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(CASE REPORT)

How do family beliefs overshadow the management of postpartum delirious mania? A rare case report of adolescent postpartum delirious mania

Atieh Sadeghniiat Haghighi [1], Farzan Vahedifard [2,*] and Arghavan Shafiee-Aghdam [3]

[1] *Department of Psychiatry, Roozbeh Hospital, Tehran University of Medical Science, Tehran, Iran.*
[2] *Department of Diagnostic Radiology and Nuclear Medicine, Rush Medical College, Chicago, USA.*
[3] *Department of Psychiatry, University of Social Welfare and Rehabilitation Sciences. Tehran, Iran.*

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Abstract

Delirious mania (D.M.), which is described as an advancement of delirium in a patient with acute mania, is related to the high morbidity and mortality rate. Despite the high occurrence of delirium (15-20%) in bipolar disorder, D.M. is frequently misdiagnosed. D.M. is not classified as a DSM diagnosis, and no treatment guidelines exist.

This case report presents a rare case report of an adolescent Postpartum Delirious Mania. Also, we will discuss how family beliefs overshadow Postpartum Delirious Mania treatment. Patients with postpartum psychosis or mania achieved favorable treatment outcomes using a structured treatment algorithm during the acute phase of the illness. After remission, maintenance with lithium appears to be highly protective against relapse.

Inpatient psychiatric treatment is required to protect the mother's and baby's safety. Emphasize are needed on sleep hygiene and a consistent feeding schedule. In practical practice, this frequently entails the discontinuation of nursing. Lactation inhibitors should be avoided at all costs.

Based on observations from our case, family beliefs overshadow the management of postpartum delirious mania. we propose the importance of psychoeducation, especially for the family and the caregivers are essential for the patient's health.

Keywords: Postpartum; Delirious; Mania; Psychoeducation; Pregnancy

1. Introduction

Delirious mania, a life-threatening disorder, has yet to be classified as a form of catatonia or a subtype of bipolar disorder in the current Diagnostic and Statistical Manual (DSM) /International Diagnostic of Diseases classification system (or perhaps even as a single exceptional, but extremely rare, basic psychiatric cause of delirium) [1, 2]. The purpose of presenting our case is to highlight how the clinical picture of delirious mania can range from a very severe form of mania, as described by Bell in 1849 ("disease resembling some advanced stages of mania and fever"), to a relatively atypical clinical picture with delirious features occurring in the context of few affective symptoms, which can be easily overlooked. The required treatment would not be done in golden time [3]. It resembles catatonia and is often misinterpreted as psychosis [4, 5].

Delirious mania (D.M.), which is described as an advancement of delirium in a patient with acute mania, is related to the high morbidity and mortality rate. Despite the high occurrence of delirium (15-20%) in bipolar disorder, D.M. is frequently misdiagnosed. D.M. is not classified as a DSM diagnosis, and no treatment guidelines exist [5].

* Corresponding author: Farzan Vahedifard. Email: Farzanvahedi@yahoo.com
Department of Diagnostic Radiology and Nuclear Medicine, Rush Medical College, Chicago, USA.

Postpartum psychosis is a psychiatric emergency requiring urgent care intervention and referral to a mental health professional. The general population's prevalence is estimated to be 1–2 cases per 1,000 births [6, 7]. In most cases, the beginning happens within two weeks following delivery. Insomnia, mood swings, and obsessive anxiety about the newborn are frequent early symptoms, typically followed by more severe symptoms, including delusions, hallucinations, and confused behavior. The condition is characterized by severe mood symptoms including mania, depression, or a mixed state. Postpartum psychosis is classified as a bipolar spectrum illness rather than a primary psychotic disorder, since the clinical presentation, family history, and chronic illness course are similar to bipolar disorder [8, 9].

This case report presents a rare case report of an adolescent Postpartum Delirious Mania. Also, we will discuss How do family beliefs overshadow Postpartum Delirious Mania treatment.

2. Case Presentation

A 14-years old woman with no history of any psychiatric problem has been referred to Zanjan psychiatric hospital due to her odd behavior and agitation from a maternity ward. She had given birth to her child two days ago, and ever since, she did not feel well; on the day of her transportation between the hospitals, she had lost her orientation and had verbal and physical aggression. On her first arrival, she was disoriented (to time, place, and persons), agitated, incoherent in thought stream, persecutory delusion, and talkativeness. During the first days of hospitalization, increased energy and decreased need to sleep were also observed. She had put on lithium tablets (600mg) and olanzapine (5mg) from the beginning and prevented from breastfeeding the baby, for the first two days, her mother kept the infant near her mother. After two days of worsening the delusions and irritability of the patient, the baby was sent home for both mother and the infant's safety. Due to her condition, her olanzapine was increased to (12.5mg), and lorazepam (2mg) was added for her. With the following drugs, her state of mind became a little stabled and oriented to persons, but everything else was followed for five days.

After seven days of the prescribed drugs, her lithium level had gone into therapeutic dosage; since the seventh day of her administration, her agitation and aggressions started to decrease. Her delusions were loose, and she was looking for her child. After two weeks of hospital care, almost all of her signs and symptoms were gone, and she could even take care of her baby, so she was cleared to go home and had a visit in a week with her doctor.

The patient had a strong family history of a mood disorder from her mother's side. Her aunt had been suffering from major depression for years. Her mother had the same symptoms except milder symptoms when she gave birth to her first child at the age of 13. She had several mood swings during her life, and every time, she was treated aggressively by the family and blamed afterward for her actions during her episodes.

After that, the patient did not come to her follow-up on time. After three weeks, the patient came with the same psychiatric symptoms. The interview revealed that all drugs were discontinued due to the doctor's refusal to allow breastfeeding due to the prescribed drugs. The patient was taken to profiteers for treatment, which caused her to recurrence more severe symptoms with herbal remedies. This time the drugs were prescribed immediately after her arrival, and lorazepam was added from the beginning. During this period, symptoms took ten days to be controlled, and after 25 days of hospitalization, she was not symptom-free when she went home. This time she, her husband, and their mothers were all forced to attend psychoeducation classes for bipolar disorder to make sure that every effective and decision-maker person in her life is well aware of her disorder, its condition, and the importance of the drugs, and side effect of them.

Her follow-ups were done every month from then, and every time her blood test was checked and made sure to be done her lithium level was stabilized at 0.9-1, and due to her weight and olanzapine, using metformin, physical activity, and checking body index in every visit was necessary for her. Within the next two weeks, the patient's condition improved. She could now recognize her daughter and doctor and the location she was in; her oral intake had improved; she had gained weight, but her self-care had much improved. With 750mg lithium, 12.5mg olanzapine, and 1mg lorazepam.

The prognosis is remarkably favorable, given that postpartum delirious mania is a serious, potentially life-threatening disease during the acute phase. Most patients required a combination of benzodiazepines, antipsychotics, and lithium to achieve clinical remission. Furthermore, patients who received maintenance monotherapy with lithium had a higher rate of prolonged remission than those who received maintenance monotherapy with an antipsychotic.[10, 11]

Although giving electromagnetic shock was always considered during her treatment, because of her age and the family's psychoeducation, they had been guarded against aggressive treatment. ECT was the last choice if the medication did not work [12].

3. Discussion

3.1. Delirious mania

Delirious mania is a diagnosis with no standardized criteria. It has been defined as "a syndrome characterized by the acute onset of the excitement, grandiosity, emotional lability, delusions, and sleeplessness characteristic of mania, as well as the disorientation and altered consciousness typical of delirium [13]. Clinical onset and course are marked by a sudden onset and rapid progression of symptoms (within hours or days), with a fluctuating course that changes between psychosis, catatonia, mania, and delirium [14]. People with this syndrome often have a hard time or cannot remember what happened during the episode once it is over.

Klerman thought that delirious mania was a form of the more typical bipolar disorder [15]. Mann et al. pointed out that delirious mania can have many different medical and neuropsychiatric causes [16]. Taylor and Fink put delirious mania in the same category as catatonia (ie, excited catatonia)[17].

3.2. Postpartum psychosis/mania

The incidence of postpartum psychosis/mania with first-lifetime onset ranges from 0.25 to 0.6 per 1,000 births. Between 20 and 50 % of women experience isolated postpartum psychosis after an early episode. The remaining women experience episodes outside of pregnancy, which are typically bipolar in nature. The onset mechanism is most likely connected to physiological changes that occur after birth (such as hormonal, immunological, and circadian alterations), exacerbating disease in women who are genetically more susceptible to it. Some women have comorbid conditions and curable reasons, like infections or autoimmune thyroiditis. After birth, psychosis can be a symptom of N-methyl-D-aspartate encephalitis or inborn metabolic disorders. Less than 30 papers have been dedicated to postpartum psychosis treatment [18].

3.3. Management of postpartum psychosis/mania

There are some treatment Strategies in General for delirious mania (D.M.):

- Inpatient psychiatric treatment is required to protect the mother's and baby's safety. Admission to a mother-baby unit is linked to higher patient satisfaction and may shorten recovery time [19].
- The clinician should investigate if the patient has ever considered injuring herself or her children.
- A detailed medical and psychiatric history and physical and neurological exams are required for the initial clinical evaluation of postpartum psychosis. A complete blood count, liver function tests, electrolytes, blood urea nitrogen, creatinine, calcium, and glucose levels should all be tested in the lab. A drug test of the urine should also be done. Thyroid-stimulating hormone, free T4, and thyroid peroxidase antibodies should be measured at the time of diagnosis and six months later. Brain CT or MRI, CSF analysis, limbic encephalitis antibody screening, serum vitamin B1, B12, and folate levels, and urinalysis should be conducted if a proper clinical cause exists.
- Emphasize sleep hygiene and a consistent feeding schedule. In practical practice, this frequently entails the discontinuation of nursing. Lactation inhibitors should be avoided at all costs.
- The interaction between a mother and her child demands special consideration [20-22]. Furthermore, from the perspective of the family unit, support for the father is a crucial part of successful treatment.

Patients with postpartum psychosis or mania achieved favorable treatment outcomes using a structured treatment algorithm during the acute phase of the illness. After remission, maintenance with lithium appears to be highly protective against relapse.

Based on observations from our case, we propose the importance of psychoeducation, especially for the family and the caregivers are essential for the patient's health.

4. Conclusion

Based on observations from our case, family beliefs overshadow the management of postpartum delirious mania. We propose the importance of psychoeducation, especially for the family and the caregivers are essential for the patient's health.

Compliance with ethical standards

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Disclosure of conflict of interest

There is no conflict of interest for any of the authors

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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