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SSRIs/SNRIs

Depression and anxiety disorders CHAPTER 3 all drugs may be effective when standard doses have failed. Efficacy of SSRIs (but not SNRIs) increases across the licensed dose range in anxiety disorders.19 Onset of action may be as long as 6 weeks. Women may respond better to SSRIs than men.20 Augmentation with clonazepam leads to a more rapid response but not a greater magnitude of response overall.18 The optimal duration of treatment is unknown but should be at least 8 months.21 A large naturalistic study showed convincing evidence of benefit for at least 3 years.22 Less than half are likely to remain well after medication is withdrawn.23 Lower starting doses are also required in PTSD, although high doses (e.g. fluoxetine 60mg) are usually required for full effect. Response is usually seen within 8 weeks, but can take up to 12 weeks.23 Treatment should be continued for at least 6 months and probably longer.11,24,25 Although the doses of SSRIs licensed for the treatment of obsessive compulsive disorder (OCD) are higher than those licensed for the treatment of depression (e.g. fluoxetine 60mg, paroxetine 40–60mg), lower (standard antidepressant) doses may be effective, particularly for maintenance treatment.26 Initial response is usually slower to emerge than in depression (it can take 10–12 weeks). Dose should be increased to gain maximal benefit. Treatment should continue for at least 1 year.11 The relapse rate in those who continue treatment for 2 years is half that of those who stop treatment after initial response (25–40% vs 80%).27 In most people with OCD, the condition is persistent and symptom severity fluctuates over time.28 Second-line treatment is usually the addition of either risperidone or aripiprazole. Very high doses of SSRIs have also been tried (e.g. 650mg/day sertraline), apparently without any major safety problems.29 Body dysmorphic disorder should be treated initially with CBT. If symptoms are moderate to severe, adding an SSRI may improve outcome.30 Buspirone may usefully augment the SSRI,30 although no RCT has been conducted. Standard antidepressant starting doses are well tolerated in social phobia,31,32 and dosage titration may benefit some patients but is not always required. Some benefit is usually seen within 8 weeks and treatment should be continued for at least 1 year and probably longer.32 In the UK, NICE recommends CBT as first-line treatment for social anxiety.33 All patients treated with SSRIs should be monitored for the development of akathisia, increased anxiety and the emergence of suicidal ideation; the risk is greatest in those younger than 30 years, those with comorbid depression and those already known to be at higher risk of suicide.30,34 SSRIs should not be stopped abruptly, as patients with anxiety spectrum disorders are particularly sensitive to discontinuation symptoms (see section on stopping antidepressants in this chapter). The dose should be reduced as slowly as tolerated over several months. Pregabalin Pregabalin is licensed for the treatment of GAD. Several large RCTs have demonstrated its efficacy and tolerability and comparable speed of onset of action to a benzodiazepine.2,35 The dose of pregabalin in GAD is initially 150mg, increased gradually to a maximum of 600mg in two to three divided doses. It is

widely misused (often alongside opioids)36 and there is a significant risk of diversion.37 Pregabalin seems to worsen the

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