Journal of Advances in Medicine and Medical Research

Volume 36, Issue 5, Page 297-302, 2024; Article no.JAMMR.115046
ISSN: 2456-8899, NLM ID: 101711724
(Past name: British Journal of Medicine and Medical Research, Past ISSN: 2231-0614, NLM ID: 101570965)

Psychosis and Pregnancy: A Case Report

Bouguermouh Yacine [a*] and Zeggane. Sofiane [b]

[a] Faculty of Medicine, Hospital Frantz Fanon, Blida, Algeria.
[b] Faculty of Medicine, Hospital of Psychiatry, Tizi Ouzou, Algeria.

Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

Article Information

DOI: 10.9734/JAMMR/2024/v36i55438

Open Peer Review History:
This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: https://www.sdiarticle5.com/review-history/115046

Case Report

Received: 15/02/2024
Accepted: 20/04/2024
Published: 27/04/2024

ABSTRACT

We report in this observation the case of a 38-year-old woman, who had presented psychosis on a five-month pregnancy. A symptomatology made essentially of a type of persecution delirium associated with behavioral disorders, it should be noted that this patient experienced before her pregnancy a state of intense stress with suicide attempts. The delivery in our patient went well thanks to a good therapeutic alliance and support

Keywords: Stress; pregnancy; psychosis; therapy; support.

1. INTRODUCTION

Pregnancy can be a difficult period in a woman's life. The body changes, hormones get carried away and lifestyle habits and relationships with others change too. It is assumed that the mother should be enthusiastic and happy about the upcoming arrival of her baby, but this is not the case for all women [1,2]. A multitude of factors make pregnant women at risk of experiencing mental difficulties. Women, who have a history of stress, depression or little social support, or

**Corresponding author: E-mail: yacine_bouguermouh@yahoo.fr;*

none, are particularly at risk and generally her mental difficulties and precisely the psychosis of pregnancy are often under diagnosed antipsychotics are the standard treatment for mothers who develop these pathologies [3-5]. The evolution is generally good. Multidisciplinary management is advised to avoid relapses in the postnatal period [6-9].

We will try to support this problem through the experience of a patient followed in our psychiatric department

2. CLINICAL CASE

A 38 years old, married, mother of 2 children (2 girls, 2 years old and 4 years old) G3P2 with a 5 month pregnancy, no occupation, housewife. Originally from Ain El Hammam and living in Tebessa (Algeria).

The Patient is brought on 01-12-2021 to the emergency room by her father and uncle for disorders made of:

- Uncontrollable psychomotor unrest, Sthenicity with incoherent remarks, a Coprolalia and a delusion of persecution towards the entourage. In this personal psychiatric history, there is a notion of attempted suicide followed in 2021 by a liberal psychiatrist and no notion of personal medical-surgical history and family psychiatric history in this patient.

In the history of her illness: The precipitating factor dates back to August 2021 following the fires, which were announced to her while she was residing in Tebessa (Algeria). She came with her husband to Tizi-Ouzou for a psychiatric management of her stress reaction; she consulted with several psychiatrists who put him on chlorpromazine hydrochloride (Largactil) drops 4%: 10 – 10 – 20.

After the departure of her husband, the patient presented instability then irritability, incoherent remarks and a Coprolalia that motivated her family to bring her to the emergency psychiatry of the CHU of Tizi-ouzou (Algeria).

His mental exam of the day in the ER: Woman of average size and build, dressed in a body dress – suitable clothing, contacts difficult or impossible, verbalizing ideas of persecution towards nursing staff and family. Logorrhea with delusion of persecution with intuitive and interpretative mechanisms (thinks to be monitored) as well as false recognitions (she gave the names of celebrities for the people in front of her) with Coprolalia, cries, accusations and vociferations. Angry irritable mood. Anosognosic.

A diagnosis of psychosis over a 5-month pregnancy was retained.

The conduct to be held on the day of 01-12-2021 was Hospitalization with a biological assessment and an ECG. Emergency: The patient was put on treatment as follows:

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

* Promethazine injectable ampoule: 01-01-02

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

It should be noted that his uncontrollable delirious agitation had required the use of neuroleptics type injectable with a stop the next day following the acceptance of the oral route by the patient. A Para-clinical assessment and adequate measures were prescribed to know:

- Pre-therapeutic assessment; Blood glucose, ECG, Blood Count, Ionogram, TSH, Renal and hepatic assessment.
- Blood pressure monitoring (120/80cmHg), temperature (37°c), side effects and awareness.
- Assessment and prevention of suicidal and aggressive heterosexual risk.
- Transient atraumatic physical restraint with protocol adherence.
- Feeding and rehydration
- We did not find it useful to have a brain scan.
- Gynecology advice (pregnancy status and subsequent follow-ups)
- Family and patient education
- Supportive psychotherapy

Table 1. Pregnancy recommendations on the basis of drug classes

Drug class	Early pregnancy recommendations		End of pregnancy recommendations	Newborn recommendations	Breast feeding recommendations
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
Mood regulator	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	avoid prolonged administration		gradually reduce doses, stop if possible	clinical monitoring	avoid except occasionally
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

Table 2. List of molecules engaged for neonatal risk

Molecules	1°t	2°t	3°t	Teratogenic risk	Monitoring	Obstetric consequences	Neonatal risk	Feeding with milk
Olanzapine	Possible in 1 st intention			reassuring data	-	metabolic adverse effects (weight gain, gestational diabetes, increased birth weight)	atropine, extra pyramidal and sedation signs	conceivable
Risperidone	Possible in 2 nd intention			little data, no worrying element	-		no atropine sign	possible under medical supervision
Clozapine	possible if maternal benefit			reassuring data	Mother NFS		atropine signs, leucopenia, sedation	Not recommended
Quetiapine	Possible in 3rd intention			Little data, no worrying element	-		withdrawal symptoms	conceivable
Amisulpiride	to avoid			No data	-		Atropine and sedation signs	not recommended
Aripiprazole	to avoid	in 3rd intention		Henry diaphragm in rats	fetal echo of the diaphragm		atropine, extra pyramidal and sedation signs	

Injectable neuroleptics, which can promote maternal blood pressure changes that, can lead to fetal pain, as well as association with antiparkinsonian correctors that increase atropinic side effects. Common sense is to prefer tablets to drinkable forms (although widely used in psychiatry).

Bearing in mind that there has been no evidence of teratogenic effect for chlorpromazine widely used during pregnancy.

The mental health status of the patient following her hospitalization: The patient was still unstable and was walking in the ward, sthenic. The contact was laborious, with a delusion of a persecutory type « you are watching me, you are responsible for my condition», and aggressive towards the staff, nevertheless the oral route was accepted. Treatment by injection is discontinued and oral treatment is started including:

- Olanzapine Cristers Pharma 5 mg, tablet: 01cp per day in the evening
- Chlorpromazine (hydrochloride) 4% soldrinkable in drop: 20–20–20
- Hydroxyzine syrup (10mg5ml): 00–00–05ml

Strict monitoring of vital consenting, efficacy treatment tolerance.

- The advice of gynecology-obstetrics was made finding no abnormalities in the evolution of the Pregnancy of 05 months.

After 20 days in hospital: Our patient was psychomotor calm; the contact was good, not delusional, criticizing her disorders. Patient was complicating treatment.

On the twenty-third day of hospitalization: The patient was released for a period of three days, which went well.

On her return from her trial and after a few days' hospitalization for a check-up , the patient is declared to have left the service with treatment consisting of:

- Olanzapine Cristers Pharma 5 mg, tablet: 01 cp per day in the evening
- Chlorpromazine (hydrochloride) 4% sol drinkable with drop: 30–30–30
- Hydroxyzine cp 25mg: 00–00–01

With a consultation appointment in 10 days. The evolution during the subsequent consultations was favorable both on the psychiatric and gynecological-obstetrical level. With amendment psychotic, thymic symptoms and behavioral disorders.

A need for close consultations as childbirth approaches (interest of Chlorpromazine). Her delivery went well; no organic abnormalities were reported in the newborn.

3. DISCUSSION

The contribution of psychological and physiological factors such as stress, suicide attempts in our patient probably accentuated the onset or development of psychosis during pregnancy.

Symptoms such as persecution type delirium is often present unlike or pregnancy delirium which is much more frequent, we also find intense behavioral disorders and controllable name, it should be noted that some studies have been done on this clinical entity, much less on the therapeutic use and the consequences on the development of the child.

Through our modest experience and based on some literature articles, we have used some recommendations (Tables 1 and 2) of certain drugs of classical and atypical neuroleptics type in order to amend these symptoms, in collaboration with gynecologists, pediatrician and child psychiatrist, we managed to maintain the pregnancy and the birth was done in acceptable conditions without any notion of fetal complications but we all insisted on the follow-up and the accompaniment of this patient by a multidisciplinary team to avoid any relapse.

4. CONCLUSION

The occurrence of psychosis in a pregnant woman is a rare clinical entity. In our case, we nevertheless noted a satisfactory evolution of symptoms under therapy but we fear that this pathology can become a public health problem, not only because of the "scarcity of study and the therapeutic use of its patients, but also because of its consequences on the newborn, on the conjugal relationship, even on family balance. Especially since it can announce the onset of a chronic mood disorder or psychosis in the

mother, hence the need for these women who suffer from these conditions to discuss with their doctor before pregnancy to develop a treatment and follow-up plan.

CONSENT

We obtained the written and signed consent of the family after informing them about the risk related to the patient's physical health, mental and obstetric and gynecological complications.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Gentile S. Clinical utilization of atypical anti-psychotics in pregnancy and lactation. Ann Pharmacother. 2004;38:1265–71.
2. Rowe M, Gowda BA, Taylor D, Hannam S, Howard LM. Neonatal hypoglycaemiafollow-ingmaternal olanzapinetherapyduringpreg-nancy: Àcasereport. Therap Adv Psychopharmacol. 2012;2:265–8.
3. Dayan P, Gérardin O Rosenblum. Troubles psychiques de la grossesse et dupost-partum. EMCpsychiatrie. Elsevier; 2014.
4. Bavoux F, Thierry M. Psychotropes et grossesse Usage à haute dose: Risque foetale tnéonatal. La Lettre du Gynécologue-n ; 265-octobre 2001.
5. Brigg GG, Freeman RK, Yaffe SJ. Drugs inpregnancy and lactation: A reference guides to fetal and neonatal risk. 8 the d. Philadelphia, Pa: Lippincott Williams and Wilkins. 2008;327.
6. Zuo J, Liu Z, Ouyang X, Liu H, Hao Y , Xu L, et al. Distinct neurobehavioral consequences of prenatal exposure to sulpiride (SUL) and risperidone (RIS) inrats. Prog Neuropsycho-pharmacol Biol Psychiatry. 2008;32:387–97.
7. Céline Bascoul, Ludivine Franchitto, Olivier Parant, Jean-Philippe Raynaud Psychotropic drugs during pregnancy and breastfeeding: Practical development. Press Med; 2015.
8. Pregnant woman and psychotropic treatments. Midwives; 2022.
9. Darves- Bornoz JM, et al. Psychiatry and pregnancy: Mother and child Psychiatry; 2001.

Peer-review history:
The peer review history for this paper can be accessed here:
https://www.sdiarticle5.com/review-history/115046