Psychiatry Mood Rx Cheats for Primary Care Talk Sep 26/2024 by Adrienne Batke, MD, FRCPC

***PSYCHIATRY FIRST LINERS**, at a glance (per Canadian guidelines)*

Table 3. Treatment of Mild to Moderate Major Depressive Disorder during Pregnancy.

Recommendation	Treatment	Level of Evidence
First line	CBT (individual or group)	Level 1
	IPT (individual or group)	Level 1
Second line	Citalopram, escitalopram, sertraline	Level 3
Third line	Structured exercise, acupuncture (depression specific), bright-light therapy	Level 2
	Bupropion, desvenlafaxine, duloxetine fluoxetine, fluvoxamine, mirtazapine, TCAs (caution with clomipramine), venlafaxine	Level 3 or Level 4
	ECT (for severe, psychotic, or treatment-resistant depression)	Level 3
	Therapist-assisted Internet CBT, mindfulness-based CBT, supportive psychotherapy, couples therapy, psychodynamic psychotherapy, rTMS	Level 4
	Combination SSRI + CBT or IPT	Level 4

For severe major depressive disorder, pharmacotherapies each move up one recommendation line (e.g., second line becomes first line).

Table 5. Current Evidence for Treatment of Perimenopausal Depression.

Recommendation	Treatment	Level of Evidence
First line	Desvenlafaxine	Level 1
	CBT	Level 2
Second line	Transdermal estradiol[a]	Level 2
	Citalopram, duloxetine, escitalopram, mirtazapine, quetiapine XR, venlafaxine XR	Level 3
	Omega-3 fatty acids, fluoxetine, nortriptyline, paroxetine, sertraline	Level 4

Youth Dep

Fluox > escit / sert / cital /

GERI Dep

dulox / mirt / sert / venla / vort/ cit/ desven / escit/

2 nortrip/ fluox / moclo / parox / phenel / Q / traz

Or comb w Ari / methylphen / Li

GAD

venla / escit / sert / parox / pregab/ dulox

Soc

venla / escit / sert / parox / pregab/ fluox / fluv

OCD

escit / sert / parox / fluox / fluv

Panic

venla / escit / sert / parox / fluox / fluv / cit

PTSD

venla / sert / parox / fluox

Bip 2 Dep

1. Q
2. Li / Lam / Bup / ECT / Sert / Venla

Bip 2 Maintenance

1. Q / Li / Lam
2. Venla

Bipolar Mania

Li / Q / V.A. / asen / Arip / pali / risp / cari

Or Combo Li/VA + Ari / risp / asen

Bipolar Dep

1. Q / Lur+LD / Li / Lam/ Lur / + Lam
2. SSRI, bupro / ECT / carip

Bipolar Maintenance

1. Li / Q / D / Lam / As / Q+LD / Ari+LD / Ari / Ari q4
2. carb / pali / Lu+LD

CANMAT 2023 tables

3.4 side-effects

	Nausea	Vomiting	Constipation	Diarrhea	Dry mouth	Headache	Dizziness	Somnolence	Nervousness	Anxiety	Agitation	Insomnia	Fatigue	Sweating	Asthenia	Tremor	Anorexia	Incr. appetite
SSRIs																		
Citalopram	21	4		8	19			17	4	3	2		5	11		8	4	
Escitalopram	15		4	8	7	2	6	4	2	2		8	5	3		2	2	2
Fluoxetine	21				10			13	14	12		16		8	9	10	11	
Fluvoxamine			18	6	26	22	15	26	2	2	16	14		11	5	11	15	
Paroxetine	26	2	14	12	18	18	13	23	5	5	2	13		11	15	8	6	1
Sertraline	26	4	8	18	16	20	12	13	3	3	6	16	11	8		11	3	1
SNRIs																		
Desvenlafaxine[1]	22	3	9	11	11	20	13	4	<1	3	0	9	7	10		2	5	2
Duloxetine	20	5	11	8	15		9	7		3		11	8	6		3	8	
Levomilnacipran	17	5	9		10	17	8			2		6		9			3	
Milnacipran[2]	37	7	16		5	18	10			4		12		9		2	2	
Venlafaxine-IR		6	15	8	22	25	19	23	13	6	2	18		12	12	5	11	
Venlafaxine-XR	31	4	8	8	12	26	20	17	10	2	3	17		14	8	5	8	
Others																		
Agomelatine	≤9	≤9	≤9	≤9		≥10	≤9	≤9		≤9	<1	≤9	≤9	<1			<1	≤9
Bupropion SR[3]	11		≥10	4	≥10	≥10	7	3	5	5		≥10		2	2	3		
Bupropion XL	15	2	10		19		8			5		10		2		4	5	
Mirtazapine			13		25		7								8	2		17
Vilazodone[4]	24	5		29	7	14	8	5				6	3					3
Vortioxetine[5]	23	4	4	5	6		5	3				3	3	2			1	

0-9%
10-29%
30% and higher

Note. When data from multiple doses were reported separately, the data from the minimum therapeutic dose was used (indicated by footnotes). Percentage rates taken from product monographs (based on clinical trial data and not placebo adjusted). Blank squares indicate no data reported. Not included are the side effects shown in Table 3.5 (sedation, weight gain, and sexual dysfunction).
[1]Data from 50 mg dose; [2]data from 50 mg dose; [3]data from 100–150 mg dose; [4]data from 40 mg dose; [5]data from 10 mg dose.

3.5 tolerability

	Efficacy and drug-specific issues[1]					Tolerability issues			
Antidepressant	Efficacy	Acceptability[1]	Drug interactions	Discontin-uation		Sedation	Weight gain	Sexual dysfunction	Other Tolerability[2]
SSRIs									
Citalopram			QTc[3]						
Escitalopram									
Fluoxetine									
Fluvoxamine									
Paroxetine									
Sertraline									
SNRIs									
Desvenlafaxine									
Duloxetine									
Levomilnacipran									
Venlafaxine-XR									
Others									
Bupropion									
Mirtazapine									
Vilazodone									
Vortioxetine									
Not available in Canada									
Agomelatine			LFTs[4]						
Mianserin									
Milnacipran									

More favourable
Less favourable
Neutral[5]

6.1 discontinuing

Line of treatment	Summary recommendations	Level of evidence
First line	• For patients who have achieved symptom remission, using maintenance pharmacotherapy and/or psychotherapy can prevent recurrence.	●
	• All patients treated with antidepressants should continue medication treatment for a minimum of 6 to 12 months after achieving symptomatic remission.	●
	• Patients with risk factors for recurrence (see Table 6.2) should continue antidepressant treatment for 2 years or more.	◐
	• Patients with recurrent and severe MDEs should use sequential treatment (adding psychotherapy after stabilizing on medications) to prevent recurrence.	●
	• When a decision is made to stop the antidepressant, it should be tapered gradually, whenever possible, for several weeks or months with more time between dose reductions near the end of the taper.	◐
	• For patients treated with medication for less than 4 weeks, the antidepressant can be tapered and discontinued quickly, over 2 weeks or less.	◐
	• Psychological treatments can be added before or during antidepressant discontinuation to help patients stop the antidepressant.	◔

● Level 1; ◔ Level 2; ◐ Level 3; ◔ Level 4.

UNIpolar Depression ***SPECIAL PROFILES*** suggested try first, based on evidence and clinical experience

Post menopause = desvanlafaxine

Cognitive sx = vortioxetine, bupropion, SNRI

Fatigue = bupropion

Pain = duloxetine

Insomnia, migraines, diarrhea = nortriptyline

Insomnia, low appetite = mirtazapine

Anhedonia = bupropion, (emerging research) MAOi, emerging research on : ketamine, psilocybin, methylphenidate

Pregnant = es/citalopram, sertraline (no bupro if preeclampsia, no paroxetine, fluox=heart defect)

Breastfeeding = paroxetine, es/citalopram

Comorbid anorexia = aug. w olanzapine

Wary of sexual s-e = bupropion, mirtazapine vortioxetine

Severe w/o psychosis MDE = Meds + Therapy

Very severe/life threatening MDE = ECT

Catatonic/psychotic MDE = ECT

MDE w psychosis classic sx: nilhism (already dead? world not real), poverty/impecunity, somatic (organs rotting)

BIPOLAR :

Bipolar II, not destructive episodes = try lamotrigine first

Fam hx of response to Li or ***crisp episodes*** = Li

Suicidal = Li

w substance = valproic acid

Anxiety = pregabalin, quetiapine, propranolol (in addition to mood stab)

Anxiety & alcohol = gabapentin

w ADHD = bupropion

Pregnant = consult. don't fear if Li, ari, quet, lam (extra folic acid). **Never valproic acid**

NB **Li** qhs for renal protection

ASA 240mg for sexual s-e of **Li**

PSYCHOSIS

Young, very mildly psychotic = aripiprazole DA partial agonist, no rebound psychosis
2,5,10,20,30mg

Severely psychotic = olanzapine 2,5,10,20,30mg

MDD on generous dose AD w partial response at highest dose? ***Augment*:**

- ✓ Stimulant (energy) see CADDRA chart for dosing
- ✓ Li (Suicidal)
- ✓ Bupropion, mirtazapine
- ✓ Antispychotic e.g. ari, quet (psychomot slow, anx, persev)
- ✓ Tiiodothyronine 25mcg

Suicide beh risk highest in +/- 1mo starting Antidep tx

...*consider clonazepam* 0.25mg BID/prn

"I'm optimistic" – Dr (tx hopeless)

"Not a burden" – Fam (tx burden)

When to call a psychiatrist

- Med formerly worked but no longer working ; aug strateg, pure meds Q

When to refer :

Suicidal (do safety plan, close followup)

Dx conundrum

?Bipolar

Perinatal BCwomens.ca/reproductive-mental-health

Psychosis

Think bipolar when:

Psychosis post-partum

++somatic proc

++cog slowing

dep w psychosis

abrupt episode

adolescent dep

Ix

Dep, Anx (at outset) CBC, Fe, A1C, TSH, B12, ext lytes Ca+

ALL bipolar (at outset) CBC, lytes, urea, Cr TSH, liver, lipids, A1C, HOMA IR, prolactin, preg, EKG if >40yo

Valproic acid (q1mo, q3mo, 12mo indef)

cbc (white, platelet), pancreas, ammonia, liver (d/c if transaminase >3x norm)

Recall, lamotrigine lessens OCP effectiveness, OCP decr lam level

Li (qdose change+5d; q3mo, q6mo then q6-12mo indef)

renal (if Cr rises, decr the dose ; consult nephro if Cr >130 mmol/L) TSH, Ca+, EKG

Antipsychotics (q3mo) metabolic (non-fasting), weight, liver, prolactin (if risp, halop)

SSRI (only if geri/risk pop) Na+, platelets

Insulin insensitivity

Tx HOMA-IR >2.0

Emerging evidence for tx'g insulin insensitivity in treatment resistant Bip/Dep

Pharmacogenetic Testing CYP450

Not enough benefit to warrant the cost/delay in tx

Weaning off meds

Unipolar remission <4 on PHQ9

>6-12mo remish + no life stressors

Risk/benefit discussion

Risk of relapse to MDE:

1ep… 50%

2ep… 70%

3ep… 90%

Measurement-based care

Stay on med if:

adverse child experience

residual sx

severe/chronic

For serotonin w/d, consider fluoxetine 10-20mg, clonazepam for comfort.

Bipolar : conservative, maintain indef at lowest effective dose,

target **Li level 0.4-0.6** (and lower for older)