

CASE REPORT

Menstrual Psychosis : A Case Report

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ABSTRACT

Menstrual Psychosis is a unique disorder (Altschule et al, 1963). Over the last 150 years, sporadic case reports of this disorder are found in the literature. As yet, the standard psychiatric diagnostic nomenclature i.e. DSM, ICD-10 does not acknowledge its individuality. We report a 16-year-old female patient who was treated for three episodes of psychosis over a period of 5 months

Key words: Menstruation, Psychosis, Gonadal Hormones

INTRODUCTION

Menstrual psychosis, though not yet included as a separate entity in any standard psychiatric nomenclature, has been recognized as a unique disorder for more than one and a half-century. It has been reported in the early 20th century.

Menstrual psychosis deserves a separate mention for many reasons. Typically, it has a short duration, runs a self-limiting course with acute positive psychotic symptoms suddenly around the menstrual period that cease spontaneously within a few days of cessation of menstruation. There is complete normalcy between two episodes without any treatment. It does not necessarily affect every menstrual cycle.

The presentation of this syndrome is purely behavioral, cognitive & psychotic but the most successful therapies are steroid hormones.

Thus, menstrual psychosis seems to be a unique category of psychiatric disorder and the closest DSM-IV & ICD-10 diagnosis are Psychotic disorder NOS and Unspecific non-organic psychoses respectively

Case Report

S.M., a 16 year old unmarried female was examined on four occasions for

symptoms of disruptive behavior, excessive somnolence, negligence of personal hygiene, loss of appetite, irrelevant talks, incongruent crying. Each of these episodes was of sudden onset. Mental status examination at each of the three episodes revealed an untidy, unkempt patient with fearful mood and an incongruent affect. Her speech was irrelevant and coherent. She complained of persecutory ideas and appeared to respond to auditory hallucinations. Physical, neurological and neuro-cognitive testing did not reveal any abnormality.

On the first two occasions, she was administered oral benzodiazepine drugs which were voluntarily discontinued within 20 days of administration. Recurrence was observed after four weeks of discontinuation of the medicine. On the third occasion, she was hospitalized, when her elder sister observed that the three episodes of psychiatric illness had preceded three sequential menstrual cycles (see table - 1). On the first two occasions, she had remained symptom free for five weeks after two weeks of illness. In the context of this relationship between her menstrual cycle and psychiatric illness, after a joint consultation with the gynecologist, Danazol was administered 50mg. b.i.d for two weeks. Several practical constraints did not permit hormonal assay. Subsequent hormonal assay was done two weeks after

discontinuation of Danazol. It revealed a low progesterone level in the follicular phase of menstrual cycle. The patient was without medication. She had remained symptom free for the two menstrual cycles in October and November 2000.

Altered behavior recurred on 15/12/2000. She was hospitalized for observation. The menstrual period started on 20/12/2000. She was started on treatment with low dose trifluoperazine. The menses stopped on 23/12/2000 and the altered behavior normalized abruptly on 25/12/2000. On follow up the antipsychotic drug was omitted and Valproic acid was started. The patient has no residual psychopathology.

DISCUSSION

Menstrual psychosis has been reported from India (Verghese, 1963). Menstrual Psychosis is a unique syndrome in that it presents with episodes of acute psychotic symptoms of sudden onset, which occur in premenstrual period, continues through menstrual period and spontaneously remits within 15 days since onset. The patient remains symptoms free till symptoms recur with the next menstrual cycle. This disorder reportedly occurs either at the onset of menarche or postpartum (Brockington, 1998). Psychotic episodes occur in a cluster of few sequential menstrual cycles and remit spontaneously. Longitudinal follow up has revealed that several cases of menstrual psychosis eventually develop some other menstrual cycle related psychiatric syndrome. Presence of psychotic symptoms more than affective symptoms differentiates it from premenstrual dysphoric disorder (Brockington, 1998).

The possible etiological factors postulated include excess estrogen (Brockington, 1998), decreased progesterone (Teja, 1976), and sodium and water retention due to aldosterone (Frank, 1931). Psychodynamically (Teja, 1976), a negative attitude and difficulty in accepting femininity evokes varying degrees of castration anxiety, leading to the crumbling of the defensive structure of the ego. This results in psychosis. Thus, menstrual psychosis is a complex interplay of possible etiological factors, best explained on the basis of bio-

psycho-social model of disease.

Administration of antipsychotic drugs is not justified, as this syndrome is self-limiting. In some countries unlike in India, suppressing the menstrual cycle is a preferred line of treatment. The drugs used for this disorder are estrogen (Felthous, 1980), Progesterone (Teja, 1976), Danazol (Dennerstein et al, 1983), and drugs promoting ovulation (Cookson, 1967). Also, Lithium (Kazuhiko, 1995), antipsychotic drugs (Gerada, 1988), benzodiazepines (Kaplan, 1998) and diuretics (Inoue, 1984) have been tried with minimal success.

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