

Duloxetine

for Depression

Jamal Shams MD

SBMU

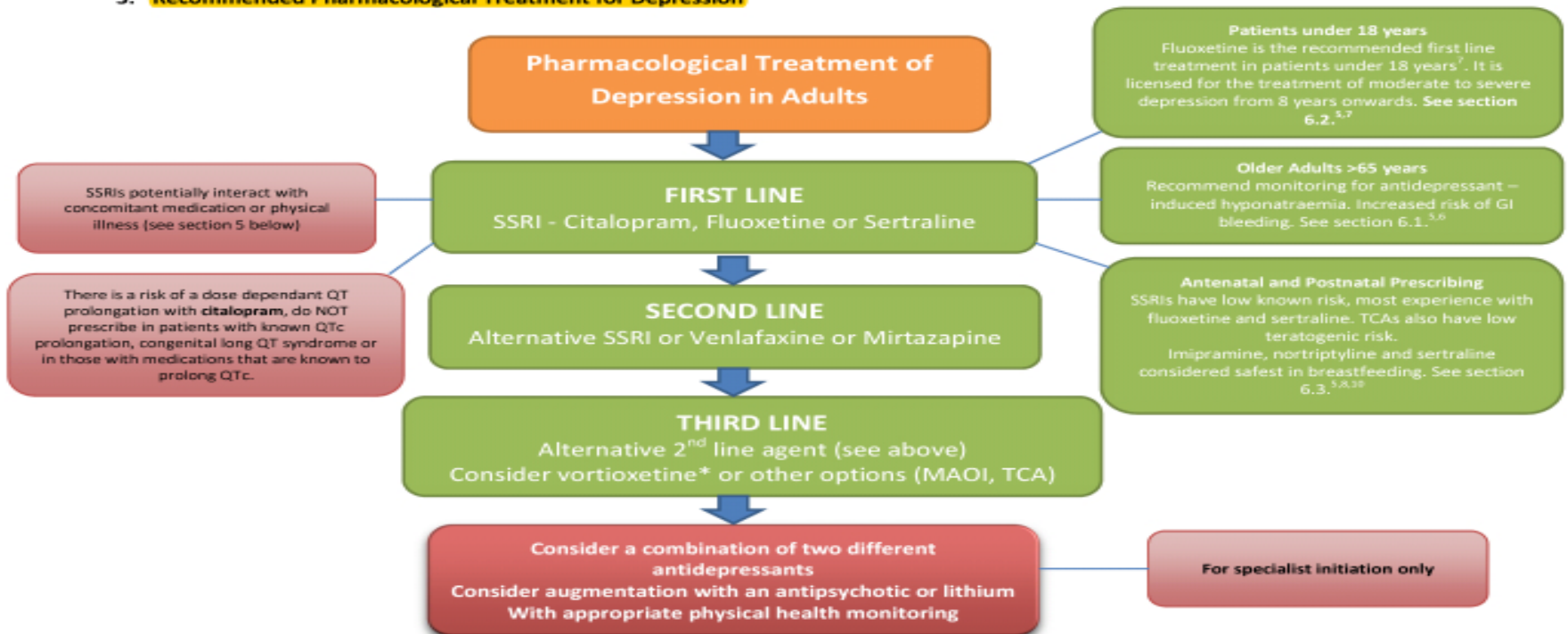
Dept of Psychiatry

Prescribing a Psychotropic Agent After Diagnostic Assessment

- Choose a medication based on FDA approval
 - Family or personal hx of response
 - Adverse effects vs. key symptoms
 - Starting dose
 - Monitor side effects & clinical response
 - Adjust dose if needed

Pharmacological treatment of Depression in Adults

3. Recommended Pharmacological Treatment for Depression





Working in partnership:

Hertfordshire Partnership University NHS Foundation Trust
East and North Hertfordshire Clinical Commissioning Group
Herts Valleys Clinical Commissioning Group

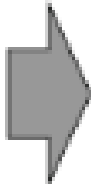
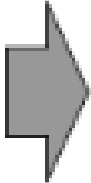
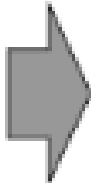
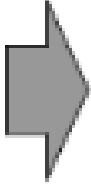
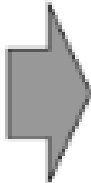
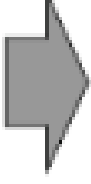
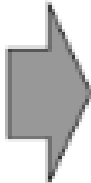
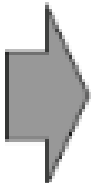
**Guidelines on Choice and Selection of Antidepressants for the
Management of Depression**

Guidelines

Pharmacological treatment recommendations for the unipolar depressive disorder

Guideline organization	First line medication
APA American Psychiatric Association	SSRIs, SNRIs, Mirtazapine, bupropion
CANMAT Canadian Network for Mood and Anxiety Treatments	SSRIs, SNRIs, Mirtazapine, bupropion, vortioxetine
TMAP The Texas Medication Algorithm Project	SSRIs, SNRIs, Mirtazapine, bupropion
RANZCP Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders	SSRIs, Mirtazapine, bupropion

Table 1 Recommendations for Switching ADT

Initial Treatment		1st Intention		2nd Intention
SSRI		<ul style="list-style-type: none"> - Duloxetine - Venlafaxine 		<ul style="list-style-type: none"> - Other SSRI - Milnacipran - α2-antagonist Agomelatine - Clomipramine
				
SNRI		<ul style="list-style-type: none"> - Escitalopram - Sertraline 		<ul style="list-style-type: none"> - Citalopram - Fluoxetine - Fluvoxamine - Paroxetine - Other SNRI - Agomelatine - α2-antagonist - Clomipramine - Imipramine
				
Tricyclic ADT		<ul style="list-style-type: none"> - Escitalopram - Duloxetine - Venlafaxine 		<ul style="list-style-type: none"> - Citalopram - Fluoxetine - Fluvoxamine - Paroxetine - Sertraline - Milnacipran - α2-antagonist - Other Tricyclic - Iproniazide
				
α 2-antagonist*		<ul style="list-style-type: none"> - Escitalopram - Fluoxetine - Paroxetine - Sertraline - Duloxetine - Venlafaxine 		<ul style="list-style-type: none"> - Citalopram - Fluvoxamine - Milnacipran - Agomelatine - Clomipramine
				

* Switching from an α 2-antagonist to another one is not recommended

- Duloxetine hydrochloride (DUL) is an antidepressant included in the pharmacological class of serotonin–norepinephrine reuptake inhibitors approved for the treatment of major depressive disorder, generalized anxiety disorder, diabetic peripheral neuropathic pain, fibromyalgia, and chronic musculoskeletal pain.

duloxetine

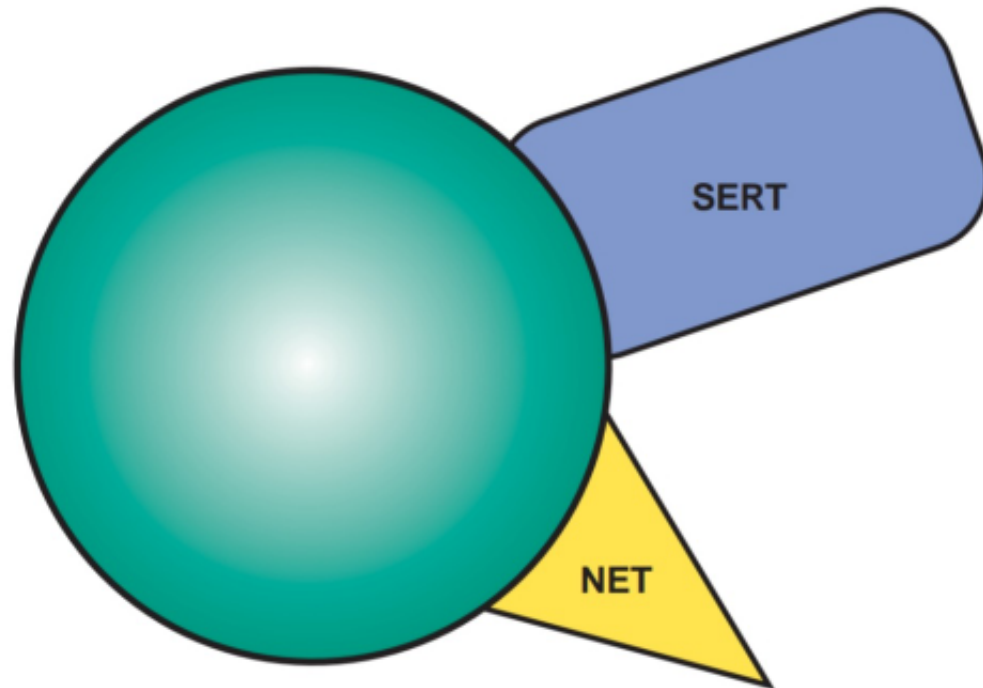


Figure 7-31. Duloxetine. Duloxetine inhibits reuptake of both serotonin (SRI) and norepinephrine (NRI). Its noradrenergic actions may contribute to efficacy for painful physical symptoms. Duloxetine is also an inhibitor of CYP 2D6.

SNRI Action

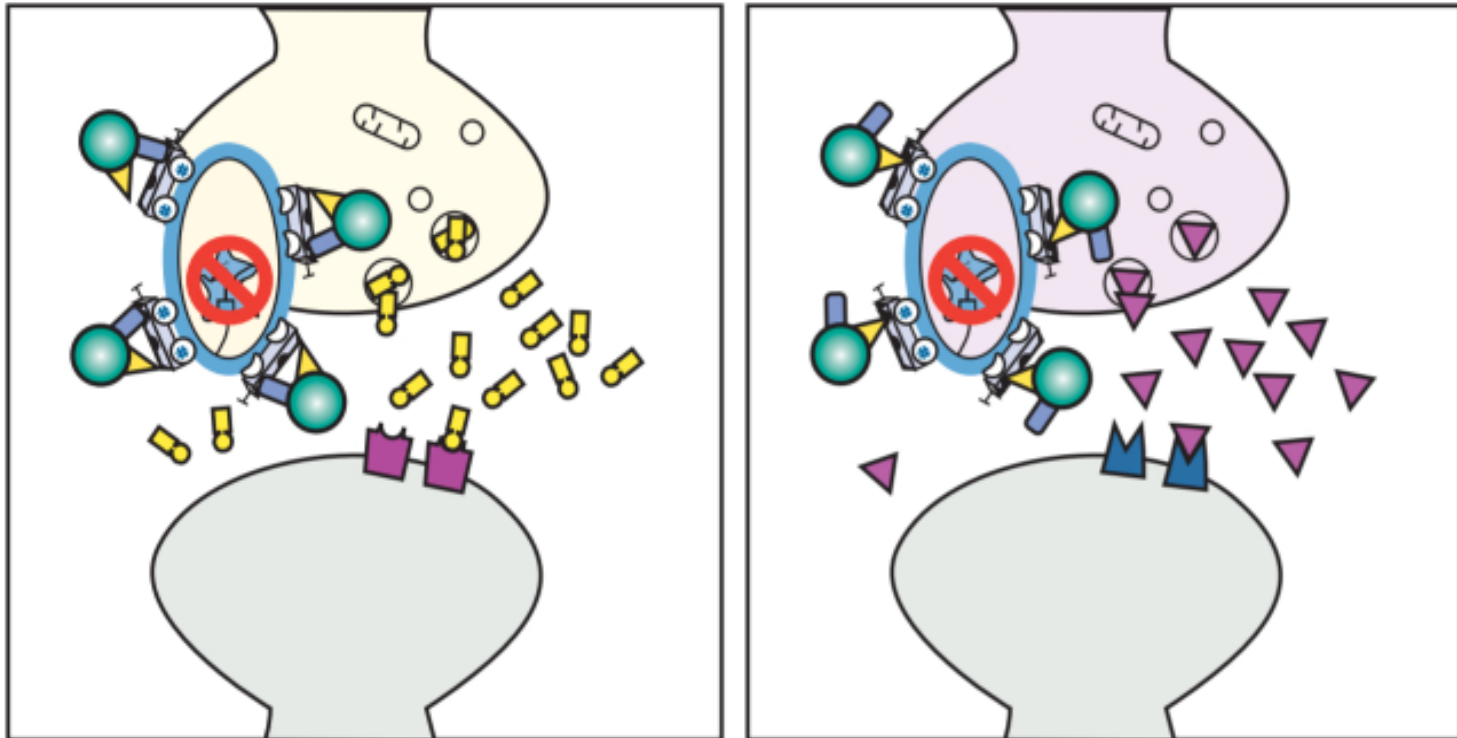


Figure 7-33. SNRI actions. In this figure, the dual actions of the serotonin–norepinephrine reuptake inhibitors (SNRIs) are shown. Both the serotonin reuptake inhibitor (SRI) portion of the SNRI molecule (left panel) and the norepinephrine reuptake inhibitor (NRI) portion of the SNRI molecule (right panel) are inserted into their respective reuptake pumps. Consequently, both pumps are blocked, and the drug mediates an antidepressant effect.

- Since DUL is extensively metabolized by the liver, any degree of hepatic insufficiency is a contraindication to treatment.

- The drug is generally safe and well tolerated across all approved indications in adults at doses ranging from 60 to 120 mg/day.
- The most commonly reported adverse reactions ($\geq 5\%$ and at least twice the incidence of placebo patients) were nausea, dry mouth, somnolence, constipation, decreased appetite, and hyperhidrosis, which occurred mainly in the early stages of the assumption and disappeared after the first weeks of treatment.

- In the longerterm therapy (for at least 6 months to 1 year), frequent treatment emergent adverse events observed in adult patients were palpitations, blurred vision, vertigo, weight gain/loss, chills/rigors, and pruritus.

- Regarding cardiovascular safety, a pooled analysis of clinical trials on MDD showed that DUL had modest effects on heart rate and blood pressure and no clinically meaningful effect on electrocardiogram (ECG) profiles; the cardiovascular effects of DUL were comparable with other antidepressants

- Overall, DUL is considered to be relatively safe in the case of overdose, but the possibility of fatal outcomes increases with concomitant assumption of multiple drugs.
- Symptoms of DUL overdose are somnolence, hypotension or hypertension, vomiting, tachycardia, syncope, serotonin syndrome, seizures, and coma.

- Duloxetine has not been recommended as a routine first-line acute treatment for major depression.



Duloxetine in Psychiatric Disorders: Expansions Beyond Major Depression and Generalized Anxiety Disorder

Maria Rosaria Anna Muscatello^{1}, Rocco A. Zoccali¹, Gianluca Pandolfo¹, Paolo Mangano², Simona Lorusso³, Clemente Cedro¹, Fortunato Battaglia⁴, Edoardo Spina² and Antonio Bruno¹*

¹Department of Biomedical and Dental Sciences and Morphofunctional Imaging, University of Messina, Italy, ²Department of Clinical and Experimental Medicine, University of Messina, Italy, ³Department of Clinical Neurosciences, Villa San Benedetto Merri, Italy, ⁴Department of Medical Sciences, Neurology and Psychiatry, Hackensack Meridian School of Medicine, Seton Hall University, United States

Antidepressants: Ranking of Side Effects

Class	Drug	Insomnia	Sedation	Headache	Tremor	Dry Mouth	Sweating	Nausea	Diarrhea	Constipation	Fatigue	Anxiety	Sexual Dysfunction
SSRI	Citalopram	Green	Yellow	Green	Green	Yellow	Yellow	Yellow	Green	Green	Green	Green	Yellow
	Escitalopram	Green	Green	Green	Green	Green	Green	Yellow	Green	Green	Green	Green	Yellow
	Fluoxetine	Yellow	Yellow	Green	Yellow	Yellow	Green	Yellow	Green	Green	Green	Yellow	Red
	Fluvoxamine	Yellow	Red	Red	Yellow	Yellow	Yellow	Red	Green	Yellow	Green	Red	Red
	Paroxetine	Yellow	Yellow	Yellow	Green	Yellow	Yellow	Yellow	Yellow	Green	Green	Green	Red
	Sertraline	Yellow	Yellow	Red	Yellow	Yellow	Green	Red	Yellow	Green	Yellow	Yellow	Red
SNRI	Duloxetine	Yellow	Green	Green	Green	Yellow	Green	Red	Green	Yellow	Green	Green	Yellow
	Venlafaxine	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Green	Yellow	Yellow	Yellow	Yellow
	Desvenlafaxine	Yellow	Green	Yellow	Green	Yellow	Yellow	Yellow	Yellow	Green	Green	Green	Yellow
Others	Bupropion	Yellow	Green	Green	Green	Yellow	Green	Yellow	Green	Yellow	Green	Green	Green
	Mirtazapine	Green	Red	Green	Yellow	Yellow	Green	Green	Green	Yellow	Green	Green	Green

0-9%  10-29%   30%
%

*Based on unadjusted rates from Product Monographs

Table 3 Recommendations for clinical dimensions of major depressive disorder

Dimension	First Intention	Second Intention
With marked anhedonia	SSRI or SNRI	α 2-antagonist or agomelatine
With marked psychomotor retardation	SNRI, SSRI	Tricyclic or α 2 antagonists
With marked sleep disturbances	SSRI or SNRI or α 2-antagonist or agomelatine	Tricyclic ADT
With atypical features (hyperphagia, hypersomnia)	SSRI or SNRI	Tricyclic or agomelatine
With psychotic features	SNRI in monotherapy or SSRI in combination with an atypical antipsychotic	SSRI, tricyclic ADT or α 2-antagonist, in monotherapy or in combination with AAP
With anxious features	SSRI or SNRI or α 2 antagonist	Tricyclic ADT
With high suicidal risk	SSRI or SNRI or α 2 antagonist	Tricyclic ADT or potentiation strategies with lithium or AAP

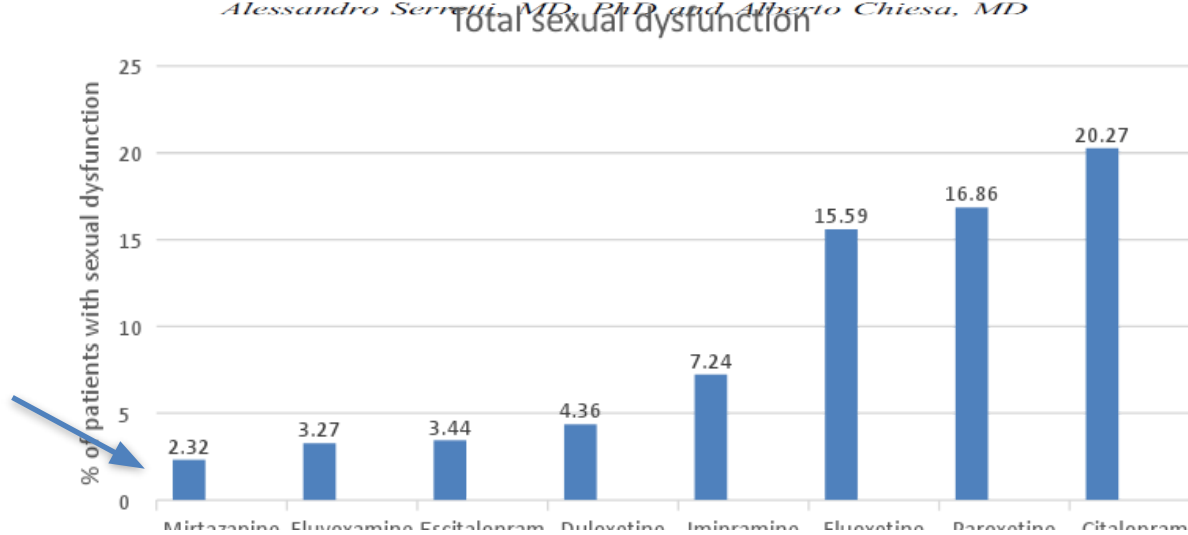
AAP Atypical Antipsychotic, SNRI Dual serotonin and norepinephrine reuptake inhibitors, SSRI Selective serotonin reuptake inhibitors

Less sexual dysfunction

Treatment-Emergent Sexual Dysfunction Related to Antidepressants

A Meta-Analysis

Alessandro Serretti, MD, PhD and Alberto Chiesa, MD



Serretti A, Chiesa A. Treatment-emergent sexual dysfunction related to antidepressants: a meta-analysis. Journal of clinical psychopharmacology. 2009 Jun 1;29(3):259-66.

RESEARCH ARTICLE

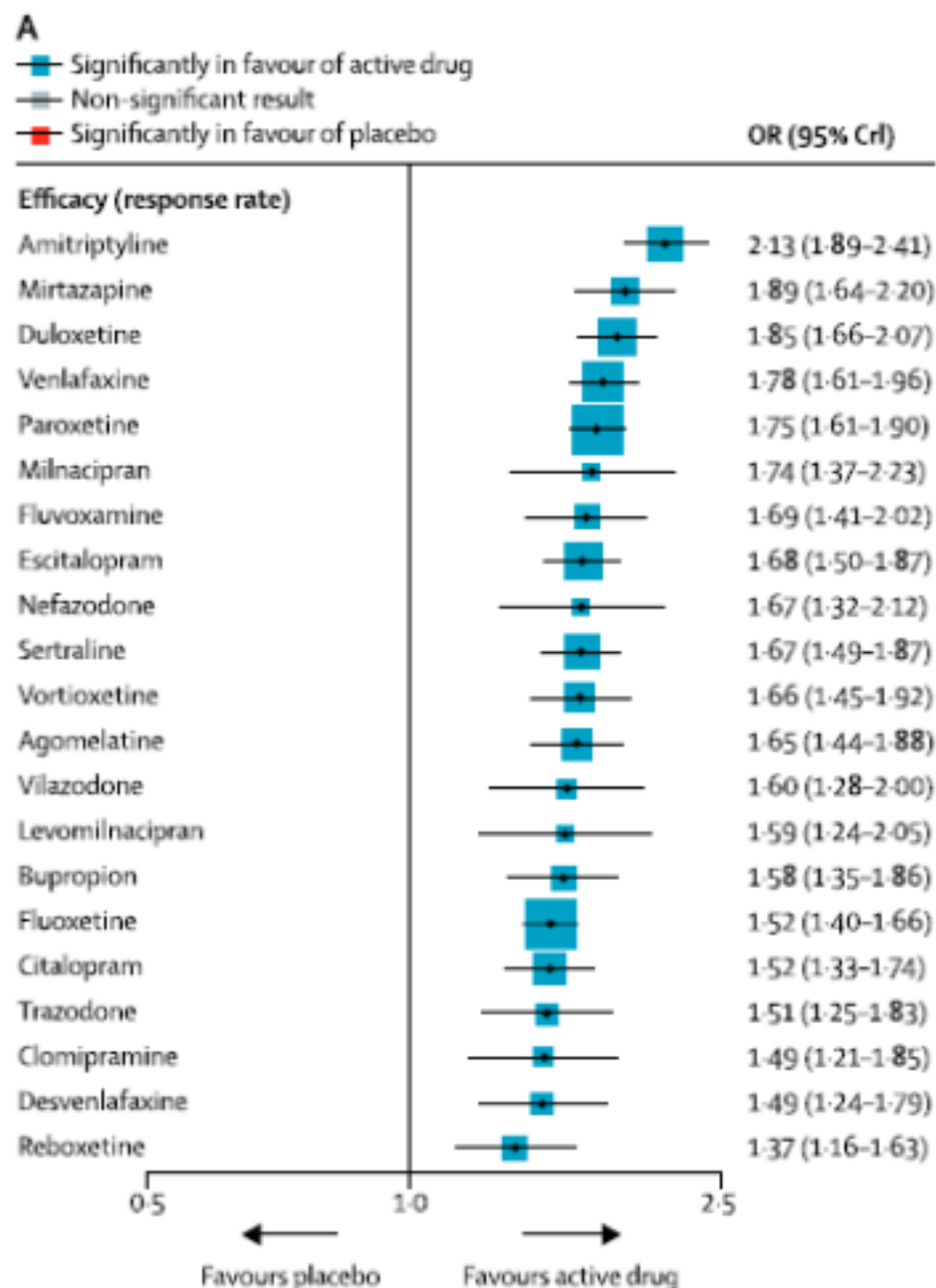
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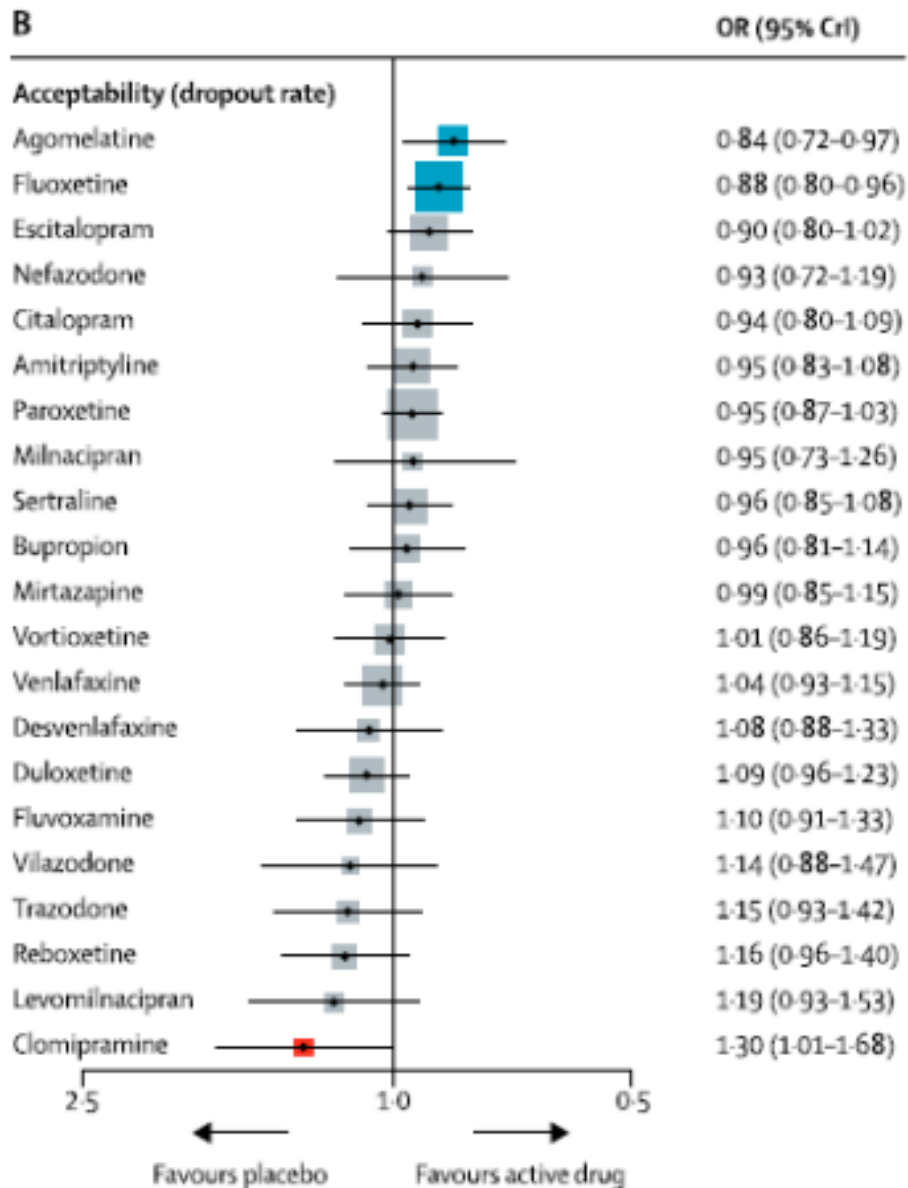
Clinical guidelines for the management of treatment-resistant depression: French recommendations from experts, the French Association for Biological Psychiatry and Neuropsychopharmacology and the foundation FondaMental



D. Bennabi^{1,18*}, T. Charpeaud², A. Yrondi³, J.-B. Genty⁴, S. Destouches⁴, S. Lancrenon⁴, N. Alaili⁵, F. Bellivier⁵, T. Bougerol⁶, V. Camus⁷, J.-M. Dorey^{8,9,10}, O. Doumy¹¹, F. Haesebaert¹², J. Holtzmann⁶, C. Lançon¹³, M. Lefebvre¹², F. Moliere¹⁴, I. Nieto⁵, C. Rabu¹⁵, R. Richieri¹³, L. Schmitt³, F. Stephan¹⁶, G. Vaiva¹⁷, M. Walter¹⁶, M. Leboyer¹⁵, W. El-Hage⁷, P.-M. Llorca², P. Courtet¹⁴, B. Auquier^{8,9,10} and E. Haffen¹

FIGURE 3. Forest Plots of Network Meta-Analysis of All Trials for Efficacy (A) and Acceptability (B)





Antidepressants were compared with placebo, which was the reference compound. OR=odds ratio. CrI=credible interval. A color version of the figure, as originally published, appears in the online version of this article (focus.psychiatryonline.org).

Comparative Efficacy and Acceptability of 21 Antidepressant Drugs for the Acute Treatment of Adults With Major Depressive Disorder: A Systematic Review and Network Meta-Analysis

Andrea Cipriani, Toshi A Furukawa, Georgia Salanti, Anna Chaimani, Lauren Z Atkinson, Yusuke Ogawa, Stefan Leucht, Henricus G Ruhe, Erick H Turner, Julian P T Higgins, Matthias Egger, Nozomi Takeshima, Yu Hayasaka, Hissei Imai, Kiyomi Shinohara, Aran Tajika, John P A Ioannidis, John R Geddes