UVM Project ECHO
Perinatal Mental Health
Preconception Through the First Year Postpartum

May 10, 2022

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- RECORDING OF SESSION TO BEGIN

Agenda

- Introductions
- Objectives
- Didactic Presentation (~20-30 min)
- Case presentation
  - Clarifying questions
  - Participants – then faculty panel
- Discussion
- Recommendations
- Summary
- Closing Announcements
  - Submission of new cases
  - Completion of evaluations

Series Objectives

Learning objectives for this ECHO series include the ability to:

- Explain clinical knowledge about presentation of perinatal mental health complications
- Discuss treatment and management approaches
- Apply appropriate diagnostic and treatment strategies for the perinatal population, with an emphasis on diversity, equity, and inclusion
- Describe statewide resources that can assist patients who may experience perinatal mood and anxiety

CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1 continuing education credits.

This activity was planned by and for the healthcare team, and learners will receive 1 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

CME Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Bipolar Disorder

Sarah Guth, MD

Child and Adolescent Psychiatry, Perinatal Psychiatry

Vermont Center for Children, Youth and Families

University of Vermont Medical Center

Also: Statewide consultant for perinatal mental health provider line (with Sandy Wood)

[No conflicts to disclose.]

Bipolar Disorder

Session Objectives:

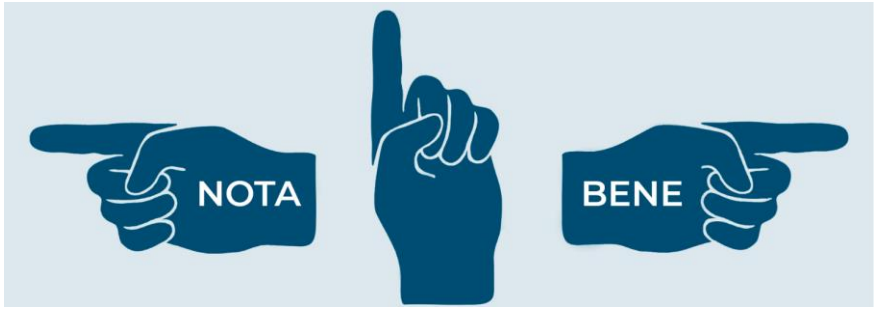
- Understand the diagnostic considerations for Bipolar Disorder in pregnancy and postpartum period.
- Describe risks and treatment strategies for Bipolar Disorder in the perinatal period.
- Apply the principles of prescribing psychotropic medications for bipolar disorder in pregnancy/postpartum.

Bipolar Disorder

Of note:

This presentation is biased toward **pregnancy**….

Next month we talk about postpartum psychosis and much of the information presented then will be relatable to the **postpartum** treatment of Bipolar Disorder



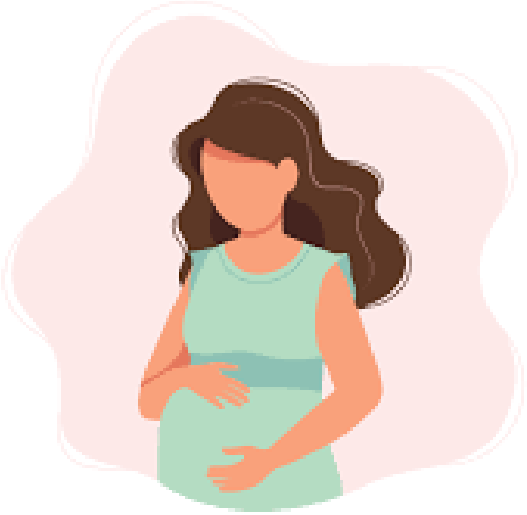
Bipolar Disorder: It's serious

- Perinatal period is a very high risk time for symptoms (depression or mania 70%)
- Presence of depression and/or manic symptoms during pregnancy predicts a 10-fold risk of continued or new mood symptoms in post-partum period
- Major depression episodes most common among pregnant patients with prior history of BD
- Rates of new onset mania and psychosis in weeks after childbirth can be as high as 50%
- Women with BD are likely to experience impairment in the maternal role accounting for adverse child outcomes

Bipolar Disorder: Typical Referral

- 32 year old woman presenting for prenatal care, moved here last month, has a history of bipolar disorder and no longer has a prescribing doctor. Should she be on a mood stabilizer??

- What do we need to know?



Bipolar Disorder: Typical Referral

- Diagnosis: Is it ACTUALLY Bipolar Disorder?
  - DSM V- Look for symptoms suggestive of a true mania
- To be considered mania, the elevated, expansive, or irritable mood must last for at least one week and be present most of the day, nearly every day
- 3 or more
  1. Inflated self-esteem or grandiosity
  2. Decreased need for sleep
  3. Increased talkativeness
  4. Racing thoughts
  5. Distracted easily
  6. Increase in goal-directed activity or psychomotor agitation
  7. Engaging in activities that hold the potential for painful consequences, e.g., unrestrained buying sprees

Bipolar Disorder: Typical Referral

- Diagnosis: Is it ACTUALLY Bipolar Disorder ?
- It is NOT someone whose mood fluctuates rapidly, or who has a chronic tendency to get angry easily- that can be PTSD, Borderline Personality Disorder, ADHD, Bipolar II
- Beyond DSM symptom endorsement look for:
  - Reports of impairment (lost job, disrupted relationships, moved away suddenly, made big purchases they couldn't afford, put self at risk)
  - When was it diagnosed? If diagnosed before 16 it is almost never Bipolar I
  - Most of the time there has been a hospitalization or a trip to the ED (note that youth hospitalizations can be deceiving.)
  - Treatment history? If someone is on SSRIs without mood stabilizers and not reporting symptoms of mania or presenting with them, this is a sign it may not be the real thing.

Bipolar Disorder: Typical Referral

Women with bipolar disorder (and schizophrenia):

- Present later for first prenatal visits
- Less likely to attend prenatal visits and to follow prenatal recommendations
- Had higher rates of smoking and illicit drug use
- Higher rates of pre-eclampsia and gestational diabetes
- Pregnancy is considered to be a high-risk period of relapse of symptoms

Bipolar Disorder: Typical Referral

So …. Let's say it is the real thing.

What do we need to know next?

-Substance Use

-History of Harm to self and others

-Severity/hospitalization history

-Prenatal Care

-Support Network (Family, social, outpatient services involved)

Bipolar Disorder: Treatment in Pregnancy

Optimize non-pharmacologic treatment:

Regular sleep schedule

Sleep is paramount to mood episode prevention

Stable home

Involve Social Work if needed

Caring supports

This is for symptom prevention but also monitoring. If there are no family members involved in care, make sure there is a therapist and good releases for communication with all team members.

Bipolar Disorder: Treatment in Pregnancy

If currently manic or depressed with suicidal ideation or delusions, consider inpatient hospitalization.

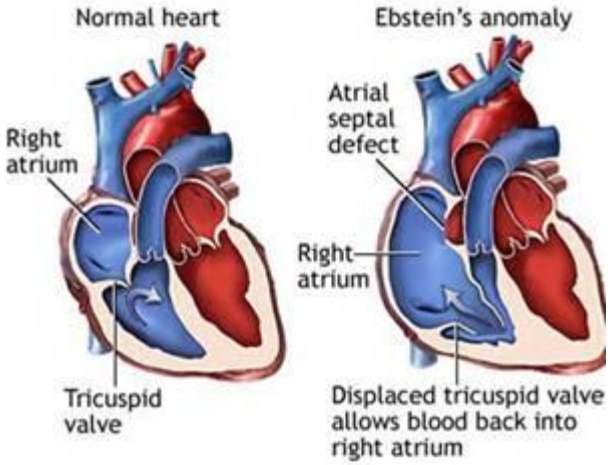
Bipolar Disorder: Treatment in Pregnancy

Prescribing Principles

- Almost no medicine is absolutely contraindicated. Some medicines seem riskier than others
- If someone has achieved stability on a medicine, think twice before switching to "something safer"
  - Especially when there are multiple med failures in history or concern for certain side effects
- Untreated Bipolar disorder is associated with risk of preterm labor, gestational diabetes, pre-eclampsia and NICU stays
- Worst case is a medication that doesn't help, then you have exposure to medicine and exposure to symptoms

Bipolar Disorder: Treatment in Pregnancy

Lithium



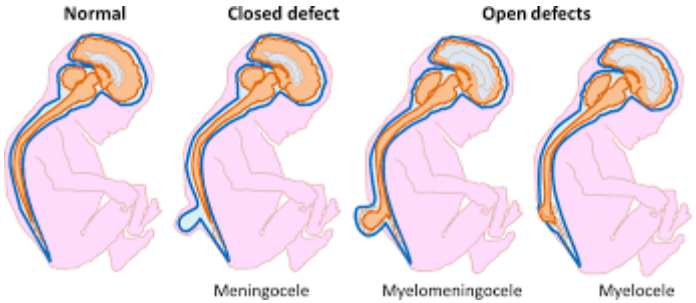
Elevated risk for Ebstein's Anomaly and miscarriage in first trimester (less risky than once thought)

Later in pregnancy can be tricky to maintain level and must be stopped prior to birth if possible; increase in preterm delivery

Bipolar Disorder: Treatment in Pregnancy

Anticonvulsants

- Valproic Acid, Carbamazepine and Trileptal all are known to cause neural tube defects



- If your patient is on one of these before they knew they were pregnant, think Folic Acid (4-5 mg)
- Lamictal is generally considered safe from case reports though isn't the best anti-manic agent

Bipolar Disorder: Treatment in Pregnancy

Antipsychotics

(Most studied are Atypicals)

- Can treat psychosis or bipolar disorder
- Frequently used as first line mood stabilizers
- High rate of side effects in children and adults (including movement related effects and alterations in blood sugar, cholesterol and weight gain)
- Most common: Olanzapine, Haloperidol (typical), Risperidone, Quetiapine, Aripiprazole

Bipolar Disorder: Treatment in Pregnancy

Antipsychotics seem fairly safe in pregnancy

- No evidence of congenital malformations

Huybrechts KF, Hernández-Díaz S, Patorno E, Desai RJ, Mogun H, Dejene SZ, Cohen JM, Panchaud A, Cohen L, Bateman BT. Antipsychotic Use in Pregnancy and the Risk for Congenital Malformations. JAMA Psychiatry. 2016 Sep 1;73(9):938-46. doi: 10.1001/jamapsychiatry.2016.1520. PMID: 27540849; PMCID: PMC5321163.

-No evidence of neurodevelopmental effects

Straub L, Hernández-Díaz S, Bateman BT, Wisner KL, Gray KJ, Pennell PB, Lester B, McDougle CJ, Suarez EA, Zhu Y, Zakoul H, Mogun H, Huybrechts KF. Association of Antipsychotic Drug Exposure in Pregnancy With Risk of Neurodevelopmental Disorders: A National Birth Cohort Study. JAMA Intern Med. 2022 May 1;182(5):522-533. doi: 10.1001/jamainternmed.2022.0375.

-Equivocal for preterm labor and SGA

-Biggest risk is Extrapyramidal Symptoms in Neonates-

Tremor, motor restlessness, hypertonicity, but no increase in NICU stays

Bipolar Disorder: Treatment in Pregnancy

Back to my referral. 32 year old woman, history of being hospitalized for mania. Currently not taking anything, euthymic. Supportive partner. Was on lithium and quetiapine in the past with good effect.

Because of the high risks associated with bipolar disorder I would resume medication. Would start with Quetiapine and titrate up.

Discuss sleep in depth, therapy referral, releases signed and CLOSE FOLLOW UP, invite partner to appointments.

Bipolar Disorder: Treatment in Postpartum

Postpartum Considerations:

- For women who have a support network, much planning and consideration should go into protecting SLEEP
- For women without a support network, home visiting nurses and all services possible should be called in for support and monitoring
- Medications are generally all safe in breastfeeding
  - Lithium needs the most monitoring
- Sedation can be the biggest issue with medications if there is not support at night

Bipolar Disorder: Treatment in Postpartum

To be continued…..

My next presentation covers postpartum psychosis and that is where I will cover new onset postpartum mania as well since the evaluation and treatment are quite similar.

Questions?

Cases/HIPAA

DO NOT INCLUDE:

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

- RECORDING TO BE STOPPED FOR CASE PRESENTATION

Case Presentation Format

Case presentation from a participant (a *real-world case, from the field)*
Then
Clarifying questions about the case from group to case presenter
Then
Ideas, suggestions, recommendations from participants
Then
Ideas, suggestions, recommendations from ECHO faculty team
Then
Additional discussion, if any (All)
Then
Summary of case discussion
(course co-directors: Katherine Mariani, MD, MPH and Jill Davis, MA)

Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

SESSIONS ARE ON TUESDAYS FROM 12:00PM TO 1:00PM		
DATES	**SESSION**	**DIDACTIC TOPICS (in addition to case review)**
Jan 11	TeleECHO Session 1	**Depression & Anxiety in the Prenatal Period** (Sandy Wood, CNM, PMHNP)
Feb 8	TeleECHO Session 2	**Cultural Considerations in Perinatal Mental Health** (Sayida Peprah, PsyD)
Mar 8	TeleECHO Session 3	**Depression & Anxiety in the Postpartum Period** (Sandy Wood, CNM, PMHNP)
Apr 12	TeleECHO Session 4	**Resources & Referrals** (Amy Wenger, RN, Elizabeth Gilman, Carol Lang-Godin, BA, and Maria Rossi, CLC, CLD, BS)
May 10	TeleECHO Session 5	**Bipolar Disorder in the Peripartum** (Sarah Guth, MD)
May 31	TeleECHO Session 6	**Postpartum Psychosis** (Sarah Guth, MD)
June 14	TeleECHO Session 7	**Birth Trauma/Perinatal Grief & Loss** (Fiona Griffin, LCMHC)

Conclusion

- Slides are posted at www.vtahec.org
- Volunteers to present cases (this is key to the Project ECHO model)
  - Please submit cases to Katherine.Mariani@uvmhealth.org
- Please complete evaluation survey after each session
- Once your completed evaluation is submitted, CE information will be emailed to you.
- Please contact us with any questions, concerns, or suggestions
  - Katherine.Mariani@uvmhealth.org
  - Elizabeth.Cote@uvm.edu