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Psychiatric Medications

Refresher for Primary Care Providers

Disclaimer / Conflicts of Interest:
-These are simplified general rules; consult / refer to psychiatrist for tricky cases or questions
-No pharmaceutical company conflicts-of-interest to report

Treatment of Depression:
-1/7 with recurrent depressive illness commits suicide; ask about suicidal thoughts! Higher risk if positive patient history or family history; plan and intent are key; have a crisis plan in place
-screen for bipolar disorder before starting treatment

Picking an antidepressant: use what worked!
-personal history of response, lack of response, side effect profile
-family history of response, lack of response, side effect profile

1. **SSRI's (Selective Serotonin Reuptake Inhibitors)**
    a. Class Notes: first line for both depression and anxiety; black box for suicidality; anxiety and GI side effects common on initiation, generally goes away; sexual side effects common (delayed ejaculation, decreased libido, anorgasmia), does not generally go away; 4 to 6 weeks for full effect of dosage.
    b. Specific SSRI's:
        i. fluoxetine (Prozac): longest acting; activating; dirty - CYP450 2D6 and 3A4 inhibitor; ideal for: patients without concurrent medical issues who tend to forget doses.
        ii. sertraline (Zoloft): favored SSRI for pregnancy and lactation – least amount in breast milk; cleaner – weaker CYP450 2D6 and 3A4 inhibitor; weight gain may be more likely
        iii. citalopram (Celexa): weak CYP450 2D6 inhibitor;
        iv. escitalopram (Lexapro): cleanest SSRI – no significant actions on CYP450; only remaining SSRI without a generic (thus expensive); S-enantiomer of citalopram (citalopram includes R and S enantiomers)
        v. paroxetine (Paxil): shortest acting SSRI, significant withdrawal with missed dose, do NOT use during pregnancy (fetal heart defects);
    c. SSRI augmentation strategies**:** bupropion, buspirone, thyroid hormone (T3 cytomel 50 ug even in euthyroid individuals), atypical antipsychotics, lithium

2. **Atypical Antidepressants:**
    a. Bupropion (Wellbutrin): Norepinephrine and Dopamine; Not effective for anxiety; Activating; Smoking cessation (Zyban); no sexual side effects; good for augmentation with SSRI's; CYP450 2D6 inhibitor; Contraindicated if history of eating disorders or seizures;
    b. Mirtazapine (Remeron): Serotonin and Norepinephrine; antihistaminic – weight gain, drowsiness; less sexual side effects; no CYP450 interactions; think geriatric – helps with poor appetite and insomnia;

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3. **SNRI's (Serotonin and Norepinephrine Reuptake Inhibitors)**
    a. Class Notes: Serotonin and Norepinephrine; Second line for depression and anxiety – more side effects, may be effective for patients who fail SSRI's, generally recommend *replacing* SSRI rather than adding to SSRI; monitor BP; possibly helpful for neuropathic pain;
    b. Specific SNRI's
        i. venlafaxine (Effexor): withdrawal with missed dose; higher risk HTN
        ii. duloxetine (Cymbalta): FDA indication for diabetic neuropathy; rare liver failure;

4. **TCA's (Tricyclic Antidepressants)**
    a. Serotonin and Norepinephrine; e.g. clomipramine (Anafranil), clomipramine (Elavil)
    b. dangerous in overdose, more side effects than SSRI's: (anticholinergic -dry mouth, blurry vision, urinary retention, constipation; antihistaminic - wt gain, sleepiness; antiadrenergic- dizziness, orthostatic hypotension).

5. **MAOI's (Monoamine Oxidase Inhibitors)**
    a. Serotonin, Norepinephrine, Dopamine; e.g. selegiline (Emsam), phenelzine (Nardil)
    b. dangerous in overdose, tyramine dietary requirements, more side effects than SSRI's, can't use with SSRI, need washout period.

6. **Atypical antipsychotics**
    a. Class notes: primarily for schizophrenia; increasingly prescribed for depression augmentation and bipolar disorder mood stabilization; side effects: weight gain, diabetes, hyperlipidemia; QT prolongation (with risk of Torsades de Pointes), EPS (akasthesia, TD (tardive dyskinesia) possible. Generally would not recommend prescribing as PCP's
    b. e.g. olanzapine (Zyprexa) – watch weight gain, diabetes, HL; aripiprazole (Abilify) – watch akasthesia; risperidone (Risperdal) – watch EPS / TD, prolactin levels; ziprasidone (Geodon) – watch QT prolongation; quetiapine (Seroquel) – watch weight gain, drowsiness;

Treatment of Anxiety Disorders:
-first line is SSRI's and Cognitive Behavioral Therapy
-benzodiazepenes: okay for short courses or as occasional PRN; chronic benzodiazepene use is NOT recommended – dependence / addiction/ withdrawal; alprazolam (Xanax) is worst culprit for addiction because short half-life; lorazepam (Ativan) or clonazepam (Klonopin) preferred when necessary.

Treatment of Insomnia:
-Acute: short course of sleep aid and stop within 1-2 weeks once sleep patterns restored.
-Chronic: treat underlying cause (medical issues-obstructive sleep apnea, other sleep disorders; psychiatric issues-depression, bipolar disorder, anxiety, etc)
1. Sleep hygiene can help immensely (regular bedtime, no naps, caffeine/EtOH intake)
2. If longer term sleep aid needed - trazodone 50-100mg qhs PRN - bad anti-depressant but effective sleep aide, generally less addictive than benzodiazepene (estazolam (ProSom), temazepam (Restoril), triazolam (Halcion)) and non-benzodiazpene alternatives (eszopiclone (Lunesta), zalepon (Sonata), zolpidem (Ambien).