

04 - Differential diagnosis of psychiatric adverse

Differential diagnosis of psychiatric adverse effects

972 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 15 Differential diagnosis of psychiatric adverse effects A wide range of confounding factors complicate the diagnosis (and perhaps also the recognition) of psychiatric adverse effects. For example, physical illness, co-prescribed medication, non-prescribed agents and pre-existing mental illness may all influence the clinical presentation and outcome. Factors determining the probability of a causal relationship between drugs and psychiatric adverse effects are shown in Box 15.1. To further support clinical decision-making, the Naranjo scale can be used to assess the likelihood of any adverse reaction being drug-related (Table 15.4). Although cessation of the implicated non-psychotropic might be indicated in some cases, such decisions require individual considerations beyond the scope of this book. Table 15.3 (Continued) Drug Psychiatric adverse effect Comment Isotretinoin¹⁷ Depression, suicidal ideation, psychosis Sporadic reports of psychiatric ADRs but a causal link between isotretinoin therapy and depression, anxiety, mood changes or suicidal ideation/suicide has not been established. A recent meta-analysis found no epidemiological evidence to suggest an increased risk of suicide and psychiatric conditions with isotretinoin.¹⁸ Moreover, isotretinoin may be associated with a lower risk of suicide attempt following treatment.¹⁸ Rare, idiosyncratic reactions cannot be ruled out; if they occur the drug should be discontinued. Risk is no higher in those with prior suicide attempts and is not dose- or treatment-duration-related. Montelukast¹⁹ Sleep disorders, hallucinations, anxiety, depression, obsessive compulsive symptoms The UK MHRA has issued warnings about neuropsychiatric reactions associated with montelukast. Reactions have been reported in adults, adolescents and children. Evidence is conflicting, with one systematic review identifying associations with anxiety and sleeping disorders but not suicide and depression--related events.²⁰ ACE, angiotensin-converting enzyme; BPH, benign prostatic hyperplasia; COMT, catechol-O-methyltransferase; 5HT, 5-hydroxytryptamine; MAO-B, monoamine oxidase B; MHRA, Medicines and Healthcare products Regulatory Agency; RCTs, randomised controlled trials.

Miscellany CHAPTER 15 Box 15.1 Factors determining the probability of a causal relationship between drugs and psychiatric adverse effects^{4,21} ■ ■Temporal relationship between the drug exposure and the psychiatric adverse effect ■ ■Evidence of the specific psychiatric adverse effect occurring with the suspected drug ■ ■Plausible pharmacological mechanism for the psychiatric adverse effect (e.g. dopamine agonists and psychosis) ■ ■Presence of alternative explanations for symptoms (e.g. pre-existing mental illness, de novo psychiatric illness, other drugs) ■ ■Response of symptoms to the withdrawal of the drug ■ ■Effect of rechallenge with the same drug Table 15.4 Adapted Naranjo adverse drug reaction (ADR) probability scale criteria.²² Questions Yes No NA/unknown

1. Are there previous conclusive reports on this reaction? +1 0
 2. Did the ADR appear after the suspected drug was administered? +2 -1
 3. Did the ADR improve when the drug was discontinued? +1 0
 4. Did the ADR appear with rechallenge? +2 -1
 5. Are there alternative causes for the ADR? -1 +2
 6. Did the reaction appear when placebo was given? -1 +1
 7. Was the drug detected in the blood at toxic levels? +1 0
 8. Was the ADR more severe when the dose was increased, or less severe when the dose was decreased? +1 0
 9. Did the patient have a similar reaction to the same or similar drugs in any previous exposure? +1 0
 10. Was the ADR confirmed by any objective evidence? +1 0
- Probability score: ≥ 9 = definite; 5-8 = probable; 1-4 = possible; ≤ 0 = doubtful.

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