

SSRIs in premenstrual dysphoric disorder and discontinuation symptoms would not generally be anticipated, especially with fluoxetine given its very long half-life. Doses appear to be within the same range as for the treatment of depression. If a higher dose than the minimum is used and luteal phase dosing is chosen, a short upwards titration is appropriate for SSRIs other than fluoxetine (for example, 50 mg of sertraline for the first three days).⁷

Conclusion

The antidepressants have efficacy in a range of disorders other than depression. In most of these disorders psychological or psychosocial treatments have established efficacy. Antidepressants offer adjunctive treatment for individuals who have a poor response, do not have access to psychological treatments, or who have comorbid depression.

References

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Self-test questions

The following statements are either true or false (answers on page 107)

3. Antidepressants are not recommended for the treatment of specific phobias.
4. Antidepressants are less efficacious than cognitive behaviour therapy in the treatment of obsessive compulsive disorder.

Book review

Australian Medicines Handbook 2005

Adelaide: Australian Medicines Handbook Pty Ltd; 2005.

909 pages. Price \$135; students \$99; plus postage. Three-year subscription also available.

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Australian prescribers who are unfamiliar with the Australian Medicines Handbook ought to be pleasantly surprised by its many differences from standard medicines guides.

First, the book's structure is noteworthy. Preceding the individual drug monographs are discussions of drug classes, as well as overviews of clinical topics (e.g. heart failure, angina, hypertension) – thus, it is a sort of hybrid of the MIMS and Therapeutic Guidelines books. In many places, and particularly the antibiotics chapter, its recommendations concur with the latter books.

A difference from MIMS is the handbook's independence from the pharmaceutical industry. It contains no advertising and favours generic drug names in the monographs and index (although brand names and manufacturers are listed).

In general, the monographs present carefully distilled drug information at a level of detail ideal for the busy but critically-minded practitioner. They also include 'practice points' and 'patient counselling' sections, which are refreshingly practical and patient-oriented.

The book has an evidence-based flavour. There are frequent references to evidence from trials, with a consistent mindfulness of clinically relevant (rather than intermediate) end points.

Changes from past editions include monographs on newly marketed drugs and some deletions and altered indications. Also new is a long but easily navigable appendix on drug interactions.

The inclusion of more Pharmaceutical Benefits Scheme (PBS) information would make the AMH more useful. Although the reproduction of the PBS schedule *in toto* in the 1998 edition was unnecessarily detailed, I'd like to see the number of available repeats included next to quantity and PBS listing information. Restricted and authority criteria are usually included, but a reproduction of the PBS lipid-lowering drugs statement would be helpful.

Quibbles aside, the 2005 AMH continues the admirable tradition set by its predecessors. It fills a valuable niche as a source of pithy, accessible, independent and evidence-based prescribing information.