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References

394 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 3 with a heightened risk of stroke recurrence for this reason. Stroke can be embolic or haemorrhagic – SSRIs may protect against the former46,47 and provoke the latter,48,49 although the evidence base for this is rather weak50 (see section on SSRIs and bleeding in this chapter). Other adverse effects may also be problematic; specifically falls, bone fractures and seizures.19,24 Agomelatine is better tolerated than SSRIs or SNRIs in the post-stroke population and seems not to affect clotting parameters.33 Antidepressants are clearly effective in post-stroke depression51 and treatment should not usually be withheld.52 Inadequate treatment of depression increases the risk of stroke.11,53 Two network meta-analyses suggested that paroxetine might be the drug of choice when considering both efficacy and tolerability post-stroke, although small sample sizes and a lack of high-quality studies in this area limit the strength of this recommendation.54,55 Each analysis included only one paroxetine trial, whereas a meta-analysis of four trials of paroxetine found no benefit.56 A 2020 large network meta-analysis of 51 trials ranked mirtazapine first for response rate, followed by venlafaxine and escitalopram, although the studies were limited to Chinese participants and so may lack generalisability.57 Box 3.3 shows recommended drugs for use in post-stroke depression. Where SSRIs are given in any patient treated with anticoagulants or aspirin, consideration should be given to the prescription of a proton-pump inhibitor for gastric protection. Nortriptyline, which does not appear to increase risk of bleeding, is an alternative. References

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