Perinatal Schizophrenia

Ramanpreet Toor, MD

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Epidemiology: Peak onset childbearing age (26-32 years), almost 50% with diagnosis get pregnant. Risk of relapse in pregnancy if untreated. Most pregnancies are unplanned, poor prenatal care, high risk of rapid repeat pregnancy

Diagnostic criteria:
2 or more of following
- Delusions
- Hallucinations
- Disorganized thinking
- Grossly disorganized or catatonic behavior
- Negative symptoms

Markedly low level of functioning in one or more major areas compared to before symptoms
Symptoms continue for 6 months or more

Pregnancy complications: more frequent smoking, alcohol and substance addictions. More Gestational hypertension, 2-fold increased risk of GDM, Genito-urinary infection, IUGR, threatened pre-term labor

Delivery Complications: Stillbirths or medical abortions, Unexplained fetal/infant death, fetal deaths from severe neurological malformation

Neonatal/neurodevelopment complications: Low birth weight, SGA, Preterm birth, development delay, higher risk of intellectual disability, Congenital malformations (6 studies), behavioral problems

Risk assessment:
Worsening symptoms can lead to denial of pregnancy, poor antenatal care. Thoughts about harming baby related to command hallucinations or delusions possible. Important to monitor psychotic symptoms and evaluate safety throughout pregnancy and postpartum
Columbia Suicide Severity Rating Scale (C-SSRS)
Evaluate for thoughts about harming baby: Ask about hallucinations and specifically about command hallucinations (for example voices can tell patients to harm baby). Ask questions assessing specific content of the thought, and emotional and behavioral responses to thoughts.
Decisional capacity assessment:
Assess capacity to make decisions for any procedures during pregnancy and postpartum. Also assess capacity to parent if psychotic symptoms present

Assessment of level of functioning, quality of parenting ability and need for social work or child protective services involvement

Treatment:
Individual risk-benefit analysis. In schizophrenia benefits of psychopharmacology mostly outweigh the risk. Increased risk of exacerbation of symptoms for 1 year postpartum so close monitoring recommended.
Psychopharmacology: Antipsychotics
-High potency typical antipsychotics preferred (e.g. Haloperidol)
- Atypical antipsychotics: start quetiapine or olanzapine if not on medication
- Long-Acting Injections: Very limited data. Consider continuing if patient stable prior to pregnancy. Levels more stable in pregnancy.
- **Psychotherapy:** More supportive approach and CBT can also help in psychosis

References

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Antipsychotic Medication Table

Typical Antipsychotic (Brand Names)	**Therapeutic dose range for psychosis**	**Pregnancy**	**Breastfeeding**
Haloperidol (Haldol)	4-20 mg/day Doses can be higher in more severe symptoms	Higher risk for extrapyramidal signs	<10 mg daily produce low levels and no adverse effects Negative effects when combined with other antipsychotics Monitor drowsiness and developmental milestones
Atypical Antipsychotics (Brand Names)			
Risperidone (Risperdal)	3-6 mg	Effective for psychosis, acute agitation Possible increase risk of cardiac malformation	Doses up to 6 mg produced low levels in milk Limited data
Quetiapine (Seroquel)	ER:400-800 mg IR: 300-750 mg	Lowest placental transfer Risk of metabolic syndrome	Doses up to 400 mg produced low levels in milk No adverse effects noted
Aripiprazole (Abilify)	10-30 mg	Lower risk of metabolic syndrome Risk of akathisia Possible low risk of neurodevelopment disorder (Straub et al 2022)	Doses up to 15 mg produced low levels in milk It can LOWER SERUM PROLACTIN
Olanzapine (Zyprexa)	10-20 mg	Effective for mood stabilization, psychosis Sedating Metabolic syndrome! Highest placental transfer: 72.1%	Doses up to 20 mg showed low levels in milk Recommended first line in breastfeeding
Ziprasidone (Geodon)	40-80 mg	Lower risk of metabolic syndrome Limited data	Other antipsychotics preferred given very little data
Clozapine (Clozaril)	300-450 mg/day	Effective for treatment resistant schizophrenia Risk of agranulocytosis for which close monitoring is needed	Limited data Sedation and risk of agranulocytosis

No human data for newer antipsychotics including: Asenapine, Cariprazine, Lurasidone, Brexiprazole.