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Depression and anxiety disorders CHAPTER 3 References

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13. Trivedi MH, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. Am J Psychiatry 2006; 163:28–40. Table 3.3 (Continued) Treatment Advantages Disadvantages Combine olanzapine and fluoxetine31 6.25–12.5mg + 25–50mg daily (US licensed dose)* ■ ■Well researched ■ ■Usually well tolerated ■ ■Olanzapine + TCA may also be effective32 ■

■Olanzapine alone may be effective33,34 ■ ■Risk of weight gain ■ ■Limited clinical experience outside USA ■ ■Most data relate to bipolar depression Add quetiapine25,26 (150mg or 300mg a day) to SSRI/SNRI ■ ■Good evidence base ■ ■Usually well tolerated ■ ■Plausible explanation for antidepressant effect ■ ■Possibly more effective than lithium ■ ■Dry mouth, sedation, constipation can be problematic ■ ■Weight gain risk in the longer term SSRI + bupropion35–40 up to 400mg/day ■ ■Well tolerated ■ ■May improve sexual adverse effects ■ ■Not licensed for depression in the UK SSRI or venlafaxine

- mianserin (30mg/day) or mirtazapine40,41 (30–45mg/day) ■ ■Recommended by NICE ■ ■Usually well tolerated ■ ■Widely used ■ ■Theoretical risk of serotonin syndrome (inform patient) ■ ■Risk of blood dyscrasia with mianserin ■ ■Weight gain and sedation with mirtazapine ■ ■One RCT showed no advantage for mirtazapine added to SSRI/SNRIs42 * 5mg + 20mg rising to 10mg + 40mg seems reasonable where combination formulations not available. TCA, tricyclic antidepressant.

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