PATIENTS TAKING ANTIDEPRESSANT DRUGS

Top tips for MURs

- Counsel patient that depression is an illness and that antidepressants are not addictive; they do not cause tolerance or cravings
- Advise patient that all antidepressants take around four weeks to have an effect on depression or anxiety
- Check that all patients (and particularly adolescents and young adults) are warned of the potential for worsening of depression and anxiety and increased risk of suicidal thoughts in the early weeks of treatment and know how to seek help
- Check that patients prescribed SSRIs & NSAIDs/ antiplatelets are co-prescribed a PPI (↑risk of bleeding)
- Counsel patient on need to take medication regularly and explain withdrawal symptoms (chills, myalgia, headache, nausea, insomnia, vivid dreams)
- Counsel patient on signs and symptoms of complications that need referral (**see red flags below**) and common side effects (**see overleaf**)
- Advise patient that they should continue treatment for 6–9 months after recovery (12 months in the elderly) from a single episode. Patients with a history of recurrent depression should continue treatment for at least 2 years
- Check that patients prescribed SSRIs & NSAIDs/ antiplatelets are co-prescribed a PPI (↑risk of bleeding)
- Advise patients to avoid taking St.John's Wort and certain OTC pain relief (aspirin, NSAIDs or tryptans)
- Ensure patients over the age of 65 years are not prescribed citalopram greater than 20mg daily
- Check that patients have had appropriate monitoring
- Be aware of the risk of arrhythmias when patients are co-prescribed citalopram with medication that can prolong the QT interval e.g antipsychotics, atomoxetine, methadone
  - ECG before starting therapy and annually if taking tricyclic antidepressants, blood pressure measured regularly if taking duloxetine or venlafaxine, full blood count every 4 weeks during first three months of treatment and regular monitoring subsequently if taking mianserin and liver function tests at 6, 12 & 24 weeks of treatment, then annually if taking agomelatine
- Advise patient that therapy should be discontinued gradually over at least a 4 week period (except fluoxetine)
- Signpost patients to local support groups or charities supporting patients with mental illness e.g. Mind
- Report any relevant adverse drug reactions to the Yellow Card Scheme

What are antidepressants used for?

To treat a range of mental health disorders including depressive illness, anxiety, panic disorder, obsessive compulsive disorder, post traumatic stress disorder, psychotic depression and bipolar depression as well as nocturnal enuresis and neuropathic pain.

Lifestyle issues

- Counsel patient on reducing alcohol intake to within safe limits (up to 14 units a week, spread evenly over 3 more days, with several alcohol free days)
- Counsel patients on healthy eating, exercise & weight loss (if BMI > 25kg/m^2) - reduce saturated fat and salt intake, avoid salt substitutes, increase oily fish intake, complete 30 minutes of aerobic exercise three to five times a week, reduce caffeine intake to no more than 5 cups a day and recommend 5 portions of fruit and vegetables a day
- Counsel patient on good sleep hygiene techniques. Recommend 7 to 9 hours sleep each night
- Advise patient who smoke of the benefits of stopping smoking and refer to Stop Smoking Wales or Pharmacy Stop Smoking services if willing to stop

How do antidepressant drugs work?

Tricyclic antidepressants (TCAs)	Monoamine reuptake inhibitors with varied selectivity for noradrenaline and serotonin.
Selective serotonin re-uptake inhibitors (SSRIs)	Inhibit the pre-synaptic reuptake of serotonin. Some SSRIs also very weakly inhibit the reuptake of noradrenaline and dopamine.
Other neurotransmitter reuptake inhibitors (duloxetine, venlafaxine, reboxetine)	SNRIs (duloxetine and venlafaxine) inhibit pre-synaptic serotonin and noradrenaline reuptake. Reboxetine inhibits noradrenaline reuptake.
Monoamine-oxidase inhibitors (MAOIs) & Reversible MAOIs (RIMA)	Inhibit the activity of monoamine oxidase enzymes preventing the breakdown of monoamine neurotransmitters. RIMAs result in reversible inhibition of monoamine oxidase type A.
Receptor agonists/antagonists (mirtazapine, mianserin, agomelatine, trazodone)	Mirtazapine – alpha-2, 5-HT$_{2A/3}$ receptor antagonist. Mianserin – 5-HT$_{2A}$ receptor antagonist. Agomelatine – melatonin receptor agonist, 5-HT$_{2B/C}$ receptor antagonist. Trazodone – 5-HT$_{1A/2A}$ antagonist, weak 5-HT reuptake inhibitor.

Written by: Mair Davies July 2012
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Red flags that need referral

- Any symptoms of possible hyponatraemia (dizziness, drowsiness, confusion and cramps)
- Any symptoms of blood dyscrasia (fever, sore throat, stomatitis and signs of infection)
- Any feelings of anxiety (note: anxiety is likely to worsen in first 2 weeks of SSRI treatment and may not need referral), restlessness or suicidal ideas
- Tachycardia as possible toxicity of tricyclic
- Hypertensive crisis with throbbing headache with MAOIs
- Signs of serotonin syndrome (restlessness, tremor, shivering, confusion, convulsions)
- Taking medication at a therapeutic dose for more than 4 weeks (6 weeks in elderly) with no improvement

What are the common side effects to look out for?

Common side effects	Recommendation
Anticholinergic side-effects (especially dry mouth, constipation, blurred vision and confusion), sedation **More commonly seen with MAOIs and TCAs**	Advise newly prescribed patient that side effects often resolve within 2–3 weeks, if not tolerated refer to prescriber.
	Advise patient to drink plenty of water, avoid sugary drinks and chew sugar free chewing gum if dry mouth persists.
	Advise patient to increase fibre, water intake and exercise or recommend a bulk forming laxative if constipation persists.
	Advise patient that close up vision can be affected and to see an optician if a problem
Hypotension (postural hypotension particularly in elderly or those prescribed antihypertensives)	Advise patient to sit up and stand slowly first thing in the morning. If problem persists refer to prescriber.
Drowsiness More commonly seen with MAOIs, TCAs mirtazapine, mianserin and trazodone	Advise patients to take at night and explain that antidepressants may affect the performance of skilled tasks (e.g. driving). The effect of alcohol is enhanced. Refer to prescriber for potential switch to less sedating drug.
Jaundice, oedema, blood dyscrasias, arthritis, arthralgia, hypersalivation, hypertension, palpitation, dyspnoea, myalgia, priapism	Urgent referral to prescriber for review.
Gastric bleeding (increased risk in elderly and patients taking NSAIDs). More commonly seen with SSRIs	Urgent referral to prescriber for review. Patients co-prescribed antidepressant with NSAID/antiplatelet should be referred for PPI coverage. Refer patients taking warfarin.
Insomnia, sleep disturbance, abnormal dreams. **More commonly seen with SSRIs**	Give sleep hygiene advice and if persistent refer to prescriber for medication review.
Gastrointestinal (nausea, vomiting, diarrhoea, dyspepsia)	Advise newly prescribed patient that side effects will usually resolve within 3 weeks, if not tolerated refer to prescriber. Advise patient to take with food.
Sexual dysfunction & menstrual disorders	Refer to prescriber for review.
Weight gain, anorexia, increased appetite	Give patient lifestyle advice and refer to prescriber if not tolerated.
Headaches	Refer to prescriber if frequent or intolerable.
Suicidal thoughts	Urgent referral to prescriber.

Potential serious drug interactions?

Due to varied mechanisms of action and effects on hepatic cytochrome P450 enzymes, antidepressants have different propensities for drug interactions. Interactions between MAOIs and tyramine containing foods and between SSRIs and drugs increasing the risk of bleeding may be particularly serious. Other interactions include: alcohol and hypnotics and anxiolytics (↑ sedative effect); St Johns Wort (↑ risk of Serotonin Syndrome); NSAIDs or aspirin and warfarin (↑ risk of bleeding, avoid concomitant use and refer to prescriber); anti-epileptics (lower seizure threshold); diuretics and carbamazepine (↑ risk of hyponatraemia, particularly in the elderly); tyramine containing foods (MAOIs & RIMA). Anti-depressant medication also interacts with: analgesics, anticoagulants, antibacterials, theophylline, antivirals, cytotoxics, antipsychotics, alpha blockers and hypotensive drugs, other antidepressants and sympathomimetic drugs - **See BNF Appendix 1: Interactions for more details**

Where can you find more information?

- Distance learning pack *"Introduction to Pharmaceutical Care in Mental Health"* found on the WCPPE website (**www.wcppe.org.uk**)
- NICE guidance: *Depression in adults CG90: Depression in children and young people CG28: Depression in adults with a chronic physical health problem CG91:* can be found on NICE website (**www.nice.org.uk**)
- The National Centre for Mental Health (NCMH) website has downloadable patient information leaflets written by specialist mental health pharmacists and other information (**http://ncmh.info**)
- Clinical Knowledge Summary depression can be found on CKS website (**http://cks.nice.org.uk**)
- Depression Alliance website (**www.depressionalliance.org**)

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