

## General Psychiatry

### Depression

#### Diagnosis by DSM-IV criteria

#### Evaluation tools...

- The HAM-D and Montgomery are for diagnosis, severity and monitoring done by a clinician (50% improvement on the HAM-D is a “response”)
- The Ham-D is the gold standard in FDA approved trials
- The Beck-inventory and Zung evaluates the same as HAM-D but done by the patient

#### Important info on antidepressants

- Usually 6 to 8 weeks for full effect

#### Antidepressant

- look at the drug interaction table

##### 1. TCA's

1. Amitriptyline – most ADRs
2. Desipramine and nortriptyline are the least sedating
3. Can cause orthostasis
4. Can lower seizure threshold
5. They should all be used cautiously in people with cardiac disease

##### 2. MOAIs

1. Phenelzine, isocarboxazid, tranylcypromine
2. CI with OTC decongestants
3. Wait 2 weeks after antidepressants are d/c...fluoxetine you should wait 5 to 6 weeks (t<sub>1/2</sub> 1-4 days)

##### 3. SSRIs

1. Fluvoxamine only approved for OCD, inhibits 1A2, 2C9, 3A4
2. Fluoxetine only one with active metabolite, long t<sub>1/2</sub>, don't really need to taper when d/c
3. Sertraline – no wt gain
4. Paroxetine – most wt gain of SSRI, more sedating, start at 10 mg in elderly or serious liver or kidney disease, inhibits 2d6
5. Citalopram-
6. In early treatment start low dose b/c they can be activating
7. ADR- initial anxiety, gi upset, delayed ejaculation, change in libido (sex dysfxn occurs in 1/3)
8. DI- citalopram least DIs

##### 4. Venlafaxine

1. SNRI
2. Not clear if dual action makes it better than SSRI, good in SSRI non-responders
3. Causes increased BP – only avoid in uncontrolled HTN patients

##### 5. Bupropion

1. Inhibits DA and NE reuptake, minimal 5HT effect
2. Don't use if seizure disorder

##### 6. Mirtazapine

1. prevent NE and 5HT release

2. Sedative
7. Duloxetine
  1. NE/5HT blocker
  2. Watch CYP2D6
  3. May cause liver toxicity
8. Augmentation therapy
  1. Bupropion is used
  2. Lithium- helps in up to 60% of treatment resistant people, helps in 48 hrs,
  3. Levothyroxine – helps 25% of people, more of the T4 effect at 25 mcg/day, barely used though
9. Sexual dysfunction – most worsen it, mirtazipine and bupropion have the lowest incidence
10. Using these agents
  1. 3 phases of treatment
    - i. Acute phase – 6to 12 weeks, help resolve the symptoms
    - ii. Continuation – 6-12 months, keep symptoms in remission
    - iii. Maintenance- long-term for people who are high risk for relapse (hx of depression, + FH\_
  2. Wait 6-8 wks maybe even 12 before considering something a failure
  3. If a pt fails, try another class
  4. Treatment resistance – 2 or more drugs from different classes were ineffective at that time t/c ECT, augmentation or combo therapy

Agents	What it inhibits
Fluoxetine	Potent 2D6, 3A4, moderate 2C9, 2C19, mild 1A2
Sertraline	Mod-potent 3A4, mild 1A2, 2D6,2C19, 2C9
Paroxetine	Potent 2D6, mild 2D6, 2C19, 1A2
Fluvoxamine	Potent 1A2, 2C19, moder 2C9
Citalopram	1A2 mild
Escitalopram	Mild-mod 2D6
Bupropion	No real problems
Venlafaxine	No real problems
Duloxetine	Moderate 2D6
Mirtazipine	No real issues

Bipolar disorder

Bipolar 1: one or manic or mixed episode, usually includes major depression

- mania – at least 1 full wk of abnormal persistently elevated mood, inflated self-esteem, no need for sleep, flight of ideas, poor

attention

Bipolar 2: one or more major depressive with at least one hypomanic episode

Rapid cyclers have 4 or more episodes per year

1. Lithium – good for manic depressive components

1. Takes 1-2 weeks to work (use antipsychotics +/- bdz's short-term)
2. 95% excreted unchanged in the urine
  - i. 70-80% in the proximal tubules and some in loop of Henle
  - ii. Proximal reabsorption is competitive with Na<sup>+</sup> (so dehydration, sodium restriction, thiazides can increase Li<sup>+</sup> levels)
  - iii. Anything that effects the GFR can effect Li<sup>+</sup> concentrations
3. Drug levels – wait 5-6 days for steady state levels
  - i. Usually goal for mania is 0.8 – 1.6
  - ii. Check the level 12 hours post the last dose
4. What to check
  - i. Prior to starting: CBC, electrolytes, Scr, thyroid, UA and ECG
  - ii. UA, thyroid fxn, SCr q6-12 months
5. ADR's and what to do
  - i. Rash- stop temp or permanently
  - ii. Tremor -   dose or add BB
  - iii. Agitation. Confusion -   dose
  - iv. N/V/D- try extended release or   dose
  - v. Hypothyroidism – stop or start levothyroxine
  - vi. Polydypsia/polyuria -   dose. Try amiloride or HCTZ (remember HCTZ will   Lithium [ ])
    1. Li<sup>+</sup> block ADH – cant concentrate your urine
  - vii. Avoid in 1<sup>st</sup> trimester if possible
  - viii. Cardiac – check ECG in people over 50 or w/ heart disease, may cause arrhythmias

2. VPA

1. Good as lithium for acute and px mgmt
2. Best for rapid-cyclers
3. Desired concentration is 45-125 mcg/ml

3. CBZ

1. Good for acute and mantanence (equetro)
2. Monitor CBC, check troughs
3. DI: autoinduction in 2-4 wks, induces 3a3 and 3a4

4. Lamotrigine

1. Start low if VPA on broad, special instructions for dosing it the PI
2. Watch for rash

5. Antipsychotics

1. Use when waiting for above drugs to kick in for agitation and anxiety
2. The atypicals except clozapine are approved

6. BDZ – lorazepam and diazepam

Schizophrenia

1. positive sx: hallucinatins, delusion, disorganized speech or behavios
2. negative sx: alogia, flat affect, poor attention

### 3. How to manage (+ = degree of EPS)

#### 1. Typical antipsychotics

- i. Conventional phenothiazines (fluphenazine (+++), trifluoperazine, thioridazine (+))
- ii. Butyrophenone: haloperidol (+++, IM deconate available)
- iii. Others: thiothixene (+++), molindone (+), loxapine
- iv. Remember the more EPS the less anticholinergic, sedating properties
- v. ADR:
  1. Parkinsonism: can treat with anticholinergics diphenhydramine, benztropine
  2. dyskinesia: muscle spasms- use anticholinergics
  3. Akathisia: restlessness: lipophilic BB, anticholinergics may help
  4. TD: only happens 6 months after tx initiated, vitamin e may help, can still occur after drug stopped in some
  5. NMS- some serious stuff, see fever, HR, sweating, labile BP – supportive care, bromocriptine or dantrolene have worked
  6. Endo
    1. DM: most with olanzapine and clozapine
    2. Menstrual irregularities – blocking DA prevents prolactin from being secreted

#### 2. Atypical antipsychotics

- i. Clozapine (0 EPS)
  1. good for tx resistant
  2. agranulocytosis: CI if WBC < 3500, 1-2% risk, occurs in 4-6 months of therapy. Therefore qwk CBC x 6 mo then q2wk after. Then qmo if WBC > 3500 and AMC > 200. STOP tx if WBC < 3000
  3. anticholinergic, sedating and causes orthostatic hypotension
- ii. Ziprasidone (0/+)
  1. may cause less wt gain, QT, in the PI, all can probably do it though
- iii. Olanzapine (0/+)
  1. just like clozapine just not issues with WBC, can give parenterally for acute agitation
- iv. Quetiapine (0/+)
  1. preferred if psychosis in someone with parkinson's
- v. Risperidone (+)
  1. Consta (IM injection that lasts 2 weeks), must keep on po for 3 weeks if changing therapy
  2. EPS possible, no difference vs. placebo for up to 6 mg/day
- vi. Aripiprazole (0/+)
  1. low risk of EPS

#### 3. Adjunct therapy

- i. Lithium
- ii. Anticonvulsants
- iii. BDZ – in the acute phase

### Anxiety

1. Generalized anxiety – 6 mo. Or more of excessive worry/anxiety
  1. BDZ, short-term till other agent begins to work
  2. SSRI, TCA
  3. Buspirone- take 2 to 4 weeks
2. Panic- usually cause not know, can lead to agoraphobia( the fear or avoidance of certain situations)
  1. BDZ can help prevent attacks
  2. SSRI

3. NO buspirone
3. OCD –SSRI and clomipramine
4. PTSD – sertraline
5. Social anxiety – SSRI
6. Agents
  1. BDZ
    - i. short t<sub>1/2</sub> = high potency: alprazolam, lorazepam
    - ii. long t<sub>1/2</sub> = low potency: chlordiazepoxide, diazepam, oxazepam
    - iii. tolerance develops for hypnotic effect
    - iv. dependence can occur in weeks to months
  2. Antidepressants
    - i. TCA
    - ii. SSRI
    - iii. Venlafaxine for GAD, PD
    - iv. \*\*\*remember pt can get anxious when they started them, so don't be confused that you are worsening things.
  3. Buspirone- good for GAD bad for PD, takes wk to work
  4. BB- for peripheral sx
  5. MAOI: panic with atypical depression

#### Insomnia

1. cannot initiate or maintain sleep
2. Avoid agents that depress RR in pts with OSA, resp disorder or substance abuse, zolpidem or remelteon maybe ok
3. BDZ – for sleep: triazolam (short acting – good to get to sleep), temazepam, estazolam (intermediate – good for staying asleep), flurazepam, quazepam (long acting)
4. Zolpidem – use lower dose in pts with kidney or renal dysfunction: helps you stay asleep
5. Zaleplon – helps get you to sleep, t<sub>1/2</sub> 1 hr, therefore should avoid hangover feeling
6. Esopiclone: t<sub>1/2</sub> 6 hrs

#### Substance abuse

1. Alcohol
  1. DT's will develop 3-5 days after discontinuation
  2. DT prevention
    - i. Intermittent dosing- need to be in a good setting for this to work, give prn, then schedule
    - ii. Scheduled: start regular and then taper
    - iii. Front loading- give a lot of diazepam 10 to 20 mg q1-2 hrs until withdrawal sx are removed
    - iv. Use lorazepam, diazepam (lower dose in liver disease) or chlordiazepoxide – caution if liver disease
  3. Nutritional stuff
    - i. Thiamine – px Wernicke-Korsakoff 100 mg thiamine IV or IM, then po, if you give po first the patients are so depleted that they will only receive ~ 1 mg of the thiamine
    - ii. Mg – give if needed
    - iii. Vitamins – usually malnourished, not a bad idea
    - iv. Haldol if BDZ ineffective with hallucinations
  4. Chronic management
    - i. Disulfiram – not really effective
    - ii. Acamprosate: reduces craving
    - iii. Naltrexone: reduces craving

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