]*Resident Physician, Department of Psychiatry, Jamaica Hospital Medical Center, Jamaica, New York, USA*

[2]*Inpatient Unit Chief, Attending Psychiatrist, Department of Psychiatry, Jamaica Hospital Medical Center, Jamaica, New York 11418, USA*

***Corresponding author**

Shivendra Shekhar, Resident Physician, Department of Psychiatry, Jamaica Hospital Medical Center, Jamaica, New York, USA

Submitted: 15 Nov 2020; **Accepted:** 02 Dec 2020; **Published:** 10 Dec 2020

Abstract

There is no single consensus on the use of antipsychotics, mood stabilizers, and benzodiazepines in pregnancy. It is well known that the first trimester of pregnancy is the most critical. We are presenting a case of a pregnant woman in the first trimester who presented to our facility in a manic state with a psychiatric history of Bipolar disorder. She was treated with Haloperidol, Clonazepam, and Lurasidone with good effect. This case emphasizes the importance of treating a psychiatric disorder in pregnancy if the benefits of treatment outweigh the risks posed to the mother and the fetus.

Keywords: Bipolar Disorder, Pregnancy, Antipsychotics, Benzodiazepines, Mood Stabilizers

Introduction

The use of psychotropic in a pregnant woman is a complex topic. There is no single consensus on the use of antipsychotics, mood stabilizers, and benzodiazepines in pregnancy. Various guidelines are available on the safe and effective use of these medications in pregnancy. The use should be tailored to the individual patient profile. The first trimester of pregnancy is the most critical. The period of most significant risk for the teratogenic effects of medications is between the third and eighth week of gestation. Our case emphasizes the fact that it is recommended to use medications that will treat a psychiatric disorder in pregnancy if the benefits of treatment outweigh the risks posed to the patient and her fetus.

Case

AB was a 30-year-old, single, African-American female with a psychiatric history of Bipolar Disorder, currently pregnant, Supportive Housing resident, unemployed who was brought in by the EMS to the Jamaica Hospital medical ER from a hotel lobby because of erratic behavior. A psychiatry consult was requested for psychiatric evaluation [1-7]. The patient was alert, evasive, had elated mood, pressured speech, with a lot of energy, denied the need to have a sleep, was grandiose, paranoid, laughing inappropriately, with impaired insight, judgment, and questionable impulse control. A diagnosis of Bipolar I disorders, current episode manic, with psychotic features, severe was made, and the patient was subsequently transferred to the CPEP after medical stabilization. It was noted that the patient was recently treated at another hospital with Haloperidol 5 mg PO BID and Clonazepam 0.5 mg PO TID. The ultrasound report at that time showed that the patient was five weeks and five days pregnant. Quantitative HCG at our facility showed that patient was now 5-6 weeks pregnant. The ultrasound was seven weeks and one-day single intrauterine pregnancy with a fetal heart rate of 122 bpm. All the other routine labs were done and regularly followed-up. It is worth mentioning that Obstetrics was periodically consulted for the ultrasound and the safe use of psychotropic in pregnancy and was on board throughout the patient hospital stay. The patient was started on Haloperidol 1 mg PO BID, Folic acid 2 mg PO daily, Prenatal Vitamin one tablet daily. The patient was eventually transferred to the psychiatric inpatient floor for further management.

Throughout the inpatient stay, the patient got STAT IM Haloperidol 2 mg and Diphenhydramine 25 mg on few occasions due to acute agitation, aggressiveness, and threatening behavior, which posed an imminent danger to herself, the fetus, and others. Diphenhydramine 25 mg PO daily was added, which was later changed to 50 mg PO HS to better control sleep and anxiety. Haloperidol was later increased to 2 mg PO BID. The patient remained unpredictable with poor impulse control, preoccupied with discharge. Haloperidol was increased to 10 mg PO BID and then to 10 mg PO TID, and Lurasidone 40 mg PO BID was added to the regimen. The patient remained unpredictable, and so the team decided to add Clonazepam 1 mg PO BID.

The patient gradually started showing improvement in her mood and impulse control. Haloperidol was reduced to 10 mg PO BID. The patient was occasionally having verbal outbursts, was not verbally redirectable, and given STAT PO Haloperidol 2 mg and PO Diphenhydramine 25 mg with good effect. The patient continued improving and eventually had a stable mood, good impulse control, and was sleeping adequately. Clonazepam was

reduced to 0.5 mg PO BID. The patient was compliant with all of her PO medications. The patient was offered and given IM Haloperidol Decanoate 150 mg for better medication compliance. The patient gained fair insight into her problem and was no more unpredictable, showed good impulse control, attended group activities, and attained ADL. The patient was subsequently discharged to her Supportive Housing with appropriate follow-up appointments made.

Discussion

Antipsychotic therapy should be considered mandatory in pregnant patients with psychotic features. When a planned or unplanned pregnancy occurs during antipsychotic treatment, it is recommended to privilege the choice to continue the previous therapy if known, as pregnancy is not the best period to experiment with new drugs' effectiveness. It is crucial to provide strict gynecological surveillance (regular clinical follow-up, biweekly ultrasound monitoring to ensure fetal well-being) during therapy with antipsychotics. It is also important to provide strict endocrinological surveillance (HbA1C, glycemia, cholesterol, triglycerides serum levels, bodyweight gain) during treatment with antipsychotics. More congenital malformations were noted with atypical antipsychotics in all the trimesters as compared to typical antipsychotics. Haloperidol does not represent a major teratogenic effect. Since a possible association between Haloperidol exposure and limb defects can't be ruled out, a level II ultrasound with an emphasis on the limbs should be considered in pregnancies with first-trimester exposure. In the case of the occurrence of psychotic symptoms in drug-naive pregnant patients, privilege the drug showing the highest number of reassuring reports and the lowest reported number of fetal anomalies (e.g., Chlorpromazine).

For bipolar patients with unplanned pregnancies, determining the gestational age will inform the decision to use pharmacotherapy with mood stabilizers. The period of most significant risk for the teratogenic effects of medications is between the third and eighth week of gestation. For bipolar patients who plan to or do become pregnant, maintenance pharmacotherapy rather than no treatment is recommended. However, it is reasonable for patients with a mild lifetime course of illness to try to avoid pharmacotherapy during pregnancy. Preference is given in the order: Lamotrigine > Quetiapine > Risperidone > Lithium > Valproate and Carbamazepine. However, it is a weak recommendation, and other alternatives may be equally reasonable based on an individual patient profile. If the patient has not completed the first trimester of pregnancy, typical or atypical antipsychotics should be tried for mood stabilization before considering Lithium, Valproate, or Carbamazepine. If the women have completed the first trimester, then also typical or atypical antipsychotics should be preferred over Lithium (because of risk associated during labor), Valproate (long-term cognitive side effects), and Carbamazepine. If one of these three agents has to be used during the second or third trimester, Lithium should be preferred over Carbamazepine and Valproate. Regarding Lurasidone, the FDA has classified it as a Pregnancy Category B agent, although no adequate or well-controlled studies of the drug's use have been conducted during pregnancy. The manufacturer recommends that Lurasidone be used during pregnancy only if the maternal benefit justifies the fetal risk. The FDA indicates it for Schizophrenia, Bipolar I depression, and as adjunctive therapy with Lithium or Valproate.

For benzodiazepine, the data is controversial. Some studies suggest that benzodiazepine exposure during pregnancy does not appear to be associated with congenital malformations, including first-trimester exposure. Others suggest a small risk of cleft lip and palate. Benzodiazepines also do not appear to be associated with low birth weight. However, antenatal exposure to benzodiazepines appears to be associated with spontaneous abortion and preterm birth. Chronic administration of benzodiazepines proximal to delivery can cause neonatal toxicity and withdrawal. Like any other medication, use in pregnancy is recommended if the benefits outweigh the risks.

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