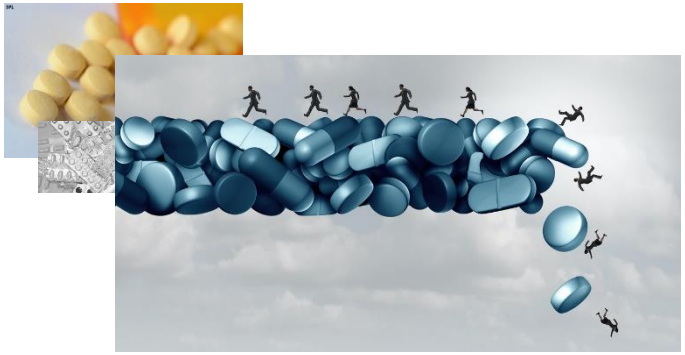
Bitesize Education and Training Session 11

Pharmacological Management of Depression and Anxiety in Primary Care: The SSRI's, SNRI's and Other Options – Part 2

15th October 2024



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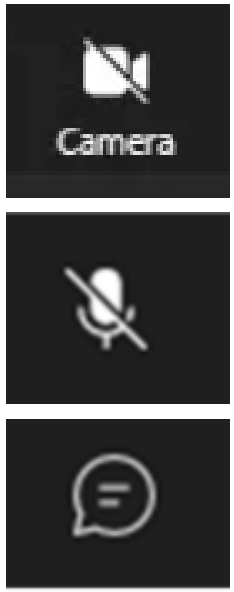
Speaker:
Vicki Jordan
Mental Health Practitioner
Independent Prescriber

Welcome & Housekeeping

Thank you for joining us today!

- ✓ The session is for 30-minutes (20-minute presentation and 10-minute Q&A session).
- ✓ Please switch off your cameras and put yourselves on mute.
- ✓ Please use the chat function if you want to ask a question or for comments.
- ✓ Please respect others' views and opinions. (We have prescribers from across the system on the call – primary, secondary care and community).
- ✓ Please use the chat function to network with your peers and share ideas.
- ✓ At the end of the session there is a short feedback questionnaire – the link to access this will be put into the chat.



Please note the 20-minute presentation will be recorded, and the slides and the recording will be uploaded to the LSC Training Hub website for you to download.

Presented By

Vicki Jordan

- Primary Care Clinical Advisor in Mental Health
- Senior Mental Health Practitioner/Independent Prescriber

- Vicki has been an RMN for over 20 years and has extensive experience working in a variety of Secondary Care Mental Health Services within LSCFT before moving to a Primary Care Setting in 2019.
- Vicki is passionate about improving the care of those experiencing mental health problems, early intervention, expert assessment, intervention and timely onward referrals.
- Vicki provides clinical advice and support to the ICB and LSCFT with regards to mental health in primary care, ensuring the voice of the MHP is represented. She is involved in several workstreams to provide clinical knowledge and expertise to senior management.
- She is also an advocate for Primary Care MHP's in terms of continued professional development, supervision and pathways for clinical progression.

Contact: vicki.jordan@nhs.net

Mental Health Practitioner – Lancashire and South Cumbria Training Hub (lscthub.co.uk)

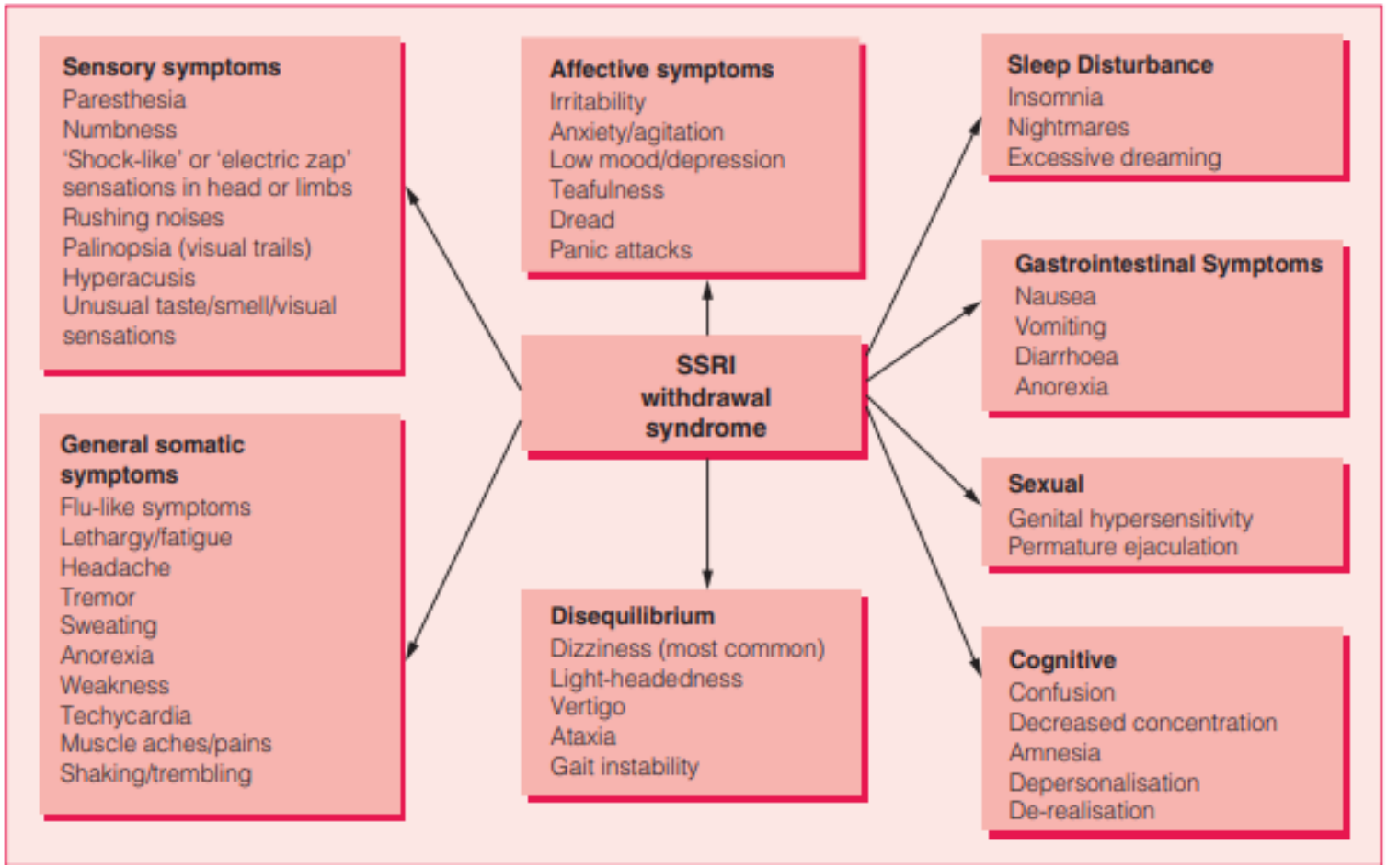
Objectives

- Antidepressants – Swapping and Stopping, general guidance.
- Antidepressants – What are the withdrawal symptoms?
- Incidence and Severity plus risk factors
- Withdrawal Symptoms or Relapse??
- Propranolol in the treatment of Anxiety – Safer Medicine Use Update

Swapping and Stopping – General Guidelines

- ALL antidepressants have potential to cause withdrawal effects, and this can vary significantly from person to person and not always explained by the pharmacokinetics of the drug.
- All patients should be informed of the risks of discontinuation symptoms with all antidepressants particularly those with reported greater likelihood such as Paroxetine and Venlafaxine.
- Discontinuation symptoms can last 1-2 weeks, are rapid and will disappear on re-administration of the drug.
- Abrupt withdrawal is not advisable and should be avoided unless there has been a severe adverse event. it can probably increase the risk of relapse
- The strategy for switching will depend on the reason for the switch and the pharmacokinetic and pharmacodynamic properties of the antidepressants involved.
- Cross tapering is a preferred method to switch antidepressants, but there are instances where this isn’t necessary or may be contraindicated.
- The speed of the switch/cross-tapering will be governed by the tolerability of the patient and there have been few studies on this.

Antidepressant Withdrawal Symptoms



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RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Appendix 1: Risk of withdrawal symptoms with individual antidepressant

Highest Risk	Moderate Risk	Low Risk	Lowest Risk
Amitriptyline	Citalopram	Bupropion	Agomelatine
Clomipramine	Escitalopram	Fluoxetine	
Paroxetine	Fluvoxamine		
Venlafaxine	Imipramine		
Duloxetine	Lofepramine		
	Nortriptyline		
	Mirtazapine		
	Reboxetine		
	Sertraline		
	Trazodone		
	Vortioxetine		

Incidence and Severity

- Generally related to the half life of the medication – onset can be within a day or two for medications like Paroxetine and Venlafaxine and can be delayed in medications between 2-6 weeks for medications like Fluoxetine.
- Symptoms can vary in duration, form and intensity and can occur in any combination.
- Perception of symptom severity is likely to be made worse by the absence of forewarnings.
- The withdrawal effects of antidepressants are worse than originally thought. It can severely affect functioning and has led confusion whether symptoms are related to discontinuation or relapse of the mental health condition.
- Clinical experience suggests that people take between 3 months and 2 years to withdraw in a tolerable manner from long term antidepressant medication.

Who is more at risk?

- People who have been on antidepressants for many years and/or at higher doses.
- People who are on antidepressants with a short half life or antidepressant with cholinergic and noradrenergic affects.
- People who stop antidepressants abruptly

Swapping And Stopping

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Tapering regimes:

Switch from:	Switch to TCA (except clomipramine)	Switch to SSRI (except fluoxetine)	Switch to fluoxetine	Switch to SNRI	Switch to mirtazapine
TCA (except clomipramine)	Direct switch possible	gradually reduce TCA to 25-50mg daily then start SSRI and slowly withdraw TCA over next 5-7 days	Halve dose of TCA, add fluoxetine and then slowly withdraw TCA	Cross taper cautiously with low dose SNRI	Cross taper cautiously
SSRI (except fluoxetine)	Cross taper cautiously with low dose TCA	Direct switch possible	Direct switch possible	Direct switch possible (caution if paroxetine used)	Cross taper cautiously (see below for example)
Fluoxetine	Stop fluoxetine, start TCA low dose 4-7 days later and increase dose very slowly	Stop fluoxetine, start other SSRI at low dose 4-7 days later	N/A	Stop fluoxetine, start SNRI at low dose 4-7 days later	Cross taper cautiously
SNRI	Cross taper cautiously with low dose TCA	Direct switch possible	Direct switch possible	Direct switch possible	Cross taper cautiously
Mirtazapine	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	N/A

- **Example for cross tapering regime from citalopram to mirtazapine:**

	Pre-switch dose	Week 1	Week 2	Week 3	Week 4
Withdrawing citalopram	40mg daily	20mg daily	10mg daily	Nil	Nil
Introducing mirtazapine	Nil	15mg daily	30mg daily	30mg daily	45mg daily (if needed)

Swapping And Stopping

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Case Study 1

Lucy, 28 years old.

- **Been on Sertraline 100mg for 6 months for an episode of mixed anxiety and depression. Did initially respond well, but now feels it isn't working.**
- **Would like to try an alternative.**

How do we go about switching?

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Influencing Factors for the incidence and severity of antidepressant withdrawal symptoms

- **Pharmacological Factors:** pharmacokinetics, drug half life, pharmacodynamics, receptor affinity.

Symptoms are typically more severe with drugs that have a short half life (e.g. Paroxetine, Venlafaxine)

- **Treatment Factors:** Duration of treatment, dose, tapering method

Generally, the slower the better, particularly if someone has been in treatment for several years

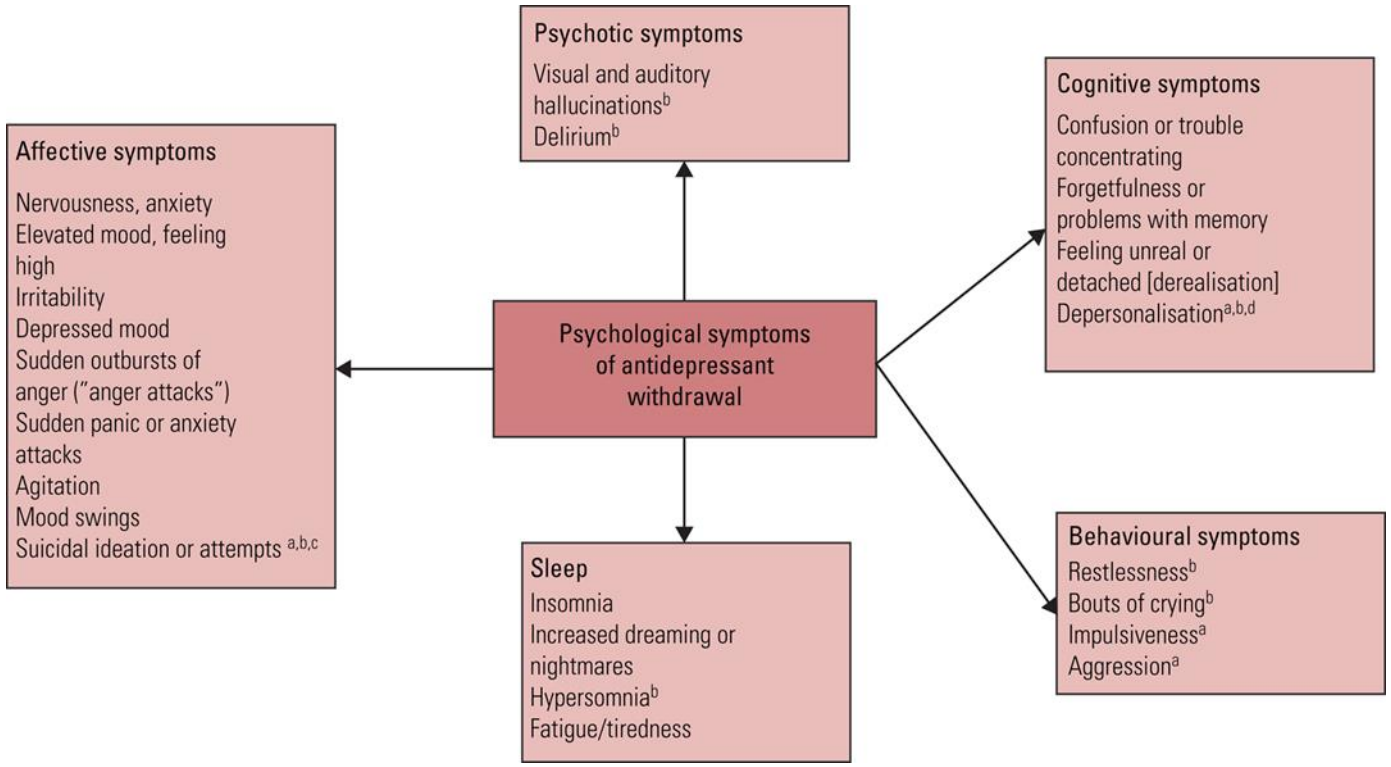
- **Patient Specific Factors:** Prior experiences and anticipation effects

- handyfactsheetstoppingantidepressantsuk.pdf (choiceandmedication.org)

Withdrawal Symptoms or Relapse?

	Withdrawal symptoms	Relapse
Time of onset	Often within hours or days of reducing or stopping antidepressant (but can be delayed for fluoxetine and in some cases of withdrawal)	Usually weeks or months after stopping an antidepressant (may not be a characteristic of some patients' conditions)
Duration	Can range from days to months or years	Variable
Response to reinstatement	Improvement can be within hours or days (especially if reinstatement occurs soon after symptom onset)	Usually delayed by weeks
Attending physical symptoms	Characteristic accompanying symptoms, e.g. dizziness, nausea, headache, sweating, muscle ache and brain 'zaps', may be pathognomonic	Not commonly associated – core symptoms are psychological and cognitive; neurovegetative symptoms can be a feature; individual patients' episodes may have typical characteristics
Pattern of symptoms	Wave pattern – onset, worsening, peak, improvement and resolution often over days or a few weeks for small dose reductions	Usually more constant over time

Psychological Symptoms of Antidepressant Withdrawal



General Advice for Clinicians

When a patient reports low mood, anxiety or insomnia following dose reduction or stopping an antidepressant the clinician should:

- in addition to considering the possibility of relapse, hold a high index of suspicion for antidepressant withdrawal symptoms, as these are common
- inquire about the symptoms of the original condition: are they different from the symptoms that are currently reported?
- inquire about the presence of symptoms indicative of withdrawal syndrome such as electric shock ('zap') sensations in the head, dizziness, nausea, headache
- inquire about the timing of these symptoms – did they arise a few days after stopping an antidepressant (or weeks after stopping fluoxetine)?
- inquire about the pattern of these symptoms – have they continued to worsen in the days and weeks after stopping or reducing the antidepressant?
- inquire about past experience of stopping antidepressants – have similar symptoms occurred?
- if the patient has trialled an increase in dose, did this lead to a lessening of these symptoms? How long did this improvement take?
- Make a diagnosis of antidepressant withdrawal syndrome if it is concluded that a withdrawal syndrome is likely
- following guidance from the RCPsych,suggest increasing the dose back to the last dose at which the patient was stable, allow a period of stabilisation and then suggest reduction in a more gradual manner than previously tried

Tapering Advice

- Withdrawal symptoms can be mild, may appear within a few days of reducing or stopping antidepressant medication, and usually go away within 1 to 2 weeks
- Withdrawal can sometimes be more difficult, with symptoms lasting longer (in some cases several weeks, and occasionally several months)
- Withdrawal symptoms can sometimes be severe, particularly if the antidepressant medication is stopped suddenly.
- Reduce the dose by 25-50% each week over a 2-4 weeks period. This can be done slower if required by reducing the frequency of the reducing dose or reducing in smaller increments.
- If a person has more severe withdrawal symptoms, consider restarting the original antidepressant medication at the previous dose, and then attempt dose reduction at a slower rate with smaller decrements after symptoms have resolved.
- Consider adding an antidepressant with a longer half life, i.e. Fluoxetine and taper more slowly

- https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants

- handyfactsheetstoppingantidepressantsuk.pdf (choiceandmedication.org)

Case Study

Derek, 68 years old.

- **Been on Citalopram 40mg for 15 years following a divorce.**
- **Symptoms in remission for a long time, just continued taking the medication without question.**

- **How do we go about stopping??**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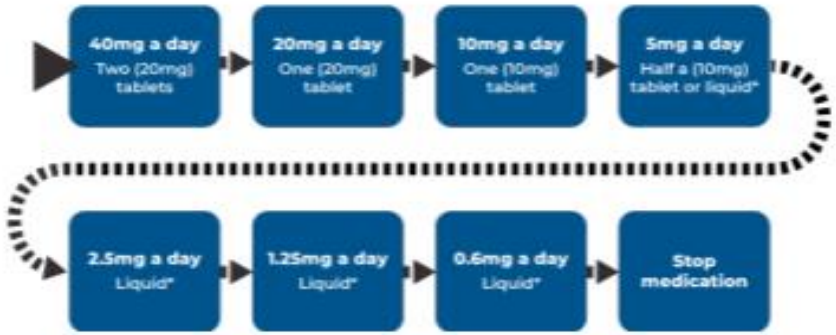
Tapering Example

Citalopram

Reduction of dose by 50%, every 2-4 weeks. Some people may need to reduce more slowly. (Updated October 2020)



* Note: 8mg of citalopram (as hydrochloride) from oral drops is equivalent to 10mg of citalopram (as hydrobromide) in tablet form, so care should be taken when converting dose.

Choice and Medication Website

https://www.choiceandmedication.org/lancashirecaretrust/

Lancashire and South Cumbria NHS Foundation Trust's Choice and Medication website provides people with information about medicines used in the mental health setting to help people make informed decisions about medication.

Use the site on your own or use it together with your family or someone you care for or your doctor, nurse or pharmacy team.

Lancashire and South Cumbria ICB Formulary Development - Lancashire and South Cumbria Medicines Management Group (lancsmmg.nhs.uk)

Joint Formulary for Psychotropic Medication :: Lancashire and South Cumbria NHS Foundation Trust (lscft.nhs.uk)

References

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Question and Answer

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Thank you for listening

Please complete our short feedback questionnaire by clicking on the link that has been put into the chat.

Please note: all feedback will be anonymous

Next session: 19th November 2024

Part 3: Depression and Anxiety Management in Primary Care

Speaker: Vicki Jordan, Primary Care Clinical Advisor in Mental Health. Senior Mental Health Practitioner/Independent Prescriber

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