Pharmacotherapy of Major Depressive Disorder
OSU College of Pharmacy-Psychiatric Module
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Learning objectives
- Identify signs and symptoms of major depressive disorder (MDD)
- Recommend appropriate treatment, including the rationale for treatment selection, given a patient with MDD
- Develop appropriate monitoring parameters for pharmacological efficacy and toxicity
- Predict and prevent potential drug-drug interactions
- Provide appropriate patient education regarding the treatment of MDD and the different treatment options available

Outline
- Epidemiology
- Etiology/Pathophysiology
- Risk Factors/Diagnosis/Subtypes
- Treatment Options
  - Pros/cons of each
  - Class Adverse Effects (AE)
- Treatment Period
- Treatment Resistance

Epidemiology
- ~16% lifetime and ~7% 12-month prevalence
- In any year, 13 to 14 million Americans are depressed
  - ~22% treated adequately
  - High rate of recurrence
- 4.4% of the total overall global disease burden
  - Comparable to ischemic heart disease
- Annually, ~$31 billion lost in productivity

Depression and physical symptoms

Suicide and depression
- 40 to 50 thousand Americans die annually because of suicide
  - ~18 suicide attempts for every suicide
  - Up to 15% of individuals with severe MDD die by suicide
  - Rule of Seven
    - 1/7 with recurrent depressive illness commits suicide
    - 70% of suicides have depressive illness
    - 70% of suicides see their primary care physician within 6 weeks of suicide
  - Suicide is the 7th leading cause of death in the US

Resources:
- Arch Fam Med. 1994;3:774-779
- Arch Psychiatry. 1985;42:496-475
Etiology

- Exact cause of depression is not known
  - Can not be totally explained by a single social, developmental, or biologic theory
- Several factors appear to work together to cause/precipitate depressive disorder
- Symptoms of patients with major depression consistently reflect changes in brain monoamine neurotransmitters (NT) and their receptors
  - Specifically: serotonin, norepinephrine and dopamine

Pathophysiology

Risk factors

- Sex
- Personal/family history
- Co-morbid medical or substance related disorder
- Marital status
- Postpartum
- Psychosocial events or stress
  - Negative life events
  - Early parental death

Differential diagnosis

- Physical exam
- Mental status exam
- Basic laboratory
  - CBC, TSH, electrolytes
- Medication
  - β-Blockers (?), reserpine, steroids, interferon
- Substance abuse

Diagnostic criteria

- Five (or more) of the following symptoms within the past 2 weeks
  - Depression
  - Sleep (↑ or ↓)
  - Interest (↓)
  - Guilt
  - Energy (↓)
  - Concentration (↓)
  - Appetite (↑ or ↓)
  - Psychomotor changes (↑ or ↓)
  - Suicidality
Depression subtypes

- Psychotic
- Melancholic
  - Anhedonia, mood worse in the AM, early AM awakening, psychomotor disturbance, excessive guilt, weight loss
- Atypical or vegetative
  - Mood reactivity, hypersomnia, hyperphagia, weight gain, lethargy, agitation, leaden paralysis, rejection sensitivity
- Seasonal affective disorder (SAD)

Rating scales: clinician administered

- Hamilton Rating Scale for Depression (HAM-D)
  - 17 item scale, rated on either a 0 to 4 spectrum or a 0 to 2 spectrum
  - Interpretation of results
    - 8-13: mild
    - 14-18: moderate
    - 19-22: severe
    - >23: very severe
  - Gold standard
- Montgomery-Asberg Depression Rating Scale (MADRS)
  - 10 items scale, rated on a 0 to 6 spectrum
  - Interpretation of results
    - 15: mild
    - 25: moderate
    - 31: severe
    - 44: very severe

Rating scales: self administered

- Beck Depression Inventory
  - 21 item scale, rated on a 0 to 4 spectrum
  - Interpretation of results
    - 10-18: mild to moderate
    - 19-29: moderate to severe
    - >30: severe
  - Gold standard
- Zung self-rating depression scale
  - 20 item scale, rated on a 0 to 4 spectrum
  - Interpretation of results
    - 50-59: mild
    - 60-69: moderate
    - ≥70: severe

Treatment Options: Non-pharmacologic therapy

- Healthy diet and exercise
- Psychotherapy
- Light therapy
- Electroconvulsive therapy (ECT)
- Others
  - Repetitive transcranial magnetic stimulation (rTMS)
  - Deep Brain Stimulation (DBS)
  - Vagus Nerve Stimulation (VNS)

Treatment Options: Pharmacologic therapy

- Monoamine oxidase inhibitors (MAOI)
- Tricyclic antidepressants (TCA)
- Selective serotonin reuptake inhibitors (SSRI)
- Serotonin norepinephrine reuptake inhibitors (SNRI)
  - Venlafaxine, desvenlafaxine, and duloxetine
- Norepinephrine dopamine reuptake inhibitor
  - Bupropion
- Alpha 2 antagonist/selective serotonin receptor antagonist
  - Mirtazapine
- Serotonin antagonist reuptake inhibitor
  - Trazodone and nefazodone
Pharmacologic Therapy

All antidepressants are equally efficacious

AND

~50% of patients will respond to an initial antidepressant trial

Rational basis for antidepressant selection

- History of prior response
  - Patient history
  - Family history of preferential response
- Identify specific target symptoms
- Consider concomitant disease states
  - Comorbid psychiatric symptoms
- Adverse effects
- Drug-drug interactions
- Cost

MAOIs - MOA

MAO inhibitor tells the enzyme to stop destroying NT

Increase in NT causes receptors to down-regulate


MAOIs

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial Dose (mg/d)</th>
<th>Maximum Dose (mg/d)</th>
<th>Recommended Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classical MAO inhibitors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenelzine (Nardil®)</td>
<td>45-60</td>
<td>90-120</td>
<td>QD-TID</td>
</tr>
<tr>
<td>Tranylcypromine (Parnate®)</td>
<td>30-40</td>
<td>60-80</td>
<td>QD-TID</td>
</tr>
<tr>
<td>Isocarboxazid (Marplan®)</td>
<td>20</td>
<td>40-60</td>
<td>BID-QID</td>
</tr>
<tr>
<td>Reversible inhibitors of MAO A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selegiline (Eldepryl®, ODTSelapa®, Zelapar®)</td>
<td>Not used as an antidepressant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moclobemide (Aurorix®)</td>
<td>Not available in US</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective inhibitors of MAO B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BID-QID 60-80 20 45-60</td>
<td></td>
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</tr>
</tbody>
</table>

Dietary Restrictions: Tyramine

- Tyramine in the diet releases NE and other sympathomimetic amines
  - Irreversibly inhibiting MAO causes the levels of these amines to rise to a dangerous level
- Hypertensive crisis
  - Blood pressure soars
    - Can lead blood vessels to rupture in the brain
  - Headache, palpitation, and neck stiffness
- Foods that contain tyramine
  - Aged cheese, yeast products, aged meats, chicken/beef liver, fava beans, draft/tapped beer

Drug Interactions

- Antidepressants

- Analgesics
  - Tramadol, methadone, propoxyphene
- Antitussive dextromethorphan
- Other
  - Meperidine, cyclobenzaprine, buspirone, St. John’s wort
  - Carbamazepine and oxcarbazepine

Not inclusive

Switching to/from MAOI

- At least 1 week should elapse after stopping contraindicated drug before starting therapy with MAOI
  - 5 weeks for fluoxetine
- At least 2 weeks should elapse after stopping MAOI before starting therapy with contraindicated drug

MAOIs

- Pearls
  - Low anticholinergic AE
  - Effective in treatment-resistant and atypical depression
  - Minimal effects on seizure threshold

- Limitations
  - Dietary restrictions
  - Drug-drug interactions
  - Moderate to severe orthostasis, insomnia, sexual dysfunction, and weight gain
  - Divided daily dosing

TCAs - MOA

- TCAs are 5 or more drugs in one
  - A serotonin reuptake inhibitor
  - A norepinephrine reuptake inhibitor
  - An anticholinergic-antimuscarinic drug
  - An α₁-adrenergic antagonist
  - An antihistamine
  - At high doses can inhibit sodium channels

Class Adverse Effects of TCAs

- Common
  - Sedation, cognitive impairment
  - Dry mouth, constipation, dizziness, blurred vision
  - Weight gain
  - Orthostatic hypotension (α₁ blockage)
  - Sexual dysfunction
- Rare
  - Arrhythmias/tachycardia
  - Heart conduction problems
TCAs

- Pearls
  - Inexpensive
  - Sedative effects may be beneficial for insomnia
  - Effective in chronic pain syndromes and migraine

- Limitations
  - Moderate to high sedation
  - Weight gain
  - Anticholinergic AE
  - Orthostasis
  - Dose titration required
  - Narrow therapeutic indices
  - Significant drug interactions
  - Fatal in overdose (cardiovascular effects and seizure)

SSRIs - MOA

**Antidepressant blocks the reuptake pump, causing more NT to be in the synapse**

**Increase in NT causes receptors to down-regulate**

Fluoxetine (Prozac®)

- **Dose**
  - Initial: 5-20mg/day
  - Maintenance: 20-60mg/day
  - Max: 80mg/day
- **Half-life**
  - Parent: 48-72 hours
  - Active metabolite: 4-16 days
- **Formulation**
  - Sarafem® - PMDD
  - Symbyax® (fluoxetine/olanzapine) – Bipolar Depression
  - Prozac Weekly

**Fluoxetine (Prozac®) cont’d**

- FDA indications: MDD, OCD, bulimia & PMDD
- Pearls
  - Long half-life
  - Hypersonnia/vegetative
- Limitations
  - May increase psychomotor agitation, anxiety and insomnia

Sertraline (Zoloft®)

- **Dose**
  - Initial: 25-50mg/day
  - Maintenance: 100-150mg/day
  - Max: 200mg/day
- **Half-life**
  - Parent: 24-26 hours
  - Active metabolite: 66 hours
- **FDA indication:** MDD, panic, OCD, social anxiety, PTSD and PMDD

**Sertraline (Zoloft®) cont’d**

- Pearls
  - No significant drug interactions (weak 2D6 inhibitor)
- Limitations
  - Higher incidence of diarrhea/GI symptoms
  - Increase in anxiety, insomnia and psychomotor agitation
  - Dose titration
Paroxetine (Paxil®)

- **Dose**
  - Initial: 10-20mg/day
  - Maintenance: 15-50mg/day
  - Max: 60mg/day
- **Half-life**
  - Parent: 21 hours
  - Active metabolite: NA
- **Formulations**
  - Paxil CR®
  - Pexeva (paroxetine mesylate)
- **FDA indication:** MDD, GAD, panic, OCD, social anxiety, PTSD & PMDD

Paroxetine (Paxil®) cont’d

- **Pearls**
  - Low incidence of agitation/anxiety
- **Limitations**
  - Mild anticholinergic properties
  - Inhibits 2D6
  - Sexual dysfunction
  - Avoid in pregnancy and children
  - Withdrawal syndrome

Fluvoxamine (Luvox® & Luvox XR®)

- **Dose**
  - Initial: 25-100mg/day
  - Maintenance: 75-300mg/day
  - Max: 300mg/day
- **Half-life**
  - Parent: 15 hours
  - Active metabolite: NA
- **FDA indication:** OCD, SP and OCD

Fluvoxamine cont’d

- **Pearls**
  - Anti-anxiety activity
- **Limitations**
  - Not FDA approved for MDD
  - Dosed twice daily, titration required
  - Increased GI complaints
  - Withdrawal syndrome
  - Inhibits 1A2, 3A4 and 2C19

Citalopram (Celexa®)

- **Dose**
  - Initial: 10-20mg/day
  - Maintenance: 20-40mg/day
  - Max: 60mg/day
- **Half-life**
  - Parent: 35 hours
  - Active metabolite: NA
- **FDA indications:** MDD

Citalopram (Celexa®) cont’d

- **Pearls**
  - Well tolerated in the elderly
  - No significant drug interactions
  - Less GI SE
- **Limitations**
  - Pure SSRI
**Escitalopram (Lexapro®)**

- **Dose**
  - Initial: 5-10mg/day
  - Maintenance: 10-20mg/day
  - Max: 20mg/day
  - 10mg escitalopram = 20-40mg citalopram
- **Half-life**
  - Parent: 35 hours
  - Active metabolite: NA
- **FDA indications**: MDD and GAD

**Pearls**

- Well tolerated in the elderly
- No significant drug interactions
- Less dose titration
- Less GI side effects

**Limitations**

- Pure SSRI
- Cost

**Common Adverse Effects of SSRIs**

- Sleep problems
- Anxiety or nervousness
- Gastrointestinal
  - Nausea/diarrhea
- Change in sexual ability or desire

- Side effects usually abate in a few weeks

**Intermission**

**Venlafaxine (Effexor®)**

- **Dose**
  - Initial: 75mg/day ← IR: BID to TID, XR: QD
  - Maintenance: 75-225mg/day
  - Max: IR 375mg/day, XR 225mg/day ← many clinicians disregard this arbitrary restriction
- **Half-life**
  - Parent: 3-7 hours
  - Active metabolite: 10 hours
- **FDA indications**: MDD, GAD, panic, and social anxiety

**Rare AE of SSRIs**

- Extrapyramidal SE
  - Bruxism, akathisia, restless leg syndrome, etc.
- Excessive sweating
- Hemostasis
  - Bleeding problems
- Syndrome of inappropriate secretion of ADH (SIADH)
  - Hyponatremia

**Venlafaxine (Effexor®)**

- **Pearls**
  - Low potential for drug interactions (mild 2D6 inhibitor)
- **Limitations**
  - Dose titration required
  - GI side effects
  - Modest ↑ in blood pressure
  - Serotonin withdrawal effects
  - Adjust dose in pt w/ hepatic and renal impairment
  - May be more dangerous in overdose
- **Cost**

**Desvenlafaxine (Pristiq®)**

- **Dose**
  - Initial: 50 mg/day
  - Maintenance: 50 mg/day
  - Max: 100 mg/day
- **Half-life**
  - Parent: 11 hrs
- **FDA indications**: MDD

**Duloxetine (Cymbalta®)**

- **Dose**
  - Initial: 20-60mg/day
  - Maintenance: 40-60mg/day
  - Max: 120mg/day
- **Half-life**
  - Parent: 11-16 hours
  - Active metabolite: NA
- **FDA indications**: MDD, GAD & neuropathic pain

**Desvenlafaxine (Pristiq®)**

- **Pearls**
  - Once daily dosing
  - No dose titration required
  - No additional benefit, but inc. AE
- **Limitations**
  - No studies evaluating long-term efficacy
  - GI side effects
  - Sustained ↑ in blood pressure at all doses
  - Serotonin withdrawal effects
  - Adjust dose in pts w/ severe renal impairment
  - May be more dangerous in overdose
- **Cost**

**Duloxetine (Cymbalta®)**

- **Pearls**
  - Effective in chronic pain syndrome
  - Less dose titration
- **Limitations**
  - Avoid in hepatic insufficiency
  - Adjust dose in pt w/ renal impairment
  - GI side effects (nausea)
  - Inhibits (moderately) 2D6
  - Serotonin withdrawal effects
  - Cost
Bupropion (Wellbutrin®)

- **Dose**
  - Initial: 75mg BID (IR), 150mg/day (SR)
  - Maintenance: 100mg TID (IR), 150mg BID (SR)
  - Max: 400mg/day (SR), 450mg/day (IR & XL)
    - IR Not >150mg/dose
    - SR Not >200mg/dose
    - XL Not >450mg/dose

- **Half-life**
  - Parent: 14 hours
  - Active metabolite: 20-37 hours
- **FDA indications:** MDD, SAD, smoking cessation assistance (Zyban®)

- **Pearls**
  - Stimulating antidepressant
  - Useful for ADHD
  - Less sexual side effects
  - Weight loss
  - No known withdrawal but should be tapered down for d/c

- **Limitations**
  - Avoid in patients with:
    - Seizure disorder
    - Prior or current diagnosis of bulimia or anorexia
    - Undergoing abrupt discontinuation of alcohol or sedatives (including benzodiazepines)
  - No effect on anxiety
  - Inhibits 2D6
  - May affect sleep ← IR dose before 6pm, SR dose before 4pm
  - Dose titration required
  - Adjust dose in pt w/ hepatic impairment

Mirtazapine (Remeron®)

- **Dose**
  - Initial: 7.5-15mg QHS
  - Maintenance: 15-45mg/day
  - Max: 45mg/day
  - Half-life
    - Active metabolite: 25 hours
    - Parent: 20-40 hours

- **Pearls**
  - Less sexual dysfunction
  - Low potential for drug interactions

- **Limitations**
  - Histaminic properties - moderate to high sedation, esp. at lower doses ← good for pt with melancholic depression
  - Weight gain
  - Agranulocytosis, neutropenia (rare)

Trazodone (Desyrel®)

- **Dose**
  - Initial:
    - Depression: 150mg/day in divided doses
    - Insomnia: 12.5-50mg QHS
  - Maintenance: 100-300mg/day
  - Max: 400mg/day
  - Half-life
    - Parent: 7 hours
    - Active metabolite: 4-9 hours

- **FDA indications:** MDD

- **Limitations**
  - Histaminic properties - moderate to high sedation, esp. at lower doses ← good for pt with melancholic depression
  - Weight gain
  - Agranulocytosis, neutropenia (rare)
Trazodone (Desyrel®)

- **Pearls**
  - Add on to other antidepressants for insomnia
  - Earlier onset of anxiolytic action
  - Inexpensive

- **Limitations**
  - Daytime sedation/hangover effect
  - Mild to moderate orthostasis
  - Divided daily dosing preferred
  - Not well tolerated at higher doses
  - Priapism risk may be higher during the 1st mo of tx at <150mg/day
  - Avoid in the initial recovery phase of MI

Nefazodone (Serzone®)

- **Dose**
  - Initial: 50-200mg/day
  - Maintenance: 300-500mg/day
  - Max: 600mg/day

- **Half-life**
  - Parent: 2-4 hours
  - Active metabolite: 2-33 hours

- **FDA indications:** MDD

- **Brand name withdrawn form the market**

Herbal supplements - St. John’s Wort

- **MOA:** SRI

- **Dosing:** 300mg TID
  - Standardized to contain 0.3% to 0.5% hypericin and/or 3% to 5% hyperforin/dose

- **Adverse effects:** similar to SSRIs, drowsiness, photosensitivity, and ↑ hepatic transaminases

- **Contraindicated in pregnancy**

- **Drug interactions:** may induce 2C9, 3A4, 2D6 and 1A2
  - Probable interactions with indinavir, cyclosporine and ↓ estrogen levels in individuals taking oral contraceptives

Outline

- **Epidemiology**
- **Etiology/Pathophysiology**
- **Subtypes/Risk Factors/Diagnosis**
- **Treatment Options**
  - Pros/cons of each
  - Class AE
- **Treatment Period**
- **Treatment Resistance**

Increase in suicidal thoughts

- Antidepressants ↑ the risk of suicidal thinking and behavior in children, adolescents and young adults ages 18-24 years old during initial treatment (generally the first one to two months).

- Anyone considering the use of antidepressant in this patient population must balance this risk with the clinical need.

- Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

- Families and caregivers should be advised of the need for close observation and communication with the prescriber.
Increase in suicidal thoughts

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>2.22 (1.40–3.56)</td>
</tr>
<tr>
<td>18–24 yr</td>
<td>1.55 (0.91–2.70)</td>
</tr>
<tr>
<td>25–30 yr</td>
<td>1.02 (0.69–1.51)</td>
</tr>
<tr>
<td>31–40 yr</td>
<td>0.77 (0.46–1.30)</td>
</tr>
<tr>
<td>≥60 yr</td>
<td>0.29 (0.18–0.79)</td>
</tr>
<tr>
<td>All adults</td>
<td>0.84 (0.63–1.10)</td>
</tr>
</tbody>
</table>

Antidepressant induced sexual dysfunction

- Types of sexual dysfunction
  - Anorgasmia, erectile dysfunction, decreased libido, vaginal and penile anesthesia
- Treatment
  - Reduce antidepressant dose
  - Drug holiday
  - Adjunctive pharmacotherapy
  - Switch antidepressants

Drug induced serotonin syndrome

<table>
<thead>
<tr>
<th>Serotonergic effect</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑ Serotonin synthesis</td>
<td>L-tryptophan</td>
</tr>
<tr>
<td>↓ Serotonin metabolism</td>
<td>MAO-I, linezolid (Zyvox®)</td>
</tr>
<tr>
<td>↓ Serotonin uptake</td>
<td>TCA, SSRI, nefazodone, trazodone, venlafaxine, amphetamines, cocaine, dextromethorphan, meperidine</td>
</tr>
<tr>
<td>Direct serotonin receptor agonists</td>
<td>Buspirone, LSD, triptans</td>
</tr>
<tr>
<td>Nonspecific ↑ in serotonin activity</td>
<td>Lithium</td>
</tr>
</tbody>
</table>

Serotonin syndrome

- Mnemonic FLUSH
  - Flu-like ⇒ fatigue, myalgia, loose stools, nausea
  - Lightheadedness/dizziness
  - Uneasiness/restlessness
  - Sleep and sensory disturbances
  - Headache
- Treatment
  - Restart the antidepressant
  - Taper dose down to D/C
Treatment response

- **1st week**
  - Improve sleep, appetite and energy

- **1-3 weeks**
  - ↑ activity, sex drive, self care and concentration

- **2-4 weeks**
  - ↑ mood, ↓ anxiety, and ↓ hopelessness

- **4-6 weeks**
  - Full response

Treatment Phases

- **NORMAL MOOD**
- **DEPRESSION**
- **REMISSION**
- **RECOVERY**

- **TIME**
  - acute 6 - 12 weeks
  - continuation 4-6 months
  - maintenance 1 or more years

Treatment duration

<table>
<thead>
<tr>
<th>Number of depressive episodes</th>
<th>Chance of getting new episode without treatment</th>
<th>Recommended duration of treatment after remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>60%</td>
<td>&gt; 6 months</td>
</tr>
<tr>
<td>2</td>
<td>70%</td>
<td>&gt; 1 year</td>
</tr>
<tr>
<td>3</td>
<td>90%</td>
<td>Indefinitely</td>
</tr>
</tbody>
</table>

Treatment Resistant Depression (TRD)
Staging TRD

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Inadequate response to 1 monotherapy</td>
</tr>
<tr>
<td>II</td>
<td>Inadequate response to 2 adequate monotherapy trials (different classes)</td>
</tr>
<tr>
<td>III</td>
<td>Stage II resistance plus inadequate response to 1 augmentation trial</td>
</tr>
<tr>
<td>IV</td>
<td>Stage III resistance plus inadequate response to a second augmentation</td>
</tr>
<tr>
<td>V</td>
<td>Stage IV resistance plus inadequate response to bilateral ECT</td>
</tr>
</tbody>
</table>

Treatment of TRD

- Optimizing antidepressant
- Switching therapies
- Augmenting or combining therapies

Treatment resistant – augmentation

- Thyroid Supplementation – T3 (liothyronine)
  - May produce a rapid response
  - Pt with sub-clinical hypothyroidism may respond better
  - Well tolerated
- Lithium
  - May produce a rapid response
  - Risk of toxicity

Treatment resistant – augmentation cont’d

- Stimulants (methylphenidate)
  - Rapid onset of action
  - Abuse potential
  - May worsen anxiety and irritability
- Anticonvulsants (valproic acid, carbamazepine)
  - Potential tolerability problems
- Antipsychotics (aripiprazole*, olanzapine, risperidone, etc.)
  - May help manage anxiety and agitation
  - Potential tolerability problems

Aripiprazole (Abilify®)

- Dose
  - Initial: 2.5 mg/day
  - Maintenance: 5-10 mg/day
  - Max: 15 mg/day
- FDA indication:
  - Adjunct to antidepressant for MDD

Aripiprazole (Abilify®)

- Pearls
  - Weight neutral
  - Not associated w/ inc. blood sugars or lipids
- Limitations
  - No studies evaluating long-term efficacy
  - May cause akathisia/restlessness
  - Dose adjustments required for pts taking potent 3A4 or 2D6 inhibitors or 3A4 inducers
  - Cost
Case

- JJ is a 52 y/o WF who complains of low mood, feeling hopeless and helpless, along with ↓ energy, motivation, concentration, and difficulty falling and staying asleep. Pt also states she cannot stop worrying. Pt has never been treated with any psychotropic medications.

Case cont’d

- Based on the patient’s current symptoms, what medication(s) would you suggest?
- Adjunctive therapy if warranted?
- How would you initiate therapy (dose and titration)?
- What medication counseling would you provide to the patient?

Any Questions?