

More Than Just Baby Blues? A Diagnostic Dilemma.

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ABSTRACT

This case report is to emphasize that postpartum depression can pose as a diagnostic dilemma. And it is essential to identify and treat it. A 27-year female, primi, 37 weeks + 5 days came with complaints of leaking per vaginum and thick meconium-stained liquor. Patient was noticed speaking differently and did not respond properly. Patient was taken up for emergency LSCS in view of oligohydramnios with fetal distress. Postop - patient became restless and refused to talk to others and refused to feed the baby. Patient was refusing eye contact and had poor social communication. Psychiatrist diagnosed the patient as postpartum depression and patient was started on T. Ativan 1mg bd, T. Serta 50 mg od and T. Sizodon 1mg hs. Neurologist advised CT brain due to sudden behavioral disturbances. CT brain showed? pituitary haemorrhage brain normal. Patient improved symptomatically with the management given and was discharged with T. Wysolone 5mg one od and half at night as per neurosurgeon's advice. Though postpartum blues or depression is quite common, it is important to always consider other differential diagnosis and to rule out organic causes before coming to a diagnosis

Key Words: Postpartum Depression, Postpartum Blues, Pituitary Haemorrhage

INTRODUCTION

Postpartum depression (PPD) is a non-psychotic mood or mental disorder which typically manifests in mothers after delivery. The global prevalence of postpartum depression has been estimated as 100–150 per 1000 births [1]. In India the prevalence of depression varied from 11% to 16% within fourteen weeks of delivery. Postpartum depression can predispose to chronic or recurrent depression, which may affect the mother–infant relationship and child growth and development [2]. Postpartum psychiatric disorders can be further subdivided into: postpartum blues, postpartum depression and postpartum psychosis with blues being on the mild end of the spectrum while postpartum psychosis being on the severe end. It may present with mood swings, irritability, tearfulness, anger outbursts, fatigue, and confusion. In addition, symptoms of sleep disturbance, appetite disturbance, loss of energy, feelings of worthlessness or guilt, diminished concentration, and thoughts of suicide may be present [3]. Pituitary apoplexy (PA) is characterized by acute infarction and/or haemorrhage of the pituitary gland. The term pituitary apoplexy was coined by Brougham in

1950, and the first index case was described by Bailey, in 1898. Routine imaging can detect even asymptomatic pituitary haemorrhage, also known as subclinical apoplexy, which is more frequent than Pituitary apoplexy. Most patients with PA end up with a hormonal deficiency, especially, deficiency of anterior pituitary hormones [4]. The increase in pituitary size during pregnancy is due to hyperplasia and hypertrophy of the lactotroph cells by oestrogen stimulation and through their transformation to prolactin-producing pregnancy cells [5]. Since both these conditions can present vaguely, it is always important to suspect and diagnose correctly, so that appropriate treatment can be started otherwise both conditions can end dreadfully.

CASE REPORT

A 27-year female, unbooked, primi, 37 weeks + 5 days came with complaints of leaking per vaginum and thick meconium-stained liquor. Patient was noticed speaking differently and did not respond properly. Patient's attender was unable to give a correct history. Patient was taken up for emergency LSCS in view of oligohydramnios with fetal distress. Baby details - girl, term, 2.09 kg, 10:49 am on 10/4/19. APGAR-7/10, 9/10. Intraop period uneventful. Postop day one and two, patient was extremely quiet and was irritable with family members. Postop 4 - patient became restless and refused to talk to others and refused to feed the baby. Patient attempted to abscond from the ward. Patient was refusing eye contact and had poor social communication. Patient seemed confused and irritable. Patient also complained of headache on and off with sleep disturbances. Basic blood work up done and was normal. Vitals were monitored and stable.

Psychiatry and neurology opinion were obtained. Psychiatrist diagnosed the patient as postpartum depression and patient was started on T. Adivan 1mg BD, T. Serta 50 mg OD and T. Sizodon 1mg HS. Neurologist advised CT brain due to sudden behavioral disturbances and confusion. CT brain - Hyperdensity of size 3*6 mm seen in left lateral aspect in anterior pituitary gland (fig 2). Likely pituitary haemorrhage. Neurosurgery opinion obtained and patient was started on T. Wysolone 5mg BD. Suggested MRI with contrast, serum cortisol, TFT, GH and ACTH which came back normal. Ophthalmology opinion obtained and it was normal. Patient started showing signs of improvement within 2-3 days of commencing treatment and started bonding with her baby (Fig1). Her sleep patterns became better and patient started communicating properly with the doctors as well as her family. Neurology and Psychiatry review obtained and they advised follow up and counselling. Patient improved symptomatically with the management given and was discharged with T. Wysolone 5mg one od and half at night as per neurosurgeon's advice. This case posed to be a dilemma as CT showed pituitary haemorrhage but hormone profile and MRI was normal and hence concluded as Postpartum Depression.

DISCUSSION

The word "apoplexy" means accumulation of blood or fluid within any organ in Greek. Pituitary volumes during pregnancy were found to be increased 120% compared to the control in another study [6]. The highest pituitary volumes and widths of the infundibulum were observed during the first three postpartum days [6]. The presentation varies from

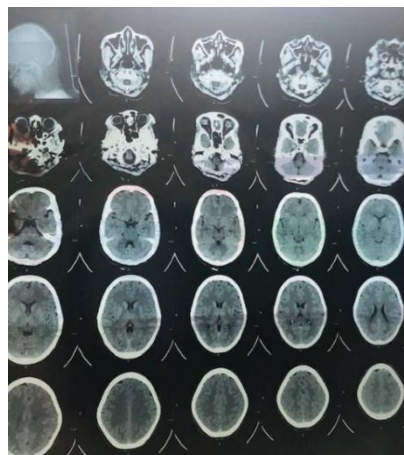
asymptomatic presentation to life-threatening subarachnoid haemorrhage. Asymptomatic pituitary haemorrhage is often termed subacute or subclinical pituitary apoplexy. Treatment varies from hormone replacement to trans sphenoidal surgery depending on the severity of symptoms and the cause.

Postpartum depression is often underdiagnosed and untreated. It is essential to treat PPD, as it will help the mother have a wholesome pregnancy and childbirth experience and will allow her to bond with her baby. Initial few months are essential for the mother and baby to bond which will have a good impact on the further development of the child. Psychosocial risk factors for PPD are anxiety during pregnancy, previous premenstrual dysphoria, stressful life events during pregnancy or the early puerperium, poor social support, marital conflict, low income, immigrant status, and young maternal age [7]. Declining levels of progesterone in the early postpartum period promote insomnia [8]. There is a well-established relationship between untreated maternal depression and impaired child development.9 Infant and child outcomes that are associated with PPD include a higher incidence of excessive infant crying or colic, sleep problems, and temperamental difficulties [10]. Psychotherapy, counselling and anti-depressants all play a role in treating a mother with postpartum depression.

Figure 1: Patient Shown Signs of Improvement & Bonding



Figure 2: CT Brain Showing Pituitary Lesion



CONCLUSION

Though postpartum blues or depression is quite common, it is important to always consider other differential diagnosis and to rule out organic causes before coming to a diagnosis. It is of prime importance that obstetricians and paediatricians have an index of suspicion to pick up and treat such cases. The family must also be counselled as they play a key role in supporting the new mother and new-born.

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CONFLICTS OF INTEREST

There are no conflicts of interest.

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