NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Emergencies

Progressive Case Conference

Trainee Guide

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Required Pre-Reading

- Rodriguez-Cabezas L, Clark C. Psychiatric Emergencies in Pregnancy and Posptartum. Clinical Obstetrics & Gynecology 2018; 61(3): 615-627.
- Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum psychosis: madness, mania, and melancholia in motherhood. *American journal of psychiatry*, *173*(12), 1179-1188.

Overview

The goal of this module is to utilize a progressive clinical case presentation to broaden learners' knowledge of how to diagnose and treat psychiatric emergencies in the perinatal period. After completion of this module, learners should have a preliminary understanding of how to assess for alcohol withdrawal and how to treat that in pregnancy; of how to manage agitation in the pregnant patient; and of the epidemiology, phenomenology, pathophysiology, diagnostic considerations, prevention, and treatment of post-partum psychosis. This session is designed to last 60 minutes but can be modified for a longer or shorter session. The session is best utilized for psychiatry residents who have some clinical experience with pregnant and/or postpartum patients. Prior to the session, residents should read the articles included in the pre-reading section of this module.

Session Outline

1. Case Presentation parts 1-4 and questions 1-6: read aloud, discuss, and answer questions as a large group (20 minutes)
2. Case Presentation part 5 and questions 6-10: Read the case presentation aloud, then divide residents into small groups to discuss questions (15 min)
3. Groups present their findings to the large group (15 minutes)
4. Large group continues with reading aloud "Case Presentation Conclusion" and wrap-up discussion led by facilitator (10 minutes)

Goals and Objectives

1. Understand how to examine a pregnant patient for withdrawal from common substances and how to treat that withdrawal in pregnancy
2. Understand how to treat psychiatric emergencies including agitation in pregnancy
3. Understand how to identify and diagnose Postpartum Psychosis utilizing phenomenology
4. Understand evidence-based treatment for postpartum psychosis

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Resources Required

1. A faculty (or senior resident) facilitator
2. A board for taking notes generated during the large group discussion
3. Relevant articles for reading prior to the session.

Case presentation, part 1:

You are a PGY3 working overnight in the emergency room of a busy city hospital. You are the sole psychiatrist in the hospital, and the attending of record is a medical ER attending. Just when you think it is shaping up to be a quiet night, the door from the ambulance bay opens up to two medics pushing a stretcher with an agitated woman. The patient is lying on her back, struggling against the restraint belts and roundly cursing the medics. You rush to examine her. She spits towards you and lets out a stream of invective; her speech is slightly slurred and her face is flushed. She is an obese woman who appears to be about 30 years old; she is tremulous and sweating. You know nothing about her history and are concerned that she may be withdrawing from a substance. Fortunately, one of the things the patient is agitated about is an urgent need to use the bathroom; you employ verbal de-escalation techniques and the patient calms enough to give you a urine sample and withstand a blood draw. You know that it will take the lab a while to conduct the tox screen, but your ER has point-of-care testing and the urine pregnancy test comes back positive.

1) How can you determine whether the patient is withdrawing from opioids?

Case presentation, part 2:

The patient, whose name is Maria, has a COWS of only 5, including pupils of normal size. You are less concerned about opioids, but you notice that, in addition to the signs you saw on admission, the patient has brisk reflexes and tongue fasciculation.

2) What substance are you now concerned about and how can you assess this?

Case presentation, part 3:

You determine that the patient is withdrawing from alcohol.

3) Should you report this patient to child protective services for lack of prenatal care and drinking?

4) What treatment do you recommend?

Case presentation, part 4:

Your attending is reluctant to treat the patient for her withdrawal due to the pregnancy, but you point out that alcohol withdrawal can be fatal, which would be worse for the fetus, and the attending reluctantly agrees. Later in the night, however, the patient again becomes acutely agitated; she attempts to kick a nurse in the face and you have to call in security. You are trying to determine what is the appropriate medication for the situation when your attending tells

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you that you can use only diphenhydramine for agitation in pregnancy. You are sure that cannot be true, and your page your local reproductive psychiatry attending for backup. What questions do you ask, and how does this attending answer?

5) Is it OK to use medications for agitation in pregnancy?

6) What about physical restraints? We can't use those in pregnancy, can we?

Case presentation, part 5:

You treat Maria for her agitation and alcohol withdrawal. When she is calmer, she tells you that she stopped her medications for bipolar 1 disorder and relapsed into alcohol use during her pregnancy. She believes she is about 22 weeks pregnant, and she lives with her mother, who is supportive but also has strong feelings about the use of both substances and medications in pregnancy. The pregnancy was unplanned but is desired, and Maria plans to continue living with her mother, who will help her with child care. She is currently unemployed, but has worked as a school janitor in the past and hopes to go back to similar work after the child is born. You transfer her to the inpatient psychiatry unit for management of her untreated bipolar 1 disorder. Maria stays only a few days and does not follow up with the recommended outpatient treatment. You are not sure what has happened to her.

A few months later, you are again working in the ER and you are getting signout from your fellow resident. She tells you about a 29-year-old G1P1 at 6 days postpartum who was brought in last night by her mother, Mrs. P. Her son was born via SVD at 39 weeks, weighing 7lbs and 3oz. Mrs. P reports that Maria seemed to do "fine" in the first couple of days after delivery- she was fatigued and sometimes anxious but seemed enamored with her son and was able to initiate breastfeeding. However, a couple of days after discharge from the hospital (postpartum day 4), Mrs. P noticed some odd behaviors, such as checking behind counters and under tables for no apparent reason. When Mrs. P approached her about daughter about these incidents, she responded "I just want to make sure the baby is safe." Over the next 2 days her behavior was increasingly bizarre; she paced around the baby's room at night while he was soundly sleeping; she appeared confused and disoriented, stating that she wasn't tired and needed to be there for her son. She threw away all the soaps and baby lotions in the house, stating that they smelled "off" and she didn't want to expose her son to "those poisons." On the day of evaluation, Mrs. P found Maria standing standing by the side of the crib holding a pillow. Maria resisted Mrs. P's efforts to take the pillow, repeatedly stating, "I must save him, what are you doing"?

You go to meet Maria; she does not remember you from prior encounters. She has uncombed hair and is wearing mismatched socks and a wrinkled shirt with visible food stains. She is guarded and often looks around the room apprehensively. She exhibits psychomotor agitation evidence by repeated rocking motion with her upper torso. Her thought process is tangential, and she reports that she has "holy powers" and that she and her son are on a "divine mission." No illicit substances were detected on initial urine toxicology screen, and blood alcohol level was <10. You are concerned that Maria has postpartum psychosis.

7) How common is PPP and when are women at highest risk? What psychiatric diagnoses are associated with PPP?

8) What are common symptoms of PPP? How are symptoms of PPP similar or distinct from affective psychosis in non-perinatal patients?

9) What are some differential diagnostic considerations? What diagnostic tests should be considered?

10) Describe potential treatment for Mrs. L. What level of care will she need? What treatment strategies might you suggest?

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Case presentation, conclusion:

After thorough evaluation, you determine that Maria does indeed have PPP. She is again transferred to the inpatient unit, where she is treated successfully with Lithium and where family psychoeducation helps her mother to understand the risks of untreated illness. Maria is discharged to the women's mood clinic, stable on Lithium, with a plan for close follow up and close involvement of her mother in her care.

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