Treatment of Postpartum Depression With Updated Pharmacotherapy

Jennifer Yoon
Lehigh Valley Health Network, jennifer.yoon@lvhn.org

Jason Gu MD
Lehigh Valley Health Network, jason.gu@lvhn.org

Katherine B. Martin MD
katherine_b.martin@lvhn.org

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Treatment of Postpartum Depression With Updated Pharmacotherapy

Jennifer Yoon, BA,[1] Jason Gu, MD[2] and Katherine Martin, MD[2]

[1]University of South Florida Morsani College of Medicine, Tampa, FL, [2]Department of Psychiatry Lehigh Valley Health Network, Allentown, PA

Introduction

Post-partum depression (PPD) is the most common complication of pregnancy.[1] Studies have shown that it can have significant long-term effects on both the mother and her newborn.[2] While early treatment of PPD is key for reducing these outcomes, there are unique challenges in treating this population.

Objective

This report will review a recent case of PPD in which a woman presented with suicidal and homicidal ideation one month after delivery. Using the case as a catalyst, this poster will review updated pharmacotherapy treatment options for PPD.

A change in paradigm considering PPD as a separate entity from MDD may lead to novel pharmacotherapy strategies.

Case

The patient was a 30-year-old female with a history of Major Depressive Disorder (MDD), self-injurious behaviors, and Attention Deficit Hyperactivity Disorder (ADHD). More recently she had been suffering from PPD after the birth of her child one month earlier. She presented to the emergency department with two days of worsening depression along with suicidal and homicidal ideation. Her plan for suicide was to overdose on medications or to stab herself with a knife. Her homicidal thoughts were less specific but were directed toward her husband and child. She denied any recent substance use and was not breastfeeding. Prior to pregnancy, she was treated with vilazodone 40mg daily and aripiprazole 5mg daily with good effect on her mood. She had stopped these medications during her pregnancy, but her mood had managed to remain stable until after her delivery. On account of her symptomatology, she was admitted voluntarily to the inpatient psychiatric unit and diagnosed with MDD, recurrent, severe, without psychotic features. She was restarted back on vilazodone 40mg daily and aripiprazole 5mg daily. Her suicidal and homicidal ideation had resolved by day 3 of admission, and she was able to be discharged home with continued medication management.

Discussion

Recent literature suggests that pathophysiology of PPD within the first eight weeks of childbirth is distinct from that of MDD.[3,4] SSRI's remain a popular and safe choice of pharmacotherapy, but low remission rates demonstrate the need for more diverse treatments. Restarting a pharmacotherapy regimen used in the pre-pregnancy period continues to be an effective plan for treatment of PPD, as in this case. Brexanolone is a new drug that was FDA approved in 2019, although its high cost and required infusion time limits current access. Use of rTMS and omega-3 fatty acid supplements are promising interventions for future study.

Conclusion

Treatment regimens for PPD can be challenging due to the changes in mood and the physiology of a woman adjusting to her new role as a mother. There is a change in paradigm in considering PPD as a separate entity from MDD, which may lead the way to novel pharmacotherapy strategies. Continued research is essential to improving treatment strategies for this population.

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