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A Diagnostic Doozy: Pseudocyesis with Newly Onset Bipolar Mania

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Abstract

Pseudocyesis is a rare condition that involves a combination of signs or symptoms that are associated with pregnancy, in the absence of an actual pregnancy, as evidenced by laboratory tests or imaging. At an intersection of psychiatric, psychological, and neuroendocrine factors, presentations may vary, and it may be difficult to distinguish from other similar conditions, such as delusion of pregnancy. Therefore, we present the case of a 35-year-old female who developed pseudocyesis in the setting of a manic episode. The patient had no documented psychiatric history prior to presenting with symptoms of pseudocyesis, which occurred in the setting of a manic episode. Due to erratic behaviors, she was taken to a local emergency department that resulted in the filing of an involuntary commitment petition. She managed to elope from this facility and navigate to another hospital, insisting that she be evaluated urgently, as she was experiencing lower abdominal pressure, contractions, and subjectively reported lactation. At that time, she was grandiose, belligerent, and agitated. She was evaluated for pregnancy, which was ruled out via laboratory testing and imaging, then transferred back to the facility of origin for psychiatric evaluation. She was ultimately committed to a psychiatric hospital for stabilization. While the mechanism(s) for development of the physical symptoms of pseudocyesis are not well understood, a reasonable case can be made that they arise from a combination of factors, including psychiatric, psychological, and neuroendocrine contributions resulting in the mental and physical changes due to fluctuating levels of neurotransmitters and other hormones in circulation. This patient's presentation is a rare case, as it occurred in the United States and is much more common in underdeveloped countries. There would likely be benefit from future studies, such as case series and systematic reviews, to better understand this rare condition and develop effective treatment strategies.

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Introduction

As defined, Pseudocyesis is a condition that can involve a combination of signs or symptoms typically associated with pregnancy, but in the absence of an actual pregnancy [1]. Confirmation of the diagnosis is typically achieved by routine labs testing and/or imaging to demonstrate the absence of a pregnancy, however persistent somatic symptoms or bodily sensations may convince the patient of the contrary [1]. These symptoms can include breast enlargement, galactorrhea, abdominal growth, amenorrhea, and the subjective feelings of a moving fetus—with abdominal growth being the most common of these physical symptoms [2]. The physical manifestations are often accompanied by a prevalent psychiatric component, and while there are multiple causes for this condition, the most common contributing factors include a strong desire to become pregnant or misinterpreting objective bodily sensations. In contrast, a delusion of pregnancy is a fixed, false belief that a patient is pregnant in the absence of any physical symptoms and may be indicative of an underlying psychotic illness [2,3]. While the mechanism of symptom development is not fully understood, it is thought that psychiatric, psychological, and endocrine contributions result in the mental and physical changes due to fluctuating levels of neurotransmitters and other hormones in circulation [4].

This condition is quite rare, especially in the United States and other developed countries, and occurs more commonly in developing countries [3]. In this case, the patient presented with pseudocyesis in the setting of a manic episode with evident psychotic features.

Case presentation

The patient is a 35- year-old African American female who was brought to the Emergency Department by authorities after an involuntary commitment petition had been filed due to her erratic and aggressive behaviors. She had no documented psychiatric history prior to this presentation. While the petition was in the process of resolution, she eloped from that facility and presented to another for evaluation by labor and delivery services. At the time, she was dressed in a hospital gown, was agitated, belligerent, and claiming she was having contractions at regular intervals and claimed that she could feel fetal movement in her lower abdomen. She was urgently admitted to labor and delivery for evaluation due to report of regular contractions and, after cervical examination, as well as a negative pregnancy test, it was confirmed that she was not pregnant. Due to her agitation and aggression during this admission, she was given Haldol 5 mg, Benadryl 50 mg, and lorazepam 2 mg intramuscularly then transferred to the facility from which she had eloped for the determination of disposition based on need for psychiatric stabilization. Her family was present during the evaluation and provided additional history, indicating that, for approximately one week prior to presentation to the hospital, she had been behaving erratically and making wild claims that were thought to be uncharacteristic of her. She had also sought care from multiple primary and emergency care providers, due to her reported symptoms and endorsement of pregnancy, and at times, including complaints about abdominal discomfort, bloating, and reflux. Two children that she had given birth to were taken care of by other family members throughout this ordeal. She was admitted to a psychiatric hospital wherein treatment was initiated. She was started on Lithium at that time, which was titrated to an effective dose. During this admission, she was stabilized on a regimen of Lithium 300 mg QAM and 600 mg QHS, having obtained diagnoses of bipolar disorder I and post-traumatic stress disorder. She was discharged with outpatient follow up. A pattern emerged of multiple inpatient admissions over the course of several years, as she had difficulty achieving consistent outpatient treatment adherence. At times, decrease in adherence coincided with traumatic events in her life, which resulted in psychiatric decompensation. During subsequent admissions, a symptom profile consistent with pseudocyesis prevailed, in one instance following the loss of several family members in a house fire. For example, she maintained that she was pregnant and that she had begun to lactate, experienced cervical tenderness, and stated she could feel the baby moving around when she laid flat. At each juncture, routine testing and imaging was utilized to rule out pregnancy. She was ultimately able to achieve long term stability on a combination of lithium and ziprasidone.

Exam

During the initial examination she was belligerent, stripping from her hospital clothing in the patient restroom in the triage area of the second hospital. She was hurling obscenities at staff and was uncooperative during physical evaluation until she was transitioned to labor and delivery department. Pregnancy was definitively ruled out with ultrasound. Her BMI at the time was 25.6. Mental status exam revealed that she was awake, alert, and oriented. She was euphoric but labile. Her speech was loud, rambling, and pressured. She exhibited flight of ideas and an illogical thought process. Thought content was without suicidal ideation at that time but seemed to be influenced by hallucinations and delusions. Her insight and judgement at that time were noted to be severely impaired.

Investigation and treatment

She was admitted to the labor and delivery department and evaluated for pregnancy. Despite endorsement of physical symptoms, she was unable to provide an approximation of the gestational age of the fetus or other information which might indicate pregnancy. A urinalysis was obtained which was suggestive of a urinary tract infection, which may have contributed to some of her physical symptoms. A pregnancy testing conducted at the time was negative. Other routine laboratory testing was unremarkable. After evaluation by labor and delivery services, she was transferred to the original facility and ultimately to the psychiatric unit in the hospital.

Discussion

Considering that this occurred during a manic episode, it is worth noting that bipolar I disorder is defined by the appearance of both manic and depressive episodes that may last weeks at a time, affecting patients' behaviors, mood, and rational thinking ability [1]. The patient's presentation at the emergency department was demonstrative of a manic episode, given the patient's uncharacteristic agitation, delusional thought content, and uncooperative behavior towards the staff, and she was treated for such.

Pseudocyesis clinically arises at the intersection of multiple factors. Its tendency to prevail in developing countries is linked to stressors specific to the cultures and expectations of females in those communities [5,6]. In some cases, childbearing is what gives women status and access to resources in societies that emphasize fertility and birthing. This can place additional pressure on females as not only the expectation, but also the desire can create a source for the symptoms seen in pseudocyesis [4].

Our patient does not fit any of these descriptions, which makes this case more unique. Per Tarrin et al, it is posited that this condition may prevail in underdeveloped countries due to their lack of readily available diagnostic testing [4]. Multiple studies have highlighted that this condition more commonly occurs in underdeveloped countries [5,7]. Social pressures can create an environment in which psychiatric and psychological issues may thrive, as they can logically lead to depression and other complications whenever the desired outcome is not achieved. In the setting of a bipolar disorder, depression will inevitably play a role, and it has long been thought that this can manifest with neuroendocrine signs [8], further setting a contrast to a delusion of pregnancy. If delusion of pregnancy is suspected, it may also necessitate that a patient receives medical evaluation; however, as documented, these cases represent the fixed belief of pregnancy, absent any physical signs or symptoms, and may be representative of a psychotic episode [9]. In some documented cases, there is notable abdominal distension [10]; however, this is not always present and in this case study the patient merely perceived distension along with the rest of the symptoms detailed.

Psychiatric and psychological conditions, and at times socioeconomic factors, pave the way for imbalances in homeostasis with respect to the central nervous system, resulting in misread sensations, decreases in dopamine, and hormonal changes. If an underlying psychiatric diagnosis is made, treatment should primarily focus on stabilization of that condition, followed then by management of the patient's expectations through the appropriate lab testing, imaging, and clinical examination by specialists [11].

In the case presented above, until psychiatric stability is achieved, there would likely have been minimal progress made in terms of psychotherapeutic treatment. Broadly speaking, in cases of pseudocyesis, the primary approach to treatment is psychotherapeutic management; however, a patient experiencing a manic episode may be less receptive to such treatment due to their improper thought processing. In following the standard of care, stabilization of acute psychiatric conditions is imperative as an initial approach, with appropriate psychotherapeutic tools being utilized as clinical course allows.

Conclusion

The presentation detailed in this case report, due to somatic symptoms endorsed by the patient, though in the setting of a manic episode, provides evidence for a diagnosis of pseudocyesis. It follows a classic pattern that could be described as misinterpreting normal bodily sensations to draw an irrational conclusion; whereas a delusion is defined as a fixed, false belief, absent any somatic complaints, sensations, or the like. When the patient achieved psychiatric stability, the symptoms abated, and she was able to return to her normal life. One could make the argument that care for pseudocyesis is largely supportive until underlying psychiatric confounders are stabilized. Additionally, it is of the utmost importance that any other potential medical cause for the symptom profile be ruled out.

Culturally, pseudocyesis can arise due to social pressures to bear children, especially when difficulty in this venue occurs. As this case aptly demonstrates, this is not always the primary driving factor. Clinical management warrants a psychotherapeutic approach towards pseudocyesis and logically is most beneficial when psychiatric comorbidities are stabilized. Additional studies, including case series and systematic reviews, should be conducted in order to better understand this condition, any variants, and how to effectively manage it.

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