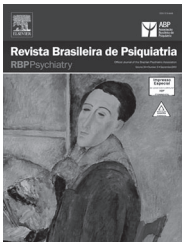
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Letter to the Editors

Lithium use during the first trimester of pregnancy followed by discontinuation, close follow-up and therapy focused on listening and support

Dear Editor,

Women with bipolar disorder (BD) often have difficulties related to treatment while pregnant[1] because there is no clear established management protocol. After pharmacological discontinuation, the risk of recurrence/chronicity is significantly higher,[1-3] during in pregnancy, and especially postpartum.[1] Furthermore, the management of treatment in this phase must consider the importance of this period in women´s lives.

I.M.S., 41 years of age, BD since 2007, had two manic episodes with psychotic symptoms: one of which was treated during a hospital admission; both were treated treated with lithium and olanzapine.

In 2010, while receiving lithium carbonate 900 mg as maintenance treatment, the patient discovered that she was pregnant, and she began to decrease her medication on her own. During follow-up, she expressed her desire to be treated without medication, despite the explanation of the risks involved. Therefore, we began weekly 30 to 40-minute follow-up sessions focused on listening and support. The first fetal ultrasonograph (USG) was performed at the 16th week of gestation and showed no abnormalities.

At the 22nd week, she complained of insomnia, irritability, emotional liability and loneliness while her husband was traveling. As her condition worsened, we increased the frequency of monitoring, maintaining a therapeutic approach, and added sleep hygiene measures. During the same period, moderate pyelocaliceal dilation and low placenta insertion was observed in a morphological USG.

Despite serious family problems that resulted in a period of sadness, the patient remained stable during the sixth month. During the seventh month, she was admitted to the obstetrics department to investigate placenta previa, the threat of preterm birth, polyhydramnios and hydronephrosis. Because of an image suggesting a hypoplastic nasal bone in the USG, the possibility of Down syndrome was suggested, but the patient declined further prenatal investigation of this possibility, and a fetal echodopplercardiogram showed the absence of cardiac malformations. Despite these problems, she did not present depressive symptoms.

A cesarean delivery was indicated and occurred without complications. No abnormality was detected at the baby's physical examination. In the puerperal period, I.M.S. expressed the desire to breastfeed her child, for as long as she could. The patient's stability during the pregnancy and a good evolution contributed to the decision to maintain a treatment plan of close follow-up and no medications. After six months, breastfeeding was suspended, followed by the reintroduction of lithium treatment.

Despite the recurrence risk and absence of strong teratogenic effects of lithium,[1-4] I.M.S. chose not to use lithium during pregnancy. Based on the patient's request, we recommended a gradual decrease in lithium over several days and close follow-up to minimize the possibility of recurrence.[1,3] Lithium exposure, morphological USG and fetal echodopplercardiogram were performed for screening purposes after the first trimester.[1-4] This case reaffirms that pregnant women with BD who remain well throughout pregnancy have a lower risk for postpartum relapse,[1] even without medication. Nevertheless, psychoeducation and close clinical monitoring are essential in pregnant women with BD.[5]

As we reported, therapeutical support and listening can be effective as a strategy for treating BD during pregnancy and postpartum. The relationship between the medical team, the patient and the family is also important, and all of those involved should support and respect the decisions made together.

Débora Bassitt,[1] Walter Soares,[1] Michel Haddad,[1] Mariana Alberti,[1] Marcela Bezerra[2]

[1] Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Psychiatry
[2] Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Psychology

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Disclosures

Débora Bassitt
Employment: *Psychiatry; Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Brazil.*
Walter Soares
Employment: *Psychiatry; Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Brazil.*
Michel Haddad
Employment: *Psychiatry; Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Brazil.*
Mariana Alberti
Employment: *Psychiatry; Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Brazil.*
Marcela Bezerra
Employment: *Psychology; Instituto de Assistência Médica ao Servidor Público Estadual de São Paulo, Brazil.*
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**** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.*

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