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References

Depression and anxiety disorders CHAPTER 3 treatment or to have antidepressants slowly stopped.²⁹ After 1 year, relapse occurred in 56% of stoppers and 39% of continuers. There was clear evidence of withdrawal symptoms despite the slow withdrawal (probably because alternate day dosing was used). In the REDUCE study,³⁰ patients receiving antidepressants for 1 year (first episode) or 2 years (multi-episode) were slowly withdrawn from treatment. Around 43% of patients were able to discontinue treatment without relapse by 6 months. The main finding from these studies, taken together, is that successful withdrawal from long-term antidepressants is possible, but that continued treatment is probably necessary (and somewhat effective) for a substantial proportion of people. Dose for prophylaxis Adults should receive the same dose as used for acute treatment.³¹ There is some evidence to support the use of lower doses in elderly patients. Dosulepin 75mg/day offers effective prophylaxis³² but is now rarely used and its relevance is dubious. There is no evidence to support the use of lower than standard doses of SSRIs.³³ Relapse rates after ECT are similar to those after stopping antidepressants.³⁴ Antidepressant prophylaxis will be required, ideally with a different drug from the one that failed in the first instance, although good data in this area are lacking. Lithium also has some efficacy in the prophylaxis of unipolar depression but efficacy relative to standard antidepressants is unknown.³⁵ Lithium treatment may have the best outcomes of any treatment for unipolar depression.³⁶ In the UK, NICE has recommended that lithium should not be used as the sole prophylactic drug in unipolar depression.³⁷ There is some support for the use of a combination of lithium and nortriptyline.³⁸ Maintenance treatment with lithium protects against suicide.³¹ References

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