Delusion of Triplet Pregnancy in a Manic Patient

To the Editor: Delusional pregnancy is defined as the belief of being pregnant despite factual evidence to the contrary. The disorder can be triggered by a wide variety of organic brain syndromes and psychiatric illnesses as well as medication-induced hyperprolactinemia.[1] Delusional pregnancy has been described in patients with bipolar disorder and is usually accompanied by antipsychotic agent–induced hyperprolactinemia.[1,2] Here, we report the case of a delusion of triplet pregnancy in a drug-naive woman experiencing her first manic episode. The treatment strategy and the importance of psychological factors in the development of delusional pregnancy are discussed.

Case report. Ms A is a 31-year-old woman with no history of psychiatric illness. She has been married for 8 years but has no children. She was admitted to the hospital because of a new-onset psychotic mania with presentation of labile mood, hypertalkativeness, decreased need for sleep, and flight of ideas accompanied by delusional pregnancy. She described some pregnancy signs such as cessation of menstrual periods, weight gain, frequency of urination, and abdominal distension. She firmly believed that she was pregnant with triplets, 2 females and 1 male, and said she could feel the babies moving. A series of examinations were arranged. The pregnancy test was negative. The results of blood count, serum chemistry, and prolactin levels were within normal limits. Her brain computed tomography scan was normal. After a full diagnostic workup, Ms A was administered lithium 900 mg/d combined with olanzapine 20 mg/d. On the 16th day of hospitalization, the delusional pregnancy resolved. Treatment with the same regimen resulted in gradual improvement of her manic symptoms.

There is no specific treatment for delusional pregnancy outlined in the literature. Antipsychotic agents may play an important role along with the treatment of underlying medical and psychiatric comorbidities.[3] Treatment of hyperprolactinemia is needed in patients with delusional pregnancy.[4] Prolactin-sparing antipsychotic agents (such as aripiprazole and the "pines" [eg, clozapine, olanzapine, quetiapine, asenapine]) might be the first choice.[4] In the case of Ms A, it would be important to take into account the possibility that olanzapine might induce hyperprolactinemia and weight gain that could mimic pregnancy and trigger her delusion. Three months after her hospitalization, lithium and olanzapine were gradually switched to aripiprazole 15 mg/d monotherapy in the outpatient clinic with no relapse of manic and psychotic symptoms.

Delusional pregnancy might be explained by organic factors and an adaptation to stress induced by psychological factors.[3] Very frequently, delusional pregnancy occurs when a married couple is infertile.[4] The infertility is usually attributed to the woman, which results in experiencing substantial distress and discrimination. Neutral sensory perception is misidentified, such as weight gain, cessation of menstrual periods, abdominal distension, frequency of urination, or abdominal movement. The same sensory perception may have occurred many times before. But, as Ms A searched for what the sensory perception might mean in her manic episode, the delusional pregnancy formed.

In psychodynamic view, Ms A's psychotic mania may have resulted from her tyrannical superego against the long-term infertility. The infertility produced intolerable self-criticism that was then replaced by euphoric self-satisfaction and became a delusion of triplet pregnancy. In this point of view, the delusion of triplet pregnancy represents a kind of grandiose delusion in her manic episode.

Our case adds to the limited literature on the phenomenon of delusional pregnancy in mania. Psychotropic drugs (lithium, olanzapine, and aripiprazole) demonstrate efficacy in treating delusional pregnancy, as was shown in our case.

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