MEDICAL PHARMACIES DRUG NEWS

Drug Information and News for Health Care Providers

March 2021

Managing Depression Exacerbated by the Pandemic

In Canada, major depression occurs in up to 44% of older adults living in residential care settings.[1] Furthermore, the fear of illness and social isolation during COVID-19 has impacted the mental health of older adults living in these settings. The table below outlines characteristics of medications used for depression in older adults.

Medication Class	Examples & Average Doses	Adverse Effects & Precautions
FIRST-LINE THERAPY		
Selective serotonin reuptake inhibitors (SSRIs)	• Sertraline (Zoloft®) 25-200 mg/d • Citalopram (Celexa®) 10-20 mg/d • Escitalopram (Cipralex®) 5-10 mg/d • Fluoxetine (Prozac®) 20-80 mg/d	• Nausea, dry mouth, insomnia, diarrhea, agitation, excess sweating, sexual dysfunction • Monitor sodium (risk of hyponatremia leading to SIADH)
Serotonin-norepinephrine reuptake inhibitors (SNRIs)	• Duloxetine (Cymbalta®) 30-60 mg/d • Venlafaxine (Effexor® XR) 37.5 – 225 mg/d • Desvenlafaxine (Pristiq®) 50-100 mg/d	• Similar to SSRIs • More common GI effects than SSRIs • Venlafaxine may increase BP at higher doses (> 150 mg)
Norepinephrine-dopamine reuptake inhibitor (NDRI)	• Bupropion (generics, Wellbutrin® XL) 100-150 mg BID or 150-300 mg XL/d	• Risk of seizures and falls (orthostatic hypotension)
Noradrenergic/ specific serotonergic antidepressant (NaSSA)	• Mirtazapine (Remeron®) 15-45 mg HS	• More sedation at lower doses (7.5-15 mg) • Monitor sodium levels, re: risk of SIADH
SECOND- OR THIRD-LINE THERAPY		
Serotonin stimulator/ serotonin modulator	• Vortioxetine (Trintellix®) 5-20 mg/d	• Nausea, constipation, vomiting, as well as others similar to SSRIs • Monitor sodium, re: risk of SIADH.
Tricyclic antidepressants (TCAs)	• Amitriptyline (Elavil®) initial dose 10-25 mg, increase gradually to 50-100 mg HS • Nortriptyline (Aventyl®) initial dose 10 mg, increase to 75-150 mg HS	• High risk for anticholinergic, CV, and CNS effects • Anticholinergic (dry mouth, urinary retention, confusion, constipation), arrhythmias, orthostatic hypotension • Risk of falls
Monoamine oxidase inhibitors (MAOIs)	• RIMA: Moclobemide (Manerix®) 100-300 mg BID • Phenelzine (Nardil) initial dose 7.5 mg HS, increase gradually by 7.5-15 mg increments to 45-75 mg/d in 3 divided doses	• Dry mouth, dizziness, headache, nausea, tremor, restlessness • Phenelzine has anticholinergic effects. • Many drug (e.g., bupropion, duloxetine) and food (e.g., salami, cheese) interactions. Usually reserved for treatment-resistant depression.
Serotonin agonist reuptake inhibitor (SARI)	• Trazodone (generics) • 25 mg HS to 200 mg BID PC	• Anticholinergic effects, orthostatic hypotension, sedation, risk of falls, priapism

References for table: 2-4 | RIMA = reversible inhibitor of monoamine oxidase A; SIADH = syndrome of inappropriate antidiuretic hormone; CNS = central nervous system; CV = cardiovascular

PHARMACY QI

Practical Tips for Quality Improvement

March 2021

Optimizing Antidepressant Therapy in Older Adults

Antidepressant therapy in older adults should be guided by a resident-centred approach, including: comorbidities, concurrent medications, clinical features of depression, previous antidepressant history, and renal and hepatic function. To optimize antidepressant therapy in older adults, consider the following:

1 START LOW AND GO SLOW

Start with a low dose (e.g., 50% of the adult starting dose) and slowly titrate to a therapeutic dose.

2 WAIT 12 weeks to assess the response to antidepressant therapy.

3 ASSESS

If a partial response is observed, there are several options:

1. Increase the antidepressant dose, if possible, to maximum dosing or tolerability;
2. Switch to another first-line antidepressant from the same or different medication class;
3. Initiate combination therapy, such as the use of an antidepressant with the addition of mirtazapine or bupropion with different mechanism of action and lower risk combinations for serotonin syndrome;
4. Combine depression-specific psychotherapy with an antidepressant; or

3 ASSESS *CONTINUED*

5. Initiate antidepressant augmentation strategies – use of lithium as an augmentation antidepressant therapy was associated with a response rate of 42%, and the use of venlafaxine with aripiprazole resulted in remission rates of 44%.

4 CONTINUE TREATMENT for 12 months from the first depressive episode, to prevent relapse.

5 CONTINUE THERAPY for another one to two years in residents with a history of two depressive episodes.

- Continue for three years, or possibly indefinitely, for those with rapid recurrence or three or more episodes.

References:

1. Canadian Institute for Health Information. Depression among seniors in residential care. 2010. https://secure.cihi.ca/free_products/ccrs_depression_among_seniors_e.pdf. Accessed January 22, 2021.
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3. Geri-RxFiles. Assessing medications in older adults. 3rd Edition. 2019.
4. Marvanova M, McGrane IR. Treatment Approach and Modalities for Management of Depression in Older People. Sr Care Pharm 2021;36:11-21.

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