What is the treatment for post partum psychosis?

Dr. Lamina Singh, Cachar, Assam.

RESPONSE FROM CMC FACULTY

Postpartum psychosis, while uncommon, is considered a psychiatric emergency which if untreated, can result in risks to the mother and baby. The symptoms are abrupt in onset and usually occur within the first 4 weeks, most often beginning within 3-10 days after childbirth.

The steps in the management of post-partum psychosis are as follows:

1. Establish the diagnosis:
   The patient with psychosis in the postpartum period usually has delusions and hallucinations, secondary to which she may be suspicious and fearful of being harmed and may have thoughts of harming herself and the baby. There may be prominent fluctuations in mood, confused thinking, with disorganized speech and behavior, agitation and irritability. Sleep and appetite are often disturbed.

2. Rule out organic factors:
   A thorough physical, including a detailed CNS examination and relevant lab investigations are important to assess for medical problems, with special efforts to identify the following which can present with symptoms described above:
   - CNS events such as cortico-venous thrombosis, arterial thromboembolic events, trauma, neoplasms
   - Metabolic encephalopathy or delirium
   - Endocrine dysfunction such as thyroid disease, hypo-parathyroidism
   - Infectious or autoimmune diseases

3. Start medication:
   Antipsychotic drugs are the drug of choice in the treatment of psychotic symptoms and for control of agitation. The general principles to be considered while prescribing psychotropics to this group of women include the use of the lowest effective dose and divided doses to avoid high peak serum concentrations.

   Choice of medication: While all antipsychotics are equally effective, patients who are more agitated may benefit from the more sedating drugs such as Olanzapine, Quetiapine, and Chlorpromazine. Atypical antipsychotic drugs have a reduced propensity to cause extrapyramidal symptoms, but their tendency to cause weight gain and metabolic syndrome require monitoring.

   Dosages for the commonly available antipsychotics are given below; increments in the dosage may be made every 2-3 days based on the clinical symptoms:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting Dose</th>
<th>Max. Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine</td>
<td>2.5 mg BD</td>
<td>20-25mg/day</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>50 mg BD</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Risperidone</td>
<td>1mg BD</td>
<td>8 mg/day</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>1.5 mg BD</td>
<td>15-20mg/day</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>50 mg BD</td>
<td>600-800mg/day</td>
</tr>
</tbody>
</table>

   In case of severe agitation, when patients require rapid tranquilization, parenteral Haloperidol 5-10 mg may be given intra muscularly with 25-50 mg of Promethazine in the same syringe. The above can be repeated up to three times in a day. Injection sites need to be assessed regularly for induration and pain.

   Mood stabilizers-are indicated in women who have a bipolar disorder. The mood stabilizers that have evidence regarding their usefulness are Sodium Valproate and Lithium; however given the risks of toxicity in the baby, lithium is not advisable in women who are breast feeding.

   Benzodiazepines-Short acting benzodiazepines like lorazepam may be considered if agitation is severe, however the breast-fed baby needs to be carefully monitored for sedation and lethargy.

   ECT-Electroconvulsive therapy is a safe and effective option for rapid control of symptoms.
4. Care for the patient:
Psychotic symptoms can interfere with the patient’s ability to take care of herself and her baby and may result in ideas of harm towards herself and the baby. It is of utmost importance that mother and child are never left unsupervised. Breast feeding may be continued with supervision by family members. The mother should get adequate hours of sleep and hence formula feeds at night may be suggested.

5. Care for the baby
With the exception mentioned above, it is found that the benefits of continuing breast feeds outweigh the risks related to antipsychotic exposure through breast milk. It is advisable that breast feeds be continued with regular monitoring of the baby. Precautions may be taken to reduce the levels of drug in the breast milk by using minimum effective dosages and splitting the dosage. Taking medication immediately after breast-feeding and avoiding hind milk while feeding can further minimize antipsychotic exposure to the baby. The baby needs to be monitored for extrapyramidal symptoms, excessive sedation, dehydration, poor feeding, poor weight gain and signs of hepatological or hematological impairment.

6. Education and long term care
In addition to discussions on the nature of the illness, the patient and family need to be educated about the fact that pregnancy and childbirth can be a trigger for recurrence of illness in susceptible individuals. The possible course of illness, need for prophylactic medication, regular follow up and careful planning of future pregnancies need to be discussed and negotiated with the patient and family.

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Can a renal transplant patient take ALENDRONATE as the patient is always under STEROID cover?

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RESPONSE FROM CMC FACULTY
Osteopenia and osteonecrosis (avascular necrosis) cause significant long term morbidity in renal transplant recipients. Patients are at increased risk for pathologic fractures due to osteopenia. Risk factors for post renal transplant bone loss involves both kidney disease related metabolic alterations (eg. hyperparathyroidism) and the adverse effects of ongoing immunosuppressive therapy.

Role of bisphosphonates: Glucocorticoid induced suppression of bone formation is one of the most important factors leading to early and long term bone loss in these patients. There is good evidence that antiresorptive agents like bisphosphonates are effective in preventing and treating bone loss in this setting. A 2006 meta-analysis that looked at five studies involving 180 patients underscored its effectiveness. Action of bisphosphonates is site specific. This was shown in a meta-analysis including 1209 patients. Treatment with bisphosphonates increased bone mineral density (BMD) in the lumbar spine and femoral neck, but not in the hip. Role of bisphosphonates in reducing fractures is not established as the pathogenesis of bone disease in renal transplant recipients is different from that in patients with typical osteoporosis. Most fractures in transplant patients occur in the appendicular skeleton (particularly the feet and ankles) whereas, in individuals with typical osteoporosis, the axial skeleton and trabecular bone sites are most common sites.

Potential complication: Also renal transplant recipients can have adynamic or low-turnover bone states; so the addition of agents that further suppress bone turnover may hamper the mechanical integrity of the bone. Hence, atypical fractures due to oversuppression of bone turnover are a potential complication of antiresorptive therapies.

Recommendations: The Kidney Disease: Improving Global Outcomes (KDIGO) guidelines suggest that, among those with GFRs ≥30 mL/min/1.73 m² and low BMD, treatment with vitamin D, calcitriol/alfacalcidol or bisphosphonates should be considered. The choice of these agents is determined by abnormal calcium, phosphate, PTH, alkaline
phosphate, and 25(OH)D levels. Management of those with low BMD and GFRs <30 mL/min/1.72 mm² should be similar to that of non-transplant patients with stage 4 to 5 CKD not yet on dialysis.³

Conclusion

Bisphosphonates like alendronate can be considered in renal transplant patients with estimated GFR greater than or equal to 30mL/min/1.73m², especially when they are on long term steroids. The drug dosages should be adjusted to the creatinine clearance.

References


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What is the simple pharmacological treatment for "HICCUPS" in a patient prone for extrapyradimal symptoms?

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RESPONSE FROM CMC FACULTY

There are numerous causes for hiccups. The most common are bloated stomach, alcohol consumption, diaphragmatic irritation, ENT related, nervous and metabolic causes. It is important to anatomically locate and determine the etiology of the hiccups. Persistent hiccups of more than 2 days duration warrants a detailed evaluation.

The underlying cause must be managed. The initial measures of symptomatic treatment should be non-pharmacological such as breath holding, Valsalva maneuver, ice water gargles, sucking a lemon or pulling knee to chest/bending forward to compress the chest.

The pharmacological treatment involves:

- **Antipsychotics** - Chlorpromazine 25 mg two times a day initially up to 50mg three times a day. To use not more than 5 days. Avoid in elderly. Can produce extrapyramidal symptoms.
- **Dopamine agonist** - Metoclopramide 10mg two to three times a day. Also can cause extrapyramidal features.
- **Muscle relaxants** - Baclofen 5mg three times a day and increase upto 50mg a day.
- **Anticonvulsants** such as phenytoin, valproate and carbamazepine can also be used.
- **Gabapentin** 200 to 1200mg divided in a day.
- **Tricyclic Antidepressants** such as Amitriptylene can also be tried.

Hence in patients prone to extrapyramidal side effects such as those with Parkinsonism, on psychiatric medication, after trying the non pharmacological causes the first drugs to be initiated are Chlorpromazine or Metoclopramide at a lower/half dose. If there is any significant in extrapyramidal features, such as new onset tremor, rigidity, abnormal posturing dystopias then the drug is withdrawn and alternate therapy- Baclofen or Gabapentin can be tried. If a gastrointestinal cause is suspected prokinetic like Mosapride and Proton pump inhibitor should be used. The underlying cause should be targeted.


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