

Choosing an antidepressant for special patient groups

The appropriateness of individual drugs in individual circumstances will vary. Consulting a specialised drug information service may be necessary. Carefully review all medications and consider potential interactions before prescribing.

Patient group	General issues and concerns	Selective serotonin reuptake inhibitors (SSRIs)	Tricyclic antidepressants (TCAs)	Other antidepressants										
Suicidal patient	<p>Refer patients with high or immediate suicide risk. If risk is difficult to assess, consider consequences of overdose.</p> <p>Prescribing points</p> <p>Consider toxicity in overdose (and the availability of other prescribed drugs) when choosing the antidepressant. Limit quantities and repeats.</p> <p>Combinations of antidepressants are more lethal in overdose and are not recommended.¹</p>	<p>Relatively safe in overdose, but limit the quantity dispensed.</p>	<p>Most toxic in overdose—avoid use in people with high suicide risk.</p>	<p>MAOIs are toxic in overdose—avoid use.</p> <p>Reboxetine, mirtazapine, mianserin and moclobemide are relatively safe in overdose—venlafaxine is relatively more toxic than these in overdose.²</p>										
Adolescents and children <small>(See ADRAC 2004 statement, Box 1, page 1, NPS News 35.)</small>	<p>Regardless of therapy chosen, monitor suicidal ideation—suicide risk is high in this age group.</p> <p>Prescribing points</p> <p>Psychological therapy is first-line.³ CBT has evidence of benefit for mild or moderate depressive disorder.⁴</p> <p>If SSRIs are considered necessary, the patient should be monitored closely and supervision by a child psychiatrist is suggested.²</p>	<p>In Australia none of the SSRIs is approved for paediatric major depression, but off-label use occurs. If used, start with lower doses.</p> <p>Paroxetine manufacturer warns against its use in children.</p> <p>Evidence for efficacy of SSRIs is poor—only fluoxetine has modest evidence of benefit.⁵</p>	<p>TCAs are no more effective than placebo in children and adolescents and toxicity in overdose is a concern due to suicide risk in this age group.⁶</p>	<p>Reboxetine, moclobemide and mianserin—safety and efficacy not established.</p> <p>Venlafaxine manufacturer warns against use in children and adolescents.</p> <p>Mirtazapine trials do not support efficacy in paediatric depression according to the UK's Committee on Safety of Medicines.⁷</p>										
Pregnancy	<p>Assess the potential for benefit and harm in both mother and foetus, of both treatment and non-treatment. Discuss clearly and document these discussions.</p> <p>For milder depression, consider psychological therapy.</p> <p>Prescribing points</p> <p>Withdrawal symptoms in infants are similar in all antidepressant classes. Their onset and severity depend on the drug's half-life (shorter half-life means slower onset and more intense symptoms).</p> <p>Review medication needs in women taking antidepressants who conceive, but change of medication not necessarily required.¹ Consider risk of recurrence if antidepressant ceased.</p> <ul style="list-style-type: none"> — Use the lowest effective dose. — Consider reducing dose closer to delivery to minimise infant withdrawal effects.^{1,2} 	<p>Considered generally safe in pregnancy. No evidence of malformation or growth retardation, but data are limited.</p> <p>Serotonergic effects such as agitation, jitteriness, diarrhoea, poor feeding, and sleep disturbances have been reported in neonates—thought to be withdrawal effects.^{1,8} Most resolved within 2 weeks.¹</p> <p>One study (n=997) suggested SSRI or TCA use in late pregnancy increased risk of some neonatal adverse effects (e.g. respiratory distress), but overall risk remained low.⁹</p> <p>Little data exists on longer-term infant development.² A small study noted developmental differences in fine motor skills in infants aged 6–40 months¹⁰, but more data are needed.</p> <p>ADEC category C</p>	<p>Considered generally safe in pregnancy. No evidence of increased risk of malformation.</p> <p>Longer experience than with SSRIs, but consider adverse effects and toxicity in overdose.</p> <p>Anticholinergic adverse effects and withdrawal reactions have been observed in infants (irritability, insomnia, fever and colic).^{1,2}</p> <p>One study (n=997) suggested SSRI or TCA use in late pregnancy increased risk of some neonatal adverse effects (e.g. respiratory distress), but overall risk remained low.⁹</p> <p>ADEC category C</p>	<p>Mirtazapine, moclobemide and reboxetine have not been studied adequately.</p> <p>Longer experience with mianserin than SSRIs, and considered generally safe in pregnancy.</p> <p>Venlafaxine does not appear to be associated with increased risk of congenital abnormality.¹¹ Data on neonatal adverse effects are limited and safety is uncertain.¹</p> <p>Tranylcypromine and other MAOIs have been suspected of decreasing uterine blood flow and increasing the risk of adverse pregnancy outcome.</p> <p>ADEC categories</p> <table border="0"> <tr> <td>Mianserin</td> <td>B2</td> </tr> <tr> <td>Mirtazapine</td> <td>B3</td> </tr> <tr> <td>Moclobemide</td> <td>B3</td> </tr> <tr> <td>Reboxetine</td> <td>not categorised by ADEC/manufacturer: B1</td> </tr> <tr> <td>Venlafaxine</td> <td>B2</td> </tr> </table>	Mianserin	B2	Mirtazapine	B3	Moclobemide	B3	Reboxetine	not categorised by ADEC/manufacturer: B1	Venlafaxine	B2
Mianserin	B2													
Mirtazapine	B3													
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Reboxetine	not categorised by ADEC/manufacturer: B1													
Venlafaxine	B2													



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The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the individual clinical circumstances of each patient.

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Patient group	General issues and concerns	Selective serotonin reuptake inhibitors (SSRIs)	Tricyclic antidepressants (TCAs)	Other antidepressants
Breastfeeding	<p>Untreated postnatal depression carries potential harm for both mother and child.</p> <p>Prescribing points</p> <p>Most antidepressants transfer to breast milk in very low quantities and are considered probably compatible with breastfeeding.^{12,13}</p> <ul style="list-style-type: none"> — Avoid sustained-release or controlled-release formulations—a simple oral dose form is preferred. — For non-sustained-release doses, to minimise infant exposure, feed just before or at time of dose. Generally avoid feeding for 2–3 hours after dose when drug concentration is usually highest.¹² Alternatively express and discard this feed (unnecessary for most drugs). — Use the lowest effective dose. — Monitor the infant response. 	<p>Minimal quantities in breast milk. Sertraline, citalopram, fluvoxamine and paroxetine show acceptably low infant doses and no short-term adverse effects.^{2,13}</p> <p>Because of fluoxetine's longer half-life, there is potential for accumulation in the infant.^{1,2} While significant adverse effects have not been reported, monitor infant for excessive crying, irritability, sleep disturbance, gastrointestinal upset.¹³</p>	<p>Transfer to breast milk is low. There is a long history of use without significant reports of adverse effects.¹³ Therefore TCAs are considered compatible with breastfeeding.</p> <p>However there is a higher adverse effect profile for the mother and greater toxicity in overdose.¹ Nortriptyline is preferred due to fewer anticholinergic effects and less likelihood of orthostatic hypotension.¹</p> <p>There have been case reports of respiratory depression with doxepin.¹</p>	<p>Mianserin, irreversible nonselective MAOIs, mirtazapine and reboxetine have not been adequately studied.</p> <p>Infant plasma concentrations higher with venlafaxine than most SSRIs but considered probably compatible.¹</p> <p>Moclobemide has low concentrations in breast milk but little is known about safety.²</p>
Late-life depression	<p>Dominant features of depression may differ. Psychosocial interventions may help—under-recognition may hamper treatment.¹⁴</p> <p>Consider referral for assessment of underlying cerebrovascular disease.¹⁴</p> <p>Can be difficult to distinguish dementia and depression. Cognitive impairment or decline should be objectively assessed where dementia is suspected.</p> <p>Prescribing points</p> <p>Start low and go slow—response may be more gradual in the elderly who may have slower drug clearance.</p>	<p>SSRIs appear to be safe in the elderly¹⁴, and have fewer adverse effects. Be aware of drug interactions due to the number and types of other medicines.</p> <p>Start with lower than usual doses and increase gradually.</p> <p>There is a greater risk of hyponatraemia in the elderly.</p>	<p>TCAs generally not recommended in the elderly because of anticholinergic and alpha₁-adrenergic blocking effects. If a TCA is chosen, nortriptyline has the least potential for adverse effects.²</p> <p>Use of TCAs for sedation increases the risk of falls.</p>	
Cardiovascular disease	<p>Co-existence of depression and cardiovascular disease appears to be relatively common.¹⁵</p>	<p>SSRIs are preferred, but note that paroxetine and fluoxetine potentially interact with some cardiovascular drugs (e.g. simvastatin, amlodipine, diltiazem, propranolol, metoprolol). Sertraline and citalopram have less potential for these interactions.¹⁵</p> <p>Trials of SSRIs in people with cardiovascular disease and depression suggest these drugs did not increase cardiovascular adverse effects on cardiovascular outcomes including left ventricular ejection fraction.¹⁵</p>	<p>TCAs not first preference because of concerns about cardiotoxic effects (e.g. arrhythmia, hypotension).</p>	<p>Venlafaxine may be used but can increase blood pressure, especially at high doses.</p> <p>Reboxetine may alter control of treated hypertension and can increase heart rate.²</p> <p>MAOIs may induce orthostatic hypotension.</p>
Depression with anxiety	<p>Anxiety symptoms often resolve with effective antidepressant therapy—additional drugs (e.g. benzodiazepines) are not usually required. Consider behavioural treatments for specific anxious behaviours.¹⁶</p>			

Prepared June 2004

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