Case report

PSYCHOTIC DISORDERS AND PREGNANCY: ABOUT A CASE

Comment [I1]: Titlecanberefine PsychoticDisorders and Pregnancy : A Case Study

Abstract

In this report, we present the case of a 38-year-old woman who presented with an episode of delirium during a five-month pregnancy.

Her delusions were of the persecutory type, associated with behavioral disturbances. It should be noted that this patient had experienced an intense state of stress before her pregnancy, with suicide attempts. We present in this work a therapeutic discussion with little literature data, linked to the rarity of these cases in practice, hence the need in our case to insist on a good therapeutic alliance and support for this patient.

Key words: Stress, Pregnancy, psychosis, therapy and support.

Introduction

Perinatal mental illness is widely under-diagnosed and under-treated, particularly psychosis of pregnancy. Some psychiatrists believe that psychosisshould be placed on the bipolar spectrum, while others consider it a separate nosological entity. Antipsychotics are the standard treatment for mothers who develop these pathologies. It is important to note the paucity of objective data available to prescribers, particularly studies on the efficacy and safety of these treatments during pregnancy. There are not enough operational trials or registries to collect data on their efficacy and safety in the postnatal period, and the side effects of these drugs prescribed in the postnatal period.

Comment [I2]: Add the Reference and Citation of the data

We will try to illustrate this issue through a rare clinical case in our psychiatry department.

Clinical case:

Patient XX, 38 years old, married, mother of 2 children (2 daughters aged 2 and 4), G3P2, 5 months pregnant, no profession, housewife. Native of Ain El Hammam and living in Tébessa (Algeria).

On 01-12-2021, the patient was brought to the emergency department by her father and uncle for disorders consisting of:

- Uncontrollable psychomotor agitation, Sthenicity with incoherent utterances, Coprolalia and delusions of persecution of those around her. His personal psychiatric history includes a suicide attempt followed up in 2021 by a private psychiatrist. The patient had no personal medical or surgical history, and no family psychiatric history.

In the history of her illness: the precipitating factor would date back to August 2021, following the fires she was told about while living in Tebessa (Algeria). She came with her husband to Tizi-

Ouzoufor psychiatric treatment of her stress reaction; she consulted several psychiatrists who put her on Largactil drops 4%: 10 - 10 - 20.

After her husband's departure, the patient showed instability, then irritability, incoherent speech and Coprolalia, which prompted her family to take her to the psychiatric emergency department of the CHU de Tizi-ouzou (Algeria).

Her mental examination of the day in the emergency room:

Woman of average height and build, dressed in appropriate corporal attire, contact difficult or impossible, verbalizing ideas of persecution towards nursing staff and family. Logorrheic with persecutory delusions using intuitive and interpretive mechanisms (she thought she was being watched), as well as false recognition (she gave the names of celebrities to the people in front of her) with Coprolalia, shouting, accusations and ranting. Irritable, angry mood. Anosognosic.

A diagnosis of first psychotic episode (BDA) in a 5-month pregnancy was retained.

The course of action on 01-12-2021 was Hospitalization with a biological workup and ECG. Emergency: The patient was put on the following treatment:

*Haldol injectable ampoule 5mg: 02-01-02

*Phenergan injectable ampoule: 01-01-02

*Parkinane gel 5 mg LP: 1-0-0si extra pyramidal side effects

It should be noted that her 'uncontrollable delirious agitation had necessitated the use of injectable NLPs, which were discontinued the following day when the patient accepted the oral route. A paraclinical workup and appropriate measures were prescribed:

- Pre-therapeutic work-up; blood glucose, ECG, haemogram,ionogram, TSH, renal and hepatic work-up.
- Monitoring of blood pressure (120/80cmHg), temperature (37°C), side effects and state of consciousness.
- Assessment and prevention of suicidal and hetero-aggressive risks.
- Transient atraumatic physical restraint with respect for protocol.
- Nutrition and rehydration
- Cerebral CT is contraindicated in this patient.
- Gynecological opinion (pregnancy status and subsequent follow-up).
- Information-education of family and patient
- Supportive psychotherapy

Injectable neuroleptics, which can cause changes in maternal blood pressure that can lead to fetal distress, and antiparkinsonian correctors, which increase atropine side-effects. It's common sense to prefer tablets to drinkable forms (which are widely used in psychiatry).

We are aware that chlorpromazine, widely used during pregnancy, has not been shown to have a teratogenic effect.

We obtained written and signed consent from the family, after informing them of the risk to the patient's physical and mental health, as well as obstetrical and gynecological complications.

Evolution of the patient's mental state on the ward:

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The day after hospitalization: the patient was still unstable, wandering around the ward, sthenic, with a prosective delirium: "You're watching me, you're responsible for my condition", and aggressive towards staff. Injectable treatments were stopped and oral treatment was started, including:

Comment [I4]: Mention injectable treatment

- Olanzapine cp 5mg: 01cp per day in the evening
- Largactil (4% drops): 20-20-20
- Atarax (Hydroxyzine) syrup (10mg5ml): 00-00-05ml
- Strict monitoring of vital consents, treatment efficacy and tolerance.
- A gynecology-obstetrics opinion was obtained, finding no abnormality in the evolution of the 05-month pregnancy.

After twenty days in hospital:

Patient was psychomotorically calm, contact was good, not delusional, critical of her disorders. Patient was compliant with treatment.

Twenty-third day of hospitalization:

The patient was discharged for three days, which went well.

On her return from her trial discharge and after a few days' hospitalization for a discharge assessment, the patient was declared discharged from the ward with a treatment consisting of:

- Olanzapine 5mg: 01 cp per day in the evening
- Largactil drops 4%: 30-30-30
- Ataraxcp 25mg : 00-00-01

With an appointment for a consultation in 10 days, subsequent consultations showed favorable psychiatric and gyneco-obstetrical progress. Psychotic, thymic and behavioral symptoms improved.

A need for close consultations in the run-up to childbirth (interest in Chlorpromazine). Her delivery went well, with no organic abnormalities reported in the newborn.

Table 1. Pregnancy recommendations on the basis of drug classes

drug class	earlypregnancyrecommendations		end of pregnancyrecommendations	newbornrecommendations	breastfeedingrecommendations
Antidepressant	SSRI (absolutely avoid paroxetine in early pregnancy because of the risk of heart defects)	TC (avoid clomipramine, if possible, in early pregnancy)	gradually reduce the doses at the end of pregnancy (depending on the clinic), avoid fluoxetine (SSRI) and clomipramine (TC) because withdrawal syndromes are more frequent	no dosage necessary in newborns but monitor clinical status	avoid fluoxetine (colic, high plasma doses in newborns) notriptiline, paroxetine and sertraline are often undetectable in breastfed newborns
Moodregulator	avoid lithium at the beginning of (Ebstein's syndrome)	do not prescribe valproate or carbamazepine except for exceptional indications, discuss Lamotrigine (reassuring but reduced data, indication not consensual)	if already prescribed, adjust doses at the end of pregnancy according to serum lithium levels, monitoring during labor	clinical and biological monitoring of the newborn in the event of administration of lithium to the mother	avoid lithium (if prescription, useful mother-child plasma doses) prefer valproate or carbamazepine
benzodiazepines	avoidprolonged administration		gradually reduce doses, stop if possible	clinical monitoring	avoidexceptoccasionally
antipsychotics	avoid in early pregnancy (but low risk), avoid combinations with another psychotropic	prefer chlorpromazine, haloperidol, if necessary, clozapine or olanzapine	gradually reduce doses at the end of pregnancy (depending on the clinic)	clinical monitoring	Avoid combinations with other Psychotropics Clinical monitoring

Comment [I5]: Add the Table in Landscap Format

Table 2. List of moleculesengaged for neonatalrisk

molecule	1° T	2° T	3° T	teratogenicrisk	monitoring	obstetricconsequences	neonatalrisk	feedingwithmilk
olanzapine	Possible in 1st intention			reassuring data	-	metabolic adverse effects (weight gain, gestational diabetes, increased birth weight)	atropine, extrapyramidal and sedation signs	concevable
Risperidone	Possible in 2nd intention			little data, no worrying element	-		no atropine sign	possible undermedical supervision
clozapine	possible if maternalbenefit			reassuring data	Mother NFS		atropine signs, leucopenia, sedation	Not recommended
Quetiapine	Possible in 3rd intention			Little data, no worrying element	-		withdrawalsymptoms	concevable
Amisulpiride	to avoid			No data	-		Atropine and sedationsigns	Not recommended
aripiprazole	To avoid In 3rd intention			Henry diaphragm	fetalechoof the		atropine, extrapyramidal	

Discussion

The contribution of psychological and physiological factors such as stress and suicide attempts in our patient probably accentuated the onset or development of a psychiatric disorder of the psychotic type (BDA) during pregnancy, with accentuation of symptoms such as persecutory delusions, which are much more frequent, It should be noted that few studies or surveys have been carried out on this clinical entity, and even fewer on its therapeutic use and consequences for the child's development. Through our modest experience and based on a few articles in the literature, we have used some recommendations (fig. 1) of certain classic and atypical neuroleptic drugs to alleviate these symptoms. In collaboration with gynecologists, pediatricians and child psychiatrists, we were able to maintain the pregnancy and the birth took place in acceptable conditions, without any notion of fetal complications, but we insisted on the follow-up and accompaniment of this patient by a multidisciplinary team in order to avoid any relapse.

Comment [I6]: References of thosestudies and surveys

Comment [I7]: Provide Reference

CONCLUSION

The occurrence of psychosis in pregnant women is a rare clinical entity. In our case, we nevertheless observed a satisfactory evolution of the symptoms under therapy, but we apprehend that this

Comment [I8]: Reference

pathology may become a public health problem, not only because of the 'rarity of study and therapeutic use in these patients, but also because of its consequences on the newborn, on the conjugal relationship, and even on the family equilibrium. All the more so as it may herald the onset of a chronic mood disorder or psychosis in the mother, hence the need for women suffering from these conditions to discuss their condition with their GP prior to pregnancy, in order to draw up a treatment and follow-up plan.

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