Nuts & Bolts: SSRI Rx in Primary Care
Amanda Downey, MD
February 3, 2022

Questions from Learning Session

What is your take on pharmacogenetic testing?

It's really tough. Most of the testing companies are a) for profit , and b) like to put medicines into these "green light, yellow light, red light categories. Which reads really nicely to patients and families. To prescribers who are not super familiar with pharmacogenetics and the way meds are metabolized, it's just awfully tempting to really lean into that and let that guide your choices. And the science really just isn't there yet in terms of the current panels, the way they stand, they really can't tell you if the young person is going to respond or not. And it's a very rare instance that you get information that will very clearly tell you that this patient is going to have wicked side effects from one of the SSRIs. So I am only ordering genetic testing on patients that have failed 2, 3, 4 robust trials of medications or have had 2 trials of a medication and are just exquisitely sensitive to the side effects. In the absence of that, there's just not a good reason to get that for someone who's relatively uncomplicated (anxiety, depression, ADHD) who's never been treated with a medication. It's just really hard to justify.

I was wondering about your thoughts on increased suicidal ideation with fluoxetine vs sertraline?

I don't remember that data off the top of my head. There is one meta-analysis that looks at suicidal ideation with the four primary SSRIs. It's negligible. It's not a difference that makes me want to prescribe differently or change my practice.

Reference: Jing E, Straw-Wilson K. Sexual dysfunction in selective serotonin reuptake inhibitors (SSRIs) and potential solutions: A narrative literature review. Ment Health Clin [Internet]. 2016;6(4):191-6. DOI:10.9740/mhc.2016.07.191.

Could you repeat what you said about stacking and how long it takes to reach the blood level for Prozac.

It's going to differ a little bit by everyone's genetic profile. But, let's assume everyone's a normal metabolizer. The half-life of Prozac is 7-10 days; it takes 7-10 days to reach steady state in terms of serum blood concentration. So let's be aggressive and say 7 days times 4 half-lives; we're looking at a month for that patient's body to see the medication as steady state. So Prozac is the only medication, because of that really long half-life, that I worry about up-titrating too quickly. If you're ramping up from 10 mg to 60 mg in a month, a month after that is when the patient's body is going to see the full effect of that medication and then you might be in hot water in terms of serotonin syndrome.

I have heard that some providers think Lexapro will cause more anxiety when they are on it long term? What is your thought on that?

I am not familiar with that data and anecdotally that has not been my experience.

I have only been able to find sertraline as a liquid for those that are really difficult to give a pill to.

Lexapro also comes in a liquid formulation, although that's been more challenging to get insurance approval for, at least in California. Those tend to be my go-tos if a need a liquid formulation. Of course, formularies are changing all the time and things are going generic so unfortunately it's just staying on top of what's available.

Participant posted in the chat that Prozac comes in a liquid.

Thoughts about SNRI (Cymbalta) for complex trauma

That is well outside the scope of this lecture. Complex trauma is this point of clinical heterogeneity that is so tough to really nail down. It is best treated in the context of therapy and if there is a depressive piece, a chronic pain piece, depression that hasn't responded to SSRIs a trial of an SNRI is absolutely reasonable and there is both safety and efficacy literature out there in terms of its use in adolescents.

Is sexual dysfunction associated more with a particular SSRI?

Data's a little gray area for that and we think that it's really dependent on the way that folks metabolize these medications. So there's a lot of variability and it's also really hard to tell because depression and anxiety also lead to sexual dysfunction so it's just a little bit gray. Paxil, the one we're no longer using, tends to be the worst offender so luckily that's probably not what you're going to be using. The least likely one to cause sexual dysfunction is Lexapro. So maybe if I've started Zoloft on a patient and the sexual side effects are not tolerable I will cross-taper or switch to Lexapro, thinking of that as a relatively clean medication.

Are there any lab tests that primary care need to obtain to monitor SSRIs? How about atypicals?

We're going to skip atypicals because that is outside the scope of this lecture. For SSRIs, no. There's no monitoring you need to do. The rare time I would monitor something would be again thinking about seratonergic agents having a platelet effect and if there's a history of bleeding disorder that I'm a little bit more nervous about. But that's really the only instance I would ever consider it. Remember, if you have a new depression, you might want to think about things like thyroid testing, anemia, vitamin D deficiency, like those other kind of medical things you can optimize to treat the depression.

At what time, will a PCP decide to refer to psychiatrist

It is ultimately up to your comfort. What is typical, and what the American Academy of Child and Adolescent Psychiatry would recommend, is if a patient has failed two robust trials of a SSRI. That's a very reasonable time to turf to a psychiatrist. That doesn't mean they were on 5 of Lexapro and they didn't feel an effect. Truly up-titrating a dose to a reasonable range and not

seeing a response, that's a really nice time to triage. And any other complexity where you're not comfortable, for example you're worried a kid is showing manic symptoms or has a lot of behavior health comorbidities; no psychiatrist is going to fault you for that referral. These kids are challenging; there's a lot of gray area and a lot of complexity so as a psychiatrist, I appreciate that there are folks out there who are trying to triage behavioral health conditions.

Best meds for PTSD and nightmares

See the attached AACAP Practice Parameters with best current evidence of use of SSRIs, alpha agonists, etc in this setting.

Reference: AACAP Official Action: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. J. Am. Acad. Child Adolesc. Psychiatry, 2010;49(4):414 – 430.

Gene Site was giving us swabs to treat and I was doing them to see if anything was really contraindicated, but then was told they are not helpful at all. Do you find it at least tells you which meds to avoid? Or not helpful.

Including a helpful but detailed article discussing pros and cons of current pharmacogenetics testing practices. Helpful graphic on page 662 in terms of how to best approach the results.

Reference: Thoughtful Clinical Use of Pharmacogenetics in Child and Adolescent Psychopharmacology. J. Am Acad of Child Adol Psych. June 2021.

Can I continue depression treatment for 1 yr without referral to psychiatrist?

Absolutely! Unless the patient has complicated comorbidities, is not improving on standard trial of 2 SSRIs, etc - no reason that mild/moderate depression shouldn't be managed in primary care.

What is the cut off time for continuation of anti-depressants?

Data here is lacking. As a general rule of thumb, most clinicians will continue prescribing for at least 6 months after achieving "remission" before consideration of discontinuation. If 2 or more episodes of depression, clinicians should consider prescribing for at least 9-12 months following remission, with consideration for longer term administration