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Perspectives on New Directions in the Management of Postpartum Depression

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Dr. Clayton:
More than half of women with postpartum depression remain undiagnosed. Of those who are diagnosed, 85% go untreated, and of those who are treated, more than 90% receive inadequate treatment. New therapies are offering more hope for managing this debilitating condition, but guidance is needed to accurately screen for, diagnose, and treat PPD. We're here today to offer insights on overcoming barriers that hinder effective screening and treatment of PPD, and we'll give you some strategies to improve your clinician-patient communication.

This is CME on ReachMD, and I'm Dr. Anita Clayton.

Dr. Byatt:
And I'm Dr. Nancy Byatt.

Dr. Payne:
And I'm Dr. Jennifer Payne.

Dr. Clayton:
Today we're going to go through a couple of cases to illustrate screening, diagnosis, and treatment approaches for PPD. So let's get started with our first case.

A 29-year-old woman gave birth 3 weeks ago. After the delivery, she started to feel sad, overwhelmed, and was consistently tearful. She reports barely eating or sleeping. Dr. Byatt, can you take us through your approach for this patient?

Dr. Byatt:
So one of the first key things would be screening. So screening tools, they're not diagnostic, but they can be really helpful in determining whether – providing a quantitative way of looking at people's symptoms, a little more objective than subjective report of symptoms. So one tool that we often use is the Edinburgh Postnatal Depression Scale, which we refer to as the EPDS, and that can be really helpful to see, one, the severity of the symptoms and also whether they screen positive. That, then, can be followed by further questioning and to determine the diagnosis.

So with someone like this, say for example, if we screened her and her EPDS was, say, 14. Typically, with an EPDS of 10 to 13, that's often consistent with a mild depression; meds may or may not be indicated then. Often, it's important to start with psychotherapy. Once someone has a score of 13 or above, that's usually suggestive of major depression and more significant illness. And often, medications may be indicated, or at least assessing for that would be really important.

There's several effective treatment options for pregnant and postpartum individuals. Cognitive behavioral therapy, or CBT, interpersonal psychotherapy, or IPT, has a very strong evidence base for this population and is really considered standard of care to offer that as first-line treatment.

Another thing that is often indicated is medication treatment. And typically, medication treatment is indicated, say for example, if this particular patient's EPDS had been a 14 and she is reporting difficulty functioning, if she had thoughts of wanting to die and/or if she was having trouble taking care of her baby, those would all be indications that medications may be indicated. In addition, it's important to ask about a psychiatric history. So say for example, if she'd reported that she had had depression before and needed an antidepressant. If she had had a lot of difficulty functioning before when she'd experienced depression, again, that would be an indication that we'd want to more strongly consider and assess for whether medications are indicated.

If medications are indicated, there's a lot of effective treatment options during pregnancy and the postpartum period. Women can absolutely take medications during this time period. Often, what we typically use as a first-line treatment is SSRIs, or selective serotonin reuptake inhibitors. That includes sertraline, citalopram, fluoxetine. But this particular patient we're referring to, who's in the postpartum period, if she was breastfeeding, people can still take medications during breastfeeding. The typical feeling in the field, and the opinions of most experts, is that the benefits of taking an antidepressant outweigh the risks of any passage of that medication through the breast milk. Because we know that it's best for babies for their moms to be well, so the thought is that the benefits outweigh the risks.

And if, for example, someone presented and they'd never been on a medication before, often we use sertraline as a first-line treatment because it does, of the antidepressants that we use, often go through the breast milk less than the others. Typically, the longer the half-life, the more passage through the breast milk. So for example, fluoxetine, which has a very long half-life, has more translactal passage than sertraline, which has a shorter half-life. However, if someone was on a medication and it was working, we would typically continue that medication. I would never switch a medication during lactation or during pregnancy because of concerns about, you know, passing their breast milk or effects in pregnancy. It's really important that we want to, specifically referring to antidepressants, it's really important that we want to use medications that have worked in the past, because by doing that, we can minimize exposure to the illness for the mom and the baby by not trying different medications or switching medications during this time period. So for example, if somebody presented, they'd been on fluoxetine, they said it worked, while that might not be our first choice because we know it has more passage through the breast milk than sertraline, if someone presented and this individual had been on fluoxetine and it had been working, I would restart fluoxetine. Similar, in pregnancy, if someone was on a medication and it was working and it was an antidepressant, I typically would not switch that medication.

Dr. Clayton:
Okay. Let's talk about Case 2.

Our second case features a 33-year-old woman who gave birth 10 weeks ago. After the delivery, she started to feel sad and overwhelmed. She frequently felt irritable and on edge. She isn't sleeping or eating and is starting to have suicidal thoughts. She reports having a prior history of depression.

Dr. Payne, what are your thoughts about this patient?

Dr. Payne:
Well, this patient certainly sounds like a more severe case of postpartum depression. And again, I think it's important to emphasize that we want to use screening and preferably use a screening tool like the EPDS. For a case like this, I would expect the EPDS to be scoring at around 20 or so because she's having suicidal thoughts, she's not eating, she's not sleeping, and it really sounds like a much more severe case. When you see a severe case of postpartum depression, there are a couple of other screenings that you really want to do. First and foremost, you want to screen for a history of psychiatric illness. This woman has a history of depression, but you want to make sure that she doesn't have a history of bipolar disorder or that she doesn't have a family history of bipolar disorder. Psychiatric illness in the postpartum time period is very common in women with bipolar disorder, and even just having a family history of bipolar disorder puts a woman at risk of developing an episode consistent with bipolar disorder in the postpartum time period. So screening for symptoms of bipolar disorder or a family history of bipolar disorder is really important.

The second thing that you really want to screen for is psychosis. Postpartum psychosis is a psychiatric emergency and can occur quite suddenly in the postpartum time period. And if someone is having hallucinations or expressing delusional material, they should be referred to the emergency room as quickly as possible.

For a patient like this who has more severe symptoms, you also have to consider hospitalization. She's having suicidal thoughts, and suicide in the postpartum time period is a real possibility for patients with severe postpartum depression. You also want to screen and ask about thoughts of harming the infant or other children in the household. And this would also increase the need for hospitalization.

Dr. Byatt, I think, did a great job talking about all the different types of psychotherapies and antidepressants that are available to treat postpartum depression. There is a new class of medications that can be used to treat postpartum depression. There's a medication that is called brexanolone, which is a synthetic version of allopregnanolone, which is a natural hormone that's produced in large amounts during pregnancy but decreases significantly in the postpartum time period. And brexanolone has been shown to be quite effective in treating severe cases of postpartum depression. It does require a hospital stay. It's a 3-day infusion, and it requires 24/7 monitoring of pulse ox and making sure that someone is not over-sedated. But it is quite effective, and it can send a case of postpartum depression into a very quick remission that appears to be sustained. So that is a new approach to treating postpartum depression.

An oral version of the synthetic allopregnanolone is going to become available over the next year or two and that will be interesting to watch develop.

Dr. Clayton:
Thank you, Dr. Payne, for that explanation of how we should manage severe postpartum depression.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Anita Clayton, and here with me today are Dr. Nancy Byatt and Dr. Jennifer Payne. We're discussing new directions for the clinical management of PPD and how to strengthen communication with our patients.

I did want to add a little bit about zuranolone, which is an oral neuroactive steroid, GABA-A receptor agonist, positive allosteric modulator. It's been studied in postpartum depression in the ROBIN study in which women had HAM-D17 [Hamilton Depression Rating Scale] scores of greater than 26, and they received either placebo or zuranolone, 30 mg orally daily in the evening, for 14 days at home. About 20% of those women were already taking an oral antidepressant. The primary endpoint was at day 15, right after the last dose of zuranolone. And significant differences were seen in reduction in the HAM-D17 total scores for zuranolone versus placebo at day 15, at day 3, and day 45. And differences in response and remission rates were also significant and favored zuranolone. It was well tolerated with rates of adverse events of 60% with zuranolone versus 52% with placebo; the most common being somnolence, headache, dizziness, upper respiratory tract infection, diarrhea, sedation, and nausea.

So those were great cases. Before our program ends, let's dive into one crucial topic. And that's communicating with our patients. What are some strategies and resources you each use to strengthen and improve communication between you and your patients with postpartum depression?

Dr. Byatt:
I'm glad you're asking this question because this is such a key part of providing psychiatric care, any mental healthcare, is building that rapport and that trust. And I think really thinking about this in a trauma-informed way. And one of the things that I've learned over the years in working with people is it's so important to be framing things in a strength-based way. So for example, if we're talking about, you know, if somebody comes to an appointment and they're late, instead of saying, "Why are you late?" you could say, "Must've been hard to get here. I'm glad you're here. How did you manage to make it here?" So really reframing it versus the – not what's wrong with you. Reframing it to what happened to you and really having that approach during, you know, throughout all of the interactions. That's something I've found to be really effective and the patients really respond well too.

Dr. Payne:
Yeah, I couldn't agree more, Nancy, and the other thing that I would say is I really consider myself an educator first, and that is whether I'm working with patients or teaching medical students or other physicians. I think it's really important to educate patients about their illness. I've seen so many patients who come to see me for a second opinion or a consult and it's simply because they don't understand what's been going on or why their psychiatrist has been taking a particular approach. And so really just taking that time to say, "This is what I'm thinking, this is why I'm choosing this medication, this is why I'm recommending this," can really strengthen the patient-physician relationship and improve outcomes.

Dr. Byatt:
I agree. And also engaging them in that process, right? Letting them to know your rationale when there are choices for the patient engaging them in that. I completely agree with you.

Dr. Clayton:
This has been a fascinating conversation, but before we wrap up, can you both share one take-home message for our audience? Dr. Byatt?

Dr. Byatt:
Yeah, I would say that, I think that a lot of times, people during pregnancy in the postpartum period think, "I'm going to ignore my needs because it's going to be best for my baby," and that's just a complete fallacy. The best thing that a pregnant or postpartum individual

can do for them and their baby is to get the mental health treatment and support that they need.

Dr. Payne:
Completely agree. The other thing I would say is that postpartum depression is absolutely treatable, and so not only should you seek help, but seek help with hope, because you can be feeling better and enjoying your time with your new baby quickly. So get help and know that you will get help.

Dr. Clayton:
I think it's also critical for us to individualize the care. You've talked about communicating with patients, but we want to hear back from them what is really important to them; what do they need? We can monitor well using the Edinburgh, and I think we can go from our baseline to get them into remission, which is really, really critical.

Unfortunately, that's all the time we have today. So I want to thank our audience for listening and thank you both, Dr. Byatt and Dr. Payne, for joining me and for sharing all your valuable insights and expertise. It was great speaking with you today.

Dr. Byatt:
Thank you. It was a pleasure to be here and discuss this important topic.

Dr. Payne:
Thank you. I really enjoyed talking with you both.

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