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ant* and ion	Standard Dose (mg/day)	Initial Suggested Dose**	Titration Schedule	Advantages	Disadvantages	Side Effects
	20 – 40	20 mg in AM w/ food (10 mg in elderly or those w/ panic disorder)	Maintain initial dose for 4 wks before dose incr. If no response, incr in 10 mg increments q 7 days as tolerated.	Helpful for anxiety disorders. Few drug interactions.		Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	10 – 30	10 mg	Increase to 20 mg if partial response after 4-wks	More potent s-enantiomer of citalopram, 10 mg dose effective for most. FDA approved for general anxiety disorder. Reduces all 3 sx grps of PTSD.	More expensive than citalopram.	Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	10 – 80	20 mg in the AM w/ food (10 mg in elderly and those w/ comorbid panic disorder)	Maintain 20 mg for 4-6 wks and 30 mg for 2-4 wks before additional dose increases. Increase in 10 mg increments at 7 day intervals. If significant side effects occur w/in 7 days, lower dose or change med.	Helpful for anxiety disorders. Long half-life good for poor adherence, missed doses; less frequent discontinuation sx. Reduces all 3 sx grps of PTSD.	Slower to reach steady state and eliminate when d/c'ed. Sometimes too stimulating. Active metabolite half life ~10 days, renal elimination. Inhibits cytochrome P450 2D6 and 3A4. Use cautiously in elderly and pts on multiple meds.	Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
ekly	90	Initiate only	Start 7days after last			Sedation

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ant* and ion	Standard Dose (mg/day)	Initial Suggested Dose**	Titration Schedule	Advantages	Disadvantages	Side Effects
y)		after stable on 20 mg QD	dose of 20 mg.			Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	10 – 50 (40 in elderly)	20 mg once daily, usually in the AM w/ food (10 mg in elderly and those w/ co morbid panic disorder)	Maintain 20 mg for 4 wks before dose increase. Increase in 10 mg increments at intervals of ~ 7 days up to maximum dose of 50 mg/day (40 mg in elderly)	FDA labeling for most anxiety disorders. Reduces all 3 symptom groups of PTSD.	Sometimes sedating. Anticholinergic effects can be troublesome. Inhibitor of CYP2D6	Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	25 – 62.5 (50 in elderly)	25 mg daily (12.5 mg in elderly and those w/panic disorder)	Increase by 12.5 mg at wkly intervals, maintain 25 mg for 4 wks before dose increase	May cause less nausea and GI distress.		Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	25 – 200	50 mg once daily, usually in the AM w/ food (25 mg for elderly)	Maintain 50 mg for 4 wks. Increase in 25-50 mg increments at 7-day intervals as tolerated. Maintain 100 mg for 4 wks before next dose increase.	FDA labeling for anxiety disorders including PTSD. Safety shown post MI.	Weak inhibitor of CYP2D6 – drug interactions less likely.	Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction

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ant* and ion	**Standard Dose (mg/day)**	**Initial Suggested Dose****	**Titration Schedule**	**Advantages**	**Disadvantages**	**Side Effects**
						Wt gain
	15 – 45	15 mg at bedtime	Increase in 15 mg increments (7.5 mg in elderly) as tolerated. Maintain 30 mg for 4 wks before incr dose further.	Few drug interactions. Less sedation as dose increases. May stimulate appetite.	Sedation at low doses only (<15 mg). Weight gain due to appetite stimulation.	Sedation Anticholinergic GI distress Seizure Wt gain Agranulocytosis
	200 – 450	100 mg twice a day (once a day in elderly)	Increase to 100 mg TID after 7 days (slower titration for elderly). After 4-wks, incr to maximum 150 mg TID. If liver dis: 75 mg/day	Can be stimulating. Less or no sexual dysfunction.	Higher doses may induce seizures. Contraindicated in pts w/ seizures, CNS lesions, recent head trauma or eating disorder,. Stimulating effect can increase anxiety / insomnia.	GI distress Restless/jittery/tremo Wt Gain
or	75 – 375	75 mg w/ food; 37.5 mg if anxious, elderly or debilitated	Immediate release (IR): divide dose BID or TID. Extended release (XR): give 37.5 mg in AM. After 1 wk, increase to 75 mg in AM. After 2 wks, incr to 150 mg in the AM. After 4 wks if partial response incr to 225 mg in AM. Norepinephrine effect occurs above 150 mg.	Helpful for anxiety disorders, neuropathic pain, and vasomotor symptoms. XR version should be taken QD. May reduce all 3 sx groups of PTSD.	May increase BP at higher doses. Risk for drug interactions similar to fluoxetine. Discontinuation/ withdrawal sx. Sexual dysfunction.	Sedation Anticholinergic GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
e	50 – 400	50 mg once daily	No evidence that higher doses are associated	Active metabolite of venlafaxine.	Dose adjustment if CrCl <30 ml/min.	Sedation Anticholinergic

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ant* and ion	Standard Dose (mg/day)	Initial Suggested Dose**	Titration Schedule	Advantages	Disadvantages	Side Effects
			w/ greater effect.		Gradually incr dosing interval when discontinuing when taken for > 6wks (taper dose if dose >50 mg/day). Sexual dysfunction.	GI distress Restless/jittery/tremo H/A Insomnia Sexual dysfunction Wt gain
	40 – 60	40 or 60 mg as a single or divided dose (20 or 40 mg in elderly)	Dose can be increased after 1 wk. Max dose 120 mg/d although doses > 60 mg/d not more effective.	Also approved for general anxiety disorder, pain from diabetic neuropathy & fibromyalgia.	Dose adjustment if CrCl <30 ml/min. Urinary hesitancy. Sexual dysfunction.	
	100 – 300 (25 – 100 in elderly)	50 mg in the AM (10 or 25 mg in elderly)	Increase by 25 to 50 mg every 3 to 7 days to initial target dose of 150 mg (75 or 100 mg elderly) for 4 wks. Target serum concentration: >115 ng/mL	More effect on norepinephrine than serotonin. Effective for diabetic neuropathy and neuropathic pain. Compliance and effective dose can be verified by serum concentration.	Can be stimulating, but sedating in some pt. Anticholinergic, cardiac, hypotensive; caution in pts w/ BPH, cardiac conduction disorder or CHF	Sedation Anticholinergic Restless/jittery/tremo Wt gain
	25 – 100	25 mg in PM (10 mg in elderly)	Increase in 10-25 mg increments every 5-7 days as tolerated to 75 mg/day. Obtain serum concentration after 4 wks; target range: 50-150 ng/mL.	Less orthostatic hypotension than other tricyclics. Compliance & effective dose can be verified by serum concentration.	Anticholinergic, cardiac, and hypotensive caution in patients w/ BPH, cardiac conduction disorder or CHF	Sedation Anticholinergic Restless/jittery/tremo Wt gain

ı sant ns s ant* and ion	Standard Dose (mg/day)	Initial Suggested Dose**	Titration Schedule	Advantages	Disadvantages	Side Effects

es a variety of drugs with side effects and act by different neurotransmitter mechanisms. *The Lancet* (1) concluded that sertraline offe
ı efficacy, acceptability, and costs compared to 11 other agents.
ns: Use of many antidepressants is contraindicated in conjunction w/ a nonselective MAOI, including caution w/ or discontinuation of I
). Selegiline is also available as a higher dose and nonselective, transdermal patch (Emsam) approved for the treatment of major dep
essants, allow four wks at a therapeutic dose, then assess response. If only partial or slight response but well tolerated, increase dos
se symptoms, or intolerable side effects, switch antidepressants. **Starting dose: For SSRIs, venlafaxine, and tricyclic antidepressants
erapeutic dose range. If side effects bothersome, reduce dose, increase slower. In the elderly, debilitated or those sensitive to meds,
en: TCAs and SSRIs (particularly fluoxetine) are generally the agents of choice. However, SSRIs have been associated w/ persistent
ertension after 20 wks of gestation, a slight decrease in gestational age, lower birth weight, and neonatal withdrawal or adaptation syr
been associated w/ first-trimester cardiovascular malformations (ventricular and atrial septal defects). Avoid paroxetine avoided durir
s are associated w/ neonatal withdrawal symptoms and anticholinergic adverse effects. There are insufficient data about other newer
s, although there may be a link between bupropion and spontaneous abortion.
women: sertraline, paroxetine and nortriptyline have lowest infant serum concentration and fewest infant adverse effects; citalopram a
st. TCAs are nearly undetectable in infant plasma.

ntidepressants are not all created equal. *The Lancet*. Early Online Publication, Jan 29, 2009. DOI:10.1016/S0140-6736(09)60047-7
al. Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis. *The Lancet*, E
ion, 29 January 2009. DOI:10.1016/S0140-6736(09)60046-5
Snow V, Denberg TD, Forciea MA, Owens DK. Using second-generation antidepressants to treat depressive disorders: a clinical prac
can College of Physicians. *Ann Intern Med*. 2008 Nov 18;149(10):725-33.