Perinatal Bipolar Disorder

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Key facts: 60–70% of women with bipolar disorder (BD) experience a mood episode during pregnancy/ postpartum. Screen for BD in all individuals with perinatal depression, especially if you are considering starting an antidepressant. For those who screen positive, prioritize safety assessment and management of sleep disturbance while awaiting psychiatric evaluation. If needing to start treatment while awaiting evaluation, quetiapine (effective in both unipolar and bipolar depression) can be started.

Diagnostic criteria for bipolar disorder:
Bipolar I disorder: at least one lifetime manic or mixed episode; Bipolar II disorder: at least one lifetime hypomanic episode and at least one episode of major depression.
Symptoms of mania (lasts 1 week or requires hospitalization): D = Distractibility, I = Irresponsibility, G = Grandiosity, F = Flight of ideas, A = Activity increase, S = Sleep deficit, T = Talkativeness. Symptoms of hypomania – same as mania, for 4 days / without impairment

Effects of untreated bipolar disorder:
On mother: Risk of relapse, suicide, comorbidities
Postpartum hemorrhage, placental abnormalities

On baby: preterm birth, low birth weight, microcephaly, neonatal hypoglycemia

Relapse of BD during pregnancy increases risk of postpartum episodes 3 to 7 fold

Risk assessment:
Also see Assessing Safety (Page 28)
Suicide risk: C-SSRS or NIMH ASQ
Risk of infant harm – First determine if thought of harming infant is an intrusive thought (unwanted negative thoughts that are frequent and difficult to dismiss) or infanticidal ideation (due to a psychotic symptom). Ask questions assessing specific content of the thought, and emotional and behavioral responses to thoughts.

Example question:
"Many postpartum women – up to 70% - have intrusive thoughts about something bad happening to their baby. These thoughts can feel terrible. Have you had any unwanted thoughts? Have you had any thoughts of harming your infant, accidentally or on purpose?" If yes, follow up questions on frequency, and how scary they are.

Screening tools:
CIDI (Composite International Diagnostic Interview) based screening tool for bipolar spectrum disorders – 3 minutes to complete, clinician administered.
MDQ (Mood Disorder Questionnaire) – 5 minutes to complete, self-report.
Critical to screen for comorbidities such as anxiety, substance use

Pharmacological treatments:
Use monotherapy where possible
Individual risk benefit analysis is important
Acute treatment of perinatal bipolar depression: lamotrigine or quetiapine
Acute treatment of mania or mixed: olanzapine, quetiapine, benzodiazepine, lithium
Maintenance: Lamotrigine, lithium, second generation antipsychotic

Non-pharmacological interventions:
Counsel on lifestyle issues and sleep, help plan how to implement positive changes
Cognitive Behavior Therapy (CBT)
CBT – Insomnia
Interpersonal and Social Rhythm Therapy
Light therapy (mid day, 7000 lux, start with 15 min, increase in 15 min increments weekly, total 6 wks)

A note on postpartum psychosis:
Also see Postpartum Psychosis (Page 85)
Higher risk in those with past episodes and bipolar disorder
A psychiatric emergency requiring hospitalization.
Rapid onset, highest risk in first 4 weeks postpartum, may occur up to 12 weeks postpartum
Symptoms: mood swings, confusion, strange beliefs and hallucinations

Perinatal Bipolar Disorder Medications (See Page 88 for Information on Antipsychotics)

Drug Name (Common brand name)	Starting Dose and titration	Common side effects / adverse effects	Use in Pregnancy	Use during Lactation
Lamotrigine (Lamictal)	25 mg / day for 2 weeks: 50 mg / day for 2 weeks; 100 mg for 1 week, 200 mg (usual maximum dose)	Serious rash including Stevens Johnson syndrome, nausea, dizziness, ataxia	No increased risk of congenital malformations 29% need dose increase during pregnancy. If dose was increased during pregnancy, taper by 25% immediately post-birth and gradually back to baseline within two weeks postpartum.	RID 1.8 – 21. Considered compatible. Monitor for sedation / rash in infant.
Lithium	Acute mania/mixed episodes / or acute bipolar major depression: Initial: 600 to 900 mg/day in 2-3 divided doses; increase based on response/tolerability by 300 to 600 mg every 1 - 5 days to therapeutic dose range of 900 mg/day to 1.8 g/day.[2]	Hypothyroidism, polyuria, weight gain, serotonin syndrome	Ebstein's anomaly[3] – rate of 0.01 – 0.05% compared to a population risk of 0.005% Higher odds of: Any congenital anomaly (4.1%, OR 1.8, NNH 33) Cardiac anomaly (1.2%, OR 1.86, NNH 71) Increased rates of neonatal readmission No known effects on neurodevelopment Check levels monthly through 34 weeks then weekly. May need increased dose. Adequate hydration during labor, pre pregnancy dose after delivery.	RID 3 – 69. Not considered compatible, however based on patient preference, may support this in consultation with pediatrics.
Valproate (Depakote)	Not safe to start during pregnancy / in reproductive age people in general	Dry mouth, tremors, headache, weight gain	Dose dependent increased rate of congenital malformations – 5 to 25% (neural tube[3] cardiac and craniofacial) and neurodevelopmental problems (reduced IQ, autism spectrum disorders, and attention-deficit/hyperactivity disorder)	RID 0.1 – 3.9. Considered relatively safe in lactation, but not considered safe in people of reproductive potential. Monitor infant for sedation
Carbamazapine (Tegretol)	Not considered safe to start during pregnancy / in reproductive age people in general	Dizziness, ataxia, blurred vision, nausea, rash	Dose dependent increased rate of congenital malformations 3 to 9% (neural tube[4], urinary tract and craniofacial malformations).	RID 1.1 – 7.3. Considered relatively safe. Monitor infant for sedation
Oxcarbazepine	Not safe to start during pregnancy / in reproductive age people in general	Dizziness, ataxia, blurred vision, nausea, rash	Insufficient information but appears to be less frequently associated with congenital malformations.	RID 1.5 – 1.7. Considered relatively safe. Monitor infant for sedation.

RID= relative infant dose; NNH – number needed to harm

1. Mother must be clinically stable to breastfeed, prioritize sleep over breastfeeding, breastfeeding must not be at the cost of maternal mental health.
2. Check serum levels - 0.8 and 1.2 mEq/L recommended; some respond to lower levels (eg, 0.6 mEq/L).
3. Displacement of the tricuspid valve into the right ventricle; prognosis depends on severity of the lesion. Obtain high resolution ultrasound and fetal echocardiogram at 16 weeks gestation.
4. Risk of neural tube defects may be reduced if folic acid 5 mg is taken for one month preconception and throughout first trimester. Obtain high resolution morphological ultrasound with assessment of nuchal translucency.

Perinatal Bipolar Disorder Resources and References

Resources

Review articles:
Review of psychotropic drug use for bipolar disorder in the perinatal period:
https://www.sciencedirect.com/science/article/pii/S0146000520300112

Course of Illness and Treatment Updates for Bipolar Disorder in the Perinatal Period
https://link.springer.com/article/10.1007/s11920-022-01323-6

Webinar:
Webinar on social rhythm therapy for bipolar disorder:
https://ibpf.org/articles/social-rhythm-therapy-for-bipolar-disorder/

Patient handouts:
Handout from the International Society of Bipolar Disorders on healthy routines and rhythms during the pandemic and beyond:
https://www.isbd.org/Files/Admin/COVID_PSA/COVID_PSA_English.pdf

Wellness tracker from Depression and Bipolar Support Alliance that includes mood, medication and lifestyle trackers:
https://www.dbsalliance.org/wellness/wellness-toolbox/wellness-tracker/

References

Chessick, C. A., & Dimidjian, S. (2010). Screening for bipolar disorder during pregnancy and the postpartum period. *Archives of women's mental health*, *13*(3), 233-248.