Q&A: Postpartum depression drug heralds new hope for moms, says physician

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For some new mothers, what should be a joyous time is anything but, due to postpartum depression. Credit: Emily Faith Morgan, University Communications

The Food and Drug Administration announced Friday its approval of the new drug zuranolone for postpartum depression. The once-daily pill,

meant for short-term use, may help those who struggle with the serious, sometimes life-threatening condition.

Mothers with postpartum depression struggle to cope in the weeks following childbirth. In the worst cases, the debilitating mental state can present dangers to both mother and child.

Sage Therapeutics and Biogen will sell the pill under the brand name Zurzuvae. The drug was not approved for patients diagnosed with major depression, which might not be related to maternity and can be more persistent.

Dr. Jennifer Payne, a UVA Health physician who serves in the School of Medicine's Department of Psychiatry and Neurobehavioral Sciences, studies postpartum depression. She spoke to UVA Today about zuranolone's prospects and why she'll be prescribing it.

Q. What is postpartum depression?

A. Postpartum depression is the most common complication of childbirth. It's essentially a major depressive episode that occurs shortly after delivery. It's thought that the hormonal changes that women go through, and the stress of becoming a mother, make it more likely that a woman will experience a depressive episode during this time period.

Q. How common is it, and what's the range of severity?

A. About 13% of women from the general population will develop it. In women with pre-existing mood disorders, such as major depression and bipolar disorder, the rate is 30-50%, particularly in women who stop their medications for pregnancy.

The range of severity is from mild symptoms to really severe cases that can result in suicide, and rarely, infanticide.

Q. Can you give us a few of the basics about zuranolone?

A. Zuranolone is the synthetic version of a natural hormone called allopregnanolone. Levels of allopregnanolone plummet after delivery. Zuranolone essentially increases those levels. The drug helps the brain calm down the stress response and reverse the symptoms of depression.

Q. When will it become available?

A. It will likely be available in November or December, and yes, I'm excited. It's exciting because zuranolone works within days and has a high response rate of about 70%, and a 50% remission rate.

In contrast, standard antidepressants have about a 50% response rate and a 30% remission rate. In addition, you only take the medication for 14 days, which is unheard of in psychiatry.

Q. Is this a better solution to postpartum depression than longer-term drugs?

A. We don't know the answer to that yet. We'll need several years of clinical experience with the drug to answer that question.

Q. What are the listed side effects?

A. The biggest one is sedation, so we will recommend taking it at night. This can work to our advantage in postpartum depression, since a lot of

women with this condition have trouble sleeping. Other side effects include dizziness, diarrhea and fatigue.

Q. Do you have any potential concerns about the drug?

A. My main concern is we will need to see how many women will need re-treatment and when that is most likely to occur.

We also don't know how much it will cost and if insurance will be reluctant to cover the cost initially.

I'm less concerned about over-prescription since less than 50% of cases of postpartum depression actually get identified, and even fewer get treated now. Over-prescription would be preferable.

Q. Who would likely prescribe the drug?

A. The most likely doctor to prescribe it is the woman's obstetrician, since they are most involved in the postpartum time period. If a woman has a psychiatrist, they will likely prescribe as well.

Q. Would best practices require follow up medication or counseling?

A. Ideally, women who develop postpartum depression and get treated with Zuranolone will be followed to see if they respond to the medication and/or need further psychiatric management. Counseling is also ideal, but difficult for many, given the time commitment and the limited numbers of mental health providers.

Q. How likely is it that a patient will receive an initial psychiatric analysis?

A. If she doesn't have a psychiatrist already, it's a low likelihood. Here at UVA, we've started a perinatal mental health clinic, and we are hoping to have a bit of a pipeline for UVA obstetricians to send their patients for psychiatric care.

Q. Does this give women new hope, or should we worry that the problem will be written off with a pill?

A. I think it's incredibly hopeful for a number of reasons. First, it's bringing the problem into the public view and forcing us to think about postpartum depression. As I mentioned, the condition is the most common complication of childbirth, and yet we screen less than half of new mothers for it. In contrast, gestational diabetes affects about 6% of pregnancies, and we screen 99% of women for it. We need to do better, and the availability of this drug will hopefully increase screening.

Second, it's a new mechanism of action for an antidepressant and will likely lead to better antidepressant treatments for all types of depression.

Third, it acts rapidly. You only take the drug for 14 days, which—again—is unheard of in psychiatry.

We will need to think carefully about follow-up and the long-term mental health needs for women with postpartum depression, but this is an exciting time for psychiatry and new mothers with the approval of this drug.

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