Indian Journal of Psychiatry, 1999, 41 (1),70-72

POSTPARTUM PSYCHOSIS IN A CASE OF SHEEHAN'S SYNDROME

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ABSTRACT

This case report describes a case of a 23 years old female who presented with clinical features of postpartum psychosis (Psychotic disorder not otherwise specified, DSM-IV). On investigation she was found to be suffering from Sheehan's syndrome (postpartum pituitary infarction). It was interesting to note that all the clinical features of Sheehan's syndrome and psychosis improved with hormone replacement therapy and she did not require treatment with antipsychotic medications.

Key Words : Postpartum psychosis, Sheehan's syndrome

Postpartum psychosis is a syndrome characterised by development of a group of symptoms like fatigue, insomnia, restlessness, suspiciousness, delusions, hallucinations and not wanting to care for the baby, which occurs in close temporal association with childbirth. The symptoms of postpartum psychosis can often begin within days of the delivery, although the mean time of onset is two to three weeks and almost within eight weeks of delivery. The incidence of this disorder seems to be around 1-2 per 1000 childbirths and 50-60 percent of the times it occurs during the first delivery (Kaplan et al., 1994). A few instances of postpartum psychosis result from a general medical condition associated with perinatal events like infection, drug intoxication, toxaemia and blood loss. Although postpartum psychosis is fundamentally a disorder of women, some rare cases affect fathers (Kaplan et al., 1994). Although, specific diagnostic criteria are not included in DSM-IV (APA, 1994), it is classified under the category of psychotic disorder not otherwise specified.

Post partum pituitary infarction occurs in a setting of haemorrhage with systemic hypotension; vasospasm is thought to mediate the pituitary destruction that ensues (Daniels et al., 1994). This leads to chronic hypopituitarism which may remain undetected for several years. Depression is marked and virtually all patients show apathy, inertia and somnolence to some degree (Lishman, 1987). They are usually indifferent to their illness and due to vague symptomatology often go from one clinic to another. They are sensitive to cold, lack energy and do not perspire. The skin is dry and atrophic, often puffiness is seen. The hair is dry and sparse and loss of axillary and pubic hair is common. Failure of lactation after childbirth, ammenorrhea and lack of libido can often lead to correct diagnosis (Rastogi, 1979).

A wide variety of psychiatric sequelae including agitation, depression, delirium, hallucinations, have been described in cases of Sheehan's syndrome (Parry, 1995).

CASE REPORT

A 23 years old married woman was brought to our hospital in emergency with

history of sudden onset of inability to speak an unresponsiveness following a quarrel with her neighbours in which she was allegedly assaulted. As, on examination, the doctor on emergency duty did not find any evidence of injury or neurological deficit, she was referred for psychiatric evaluation and was admitted in the psychiatric ward for observation.

On detail enquiry, her husband informed that he had noticed change in her behaviour for last five months which apparently started about 15-20 days after her first delivery five and a half months back. Patient had a full term hospital delivery with some complications during the delivery about which details were not available. About 15-20 days later it was observed that she was taking a long time for her daily activities and she had become apathetic. After some days she complained of fearfulness and started feeling that some people in the neighbourhood are against her and are out to harm her. She also complained of hearing voices conspiring against her. She neglected her personal hygiene as well as her child's care. Along with this history which was suggestive of psychosis, it was brought out that there was failure of lactation after her delivery and since then she had ammenorrhea. There was no history of any psychiatric illness in the past or in her family. Surprisingly, no psychiatric opinion was sought for inspite of her altered behaviour for last 5 months.

On examination, she looked pale and anaemic with puffiness of face. She was a febrile with a pulse rate of 60 per minute and blood pressure of 90/60 mm of Hg in supine position. On mental status examination, her appearance was untidy and dishevelled. She was apathetic and uncooperative. She was muttering to herself and showed hallucinatory behaviour. She had persecutory delusions and delusions of infidelity. Though formal testing was not possible, she had appeared to be well oriented. She had no insight into her illness and her social judgement was poor.

She was provisionally diagnosed as a case of postpartum psychosis and was started on tablet haloperidol 3 mg/day divided in two doses.

In view of the history of some complications during labour, failure of lactation, persistent ammenorrhea and low pulse rate her hormonal profile was studied and a CT scan with sections through the pituitary fossa was performed.

Hormonal profile revealed low levels of serum T3, T4, cortisol, FSH & LH.

S. T3=51.3 ng/100 ml (normal range = 70-200 ng/100 ml)

S. T4=1.0 μg/100 ml (normal range = 5.5-13.5 μg/100 ml)

S. TSH=2.37 μIU/ml (normal range = 0.25-4.5 μIU/ml)

S.Cortisol=0.6 μg/ml (normal range = 5-23 μg/ml)

S. FSH=2.4 μIU/ml (normal range = 3-10 μIU/ml)

S.LH=0.72 μIU/ml (normal range = 5-18 μIU/ml)

(ng=nanogram, μg=microgram, μIU=micro international units) CT scan revealed an empty pituitary fossa suggestive of empty sella syndrome (Sheehan's syndrome).

Once the diagnosis of Sheehan's syndrome was confirmed tablet haloperidol was discontinued and patient was started on tablet prednisolone 5 mg/day and tablet thyroxine sodium 100 mcg/day. Over a period of 15 days a complete remission of all her physical and psychiatric symptoms was noticed. Patient was discharged after counselling about continuation of treatment for her life time and importance of maintaining a regular follow-up.

DISCUSSION

In the above mentioned case, it seems that the development of psychotic symptoms was a blessing in disguise. Otherwise, it is likely that like many other cases of Sheehan's syndrome she would have remained undetected for many years.

It has been postulated that the psychiatric disorders during postpartum period may be

due to a relative deficit in pituitary hormones. Hormones in pregnancy are maintained at a higher level. After delivery there is a sudden drop in the levels of these hormones leading to a relative deficiency of these hormones which may be responsible for some of the psychiatric symptoms (Parry, 1995).

Like many other cases of psychiatric disorders associated with endocrine disorders, in cases of Sheehan's syndrome too, complete remission of psychiatric symptomatology may be achieved with hormone replacement therapy alone though, in one case report the therapy with prednisolone has been reported to provoke psychosis (Sabharwal, 1987). The use of antipsychotics in Sheehan's syndrome is controversial and may be necessary as an adjunct in the initial stages if the patient shows psychotic symptoms (Thomas, 1985). Only in a very few cases when the psychiatric symptomatology persists after an adequate trial with hormones, the use of psychotropic medication is warranted.

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