Common Antidepressant Medications for Adults

Antidepressant* Generic (and Trade) Name	Standard Dose (mg/day)**	Titration Schedule	Advantages	Disadvantages	Side Effects	Therapeutic Consideration
Citalopram (Celexa) Generic	Initial 20 in AM w/ food (10 mg in elderly or those w/ panic disorder) Range 20 – 40 Max 40 (If age >60yo, max 20)	Maintain initial dose for 4 wks before dose incr. If no response, incr in 10 mg increments q 7 days as tolerated.	Few drug interactions.	>40 mg QD ↑ risk of QT prolongation; doses > 40 mg/day not proven to be effective.	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	Anxiety disorders
Escitalopram (Lexapro)	Initial 10 Range 10 – 20 Max 20	Increase to 20 mg if partial response after 4-wks	More potent s-enantiomer of citalopram, 10 mg dose effective for most.	More expensive than citalopram.	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	FDA approved for general anxiety disorder. Reduces all 3 sx grps of PTSD: reliving, avoidance, and arousal.
Fluoxetine (Prozac) Generic	Initial 10 – 80 20 mg in the AM w/ food (10 mg in elderly and those w/ comorbid panic disorder) Range 20-60 Max 80	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	Long half-life good for poor adherence, missed doses; less frequent discontinuation sx.	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/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	Helpful for anxiety Disorders Reduces all 3 sx grps of PTSD: reliving, avoidance, and arousal.
Fluoxetine Weekly (Prozac Weekly)	90 But start only after stable on 20 mg QD of short acting fluoxetine	Start 7days after last dose of 20 mg.			Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia +	

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					Sexual dysfunction ++ Wt gain +/-	
Paroxetine (Paxil) Generic	Initial 10 20 mg QD, usually in the AM w/ food (10 mg in elderly and those w/panic disorder) Range 10 – 50 Max 50 in depression 60 in anxiety (40 in elderly)	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)		Sometimes sedating. Anticholinergic effects can be troublesome. Inhibitor of CYP2D6 Withdrawal syndrome	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	FDA labeling for most anxiety disorders. Reduces all 3 symptom groups of PTSD.
Paroxetine (Paxil CR)	Initial 25 mg QD (12.5 mg in elderly and those w/panic disorder) Range 25 – 62.5 Max (50 in elderly)	Maintain 25 mg for 4 wks before dose increase Increase by 12.5 mg at wkly intervals	May cause less nausea and GI distress than regular paroxetine.	Sedation Withdrawal syndrome	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	
Sertraline (Zoloft) Generic	Initial 50 usually in the AM w/ food (25 mg for elderly) Range 25 – 200 Max 200	Maintain 50 mg for 4 wks. Increase in 25-50 mg increments at 7-day Maintain 100 mg for 4 wks before next dose increase.intervals as tolerated.	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/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	
Mirtazapine (Remeron) Generic	Initial 15 at bedtime Range 15 – 45 Max	Maintain 30 mg for 4 wks before incr dose furthe. Increase in 15 mg increments (7.5 mg	Few drug interactions. Less sedation as dose increases. May	Sedation at low doses only (<15 mg). Weight gain due to appetite stimulation.	Sedation + Anticholinergic +/- GI distress +/- Seizure +/- Wt gain ++	Consider for those who are underweight from depression.

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	45	in elderly) as tolerated.	stimulate appetite.		Agranulocytosis +/-	
Bupropion (Wellbutrin) Generic	Initial 75-100 BID 100 mg twice a day (once a day in elderly) Range 200 – 450 should be an interval of at least 6 hrs between doses in immediate release and 8 hr in sustained release Max 450	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. Caution in renal and hepatic impairment	GI distress + Restless/jittery/tremors ++ Wt Gain +/-	Smoking cessation Try in ADHD to ↑ concentration. Improves sexual function
Venlafaxine (Effexor, Effexor XR) Generic	Initial 75 immediate release divided dose of 2-3x/day XR 37.5 QD AM w/ food; 37.5 if anxious, elderly or debilitated Range 75 – 375 Max 375 for severe depression	After 1 wk, ↑ to 75 mg in AM. After 2 wks, ↑ to 150 in the AM. After 4 wks if partial response ↑ to 225 mg in AM. Norepinephrine effect occurs above 150 mg.		May increase BP at higher doses. Risk for drug interactions similar to fluoxetine. Discontinuation/ withdrawal sx. Sexual dysfunction. In moderate liver disease, ↓dose by 50%. If GFR 10-70 ml/min, ↓ dose 25%; if on dialysis, ↓ dose 50%	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia + Sexual dysfunction ++ Wt gain +/-	anxiety disorders, neuropathic pain, and vasomotor symptoms May reduce all 3 sx groups of PTSD:
Desvenlafaxine (Pristiq)	Initial 50 Max 400	No evidence that higher doses are associated w/ greater effect.	Active metabolite of venlafaxine.	↓ dose if CrCl <30 ml/min. When d/cing after taking > 50 mg/da for > 6 wks: gradually ↑ dosing	Sedation +/- Anticholinergic +/- GI distress ++ Restless/jittery/tremors ++ H/A + Insomnia +	

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					Sexual dysfunction ++ Wt gain +/-	
Duloxetine (Cymbalta)	Initial 40 – 60 single or divided dose Elderly:(20 or 40) Range 60-120 Max 120 but doses > 60 /d are not more effective	Dose can be increased after 1 wk. Max dose 120 mg/d although doses > 60 mg/d not more effective.	Pts may respond well when added to SSRIs or TCAs or when switching SSRI or TCAs to duloxetine	Caution when using this drug with other drugs that inhibit CYP2D6: lower dose of those drugs may be needed. Dose adjustment if CrCl <30 ml/min. Hepatotoxicity	Sexual dysfunction + Urinary hesitancy +	Also approved for general anxiety disorder, pain from diabetic neuropathy, fibromyalgia & chronic musculo-skeletal pain, eg OA or chronic LBP. Useful for those w/ stress incontinence (unlabeled use)

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Desipramine (Norpramin) Generic	Initial 50 in the AM (10 or 25 mg in elderly) Range 75-200 (25 – 100 in elderly) Max 300 reserved for very ill	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.. 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 Seizure	Sedation ++ Anticholinergic +++ Restless/jittery/tremor +/- Wt gain +/-	Effective for diabetic neuropathy and neuropathic pain
Nortriptyline (Pamelor) Generic	Initial 25 TID or 75 HS 25 mg in PM (10 mg in elderly) Range 25 – 100	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 Seizure	Sedation ++ Anticholinergic +++ Restless/jittery/tremor +/- Wt gain +/-	
Trazodone (Oleptro)	Initial 150 divided doses (25-50 HS in elderly) Range 150-400 divided doses (75-150 in elderly) Max (reseved for severely ill pt) 600 divided doses	may increase by 50 mg/day every 3-7 days	does not cause anticholinergic or cardiotoxic effects like TCAs	Potential for priaprism	Orthostatic hypotension + Sedation +++	Useful for insomnia from depression

- *This list includes a variety of drugs with side effects and act by different neurotransmitter mechanisms. Parikh et al (1) conclude that sertraline offers the best balance among efficacy, acceptability, and costs compared to 11 other agents. Gartlehner et al 4) conclude that possible side effects, convenience of

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dosing regimens, and costs may best guide the choice of a second-generation antidepressant for treating major depression in adults, because these agents probably have similar efficacy.

Contraindications: Use of many antidepressants is contraindicated in conjunction w/ a nonselective MAOI, including caution w/ or discontinuation of Eldepryl (used for Parkinson's). Selegiline is also available as a higher dose and nonselective, transdermal patch (Emsam) approved for the treatment of major depression.

For all antidepressants, allow four wks at a therapeutic dose, then assess response. If only partial or slight response but well tolerated, increase dose. If no response, worse symptoms, or intolerable side effects, switch antidepressants.

**Starting dose: For SSRIs, venlafaxine, and tricyclic antidepressants, start at beginning of therapeutic dose range. If side effects are bothersome, reduce dose, increase slower. In the elderly, debilitated or those sensitive to meds, start lower.

Pregnant women: TCAs and SSRIs (particularly fluoxetine) are generally the agents of choice. However, SSRIs have been associated w/ persistent newborn pulmonary hypertension after 20 wks of gestation, a slight decrease in gestational age, lower birth weight, and neonatal withdrawal or adaptation syndrome. Paroxetine has been associated w/ first-trimester cardiovascular malformations (ventricular and atrial septal defects). Avoid paroxetine avoided during the first trimester. TCAs are associated w/ neonatal withdrawal symptoms and anticholinergic adverse effects. There are insufficient data about other newer antidepressants, although there may be a link between bupropion and spontaneous abortion.

Breastfeeding women: sertraline, paroxetine and nortriptyline have lowest infant serum concentration and fewest infant adverse effects; citalopram and fluoxetine have the highest. TCAs are nearly undetectable in infant plasma.

1. Parikh SV. Antidepressants are not all created equal. *The Lancet*. Early Online Publication, Jan 29, 2009. DOI:10.1016/S0140-6736(09)60047-7
2. Cipriani A et al. Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis. *The Lancet*, Early Online Publication, 29 January 2009. DOI:10.1016/S0140-6736(09)60046-5
3. Qaseem A, Snow V, Denberg TD, Forciea MA, Owens DK. Using second-generation antidepressants to treat depressive disorders: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2008 Nov 18;149(10):725-33.
4. Gartlehner G et al. Comparative benefits and harms of second-generation antidepressants fro treatment major depressive disorder: An updated meta-analysis. Ann Intern Med 6 2011;155(11):772-785.