

## Is your depressed postpartum patient bipolar?

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**M**any individuals think of postpartum depression as an episode of major depressive disorder within 4 weeks of delivery; however, postpartum depressive symptoms also can occur in the context of bipolar I disorder (BD I) or bipolar II disorder (BD II). Despite the high prevalence of postpartum hypomania (9% to 20%), clinicians often fail to screen for symptoms of mania or hypomania.<sup>1</sup> Determining if your patient's postpartum depressive episode is caused by BD is essential when formulating an appropriate treatment plan that protects the mother and child.

Postpartum depression literature offers little guidance on the recognition and management of postpartum bipolar disorder.<sup>2</sup> For example, there is scant evidence on pharmacologic or psychotherapeutic treatment of postpartum bipolar depression, and no studies have evaluated the use of screening instruments such as the Edinburgh Postnatal Depression Scale to detect bipolar disorder.

Misdiagnosis of postpartum depression is more likely in cases of subtle bipolarity—BD II and BD not otherwise specified—than in BD I because:<sup>3</sup>

- physicians often fail to ask postpartum patients about hypomanic symptoms such as feelings of elation, being overly talkative, racing thoughts, and decreased need for sleep
- DSM-IV-TR does not recognize hypomania with a postpartum onset specifier
- hypomania symptoms overlap normal feelings of elation and sleep disturbance following childbirth.

Clues to postpartum bipolar disorder include:

- hypomania: persistently elevated, expansive, or irritable mood
- depression onset immediately after delivery
- atypical features such as hypersomnia, leaden paralysis, and increased appetite
- racing thoughts
- concomitant psychotic symptoms
- history of BD in a first-degree relative
- antidepressants “misadventures” (rapid response; loss of response; induction of mania, hypomania, or depressive mixed episodes; and poor response).

### Treatment strategies

**Avoid antidepressants.** Bipolar depression does not respond to antidepressants as well as unipolar depression. Moreover, antidepressants can induce mania, hypomania, or mixed states, and can increase mood cycle frequency.

**Administer mood stabilizers** such as lithium or lamotrigine, or atypical antipsychotics such as quetiapine.

In breast-feeding women the benefits of treatment should be balanced carefully against the risk of infant exposure to medications. Lamotrigine should be used cautiously because of concerns of skin rash

Despite the high prevalence of postpartum hypomania, clinicians often fail to screen for symptoms of mania or hypomania

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and higher-than-expected drug levels in the infant. In light of recent data showing no significant adverse clinical or behavioral effects in infants, breast-feeding while taking lithium should be considered in carefully selected women. The preliminary evidence supporting the use of quetiapine during breast-feeding appears promising; however, data on the safety of atypical antipsychotics in lactating women are limited.

**Promote sleep.** Sleep disruption can be a symptom of as well as a trigger for postpartum bipolar depression. In women

with BD, the benefits of breast-feeding should be balanced carefully against the potential for the deleterious effects of sleep deprivation in triggering mood episodes. Women should consider using a breast pump allowing others to assist with feeding or supplementing breast milk with formula to help get uninterrupted sleep.<sup>3</sup>

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