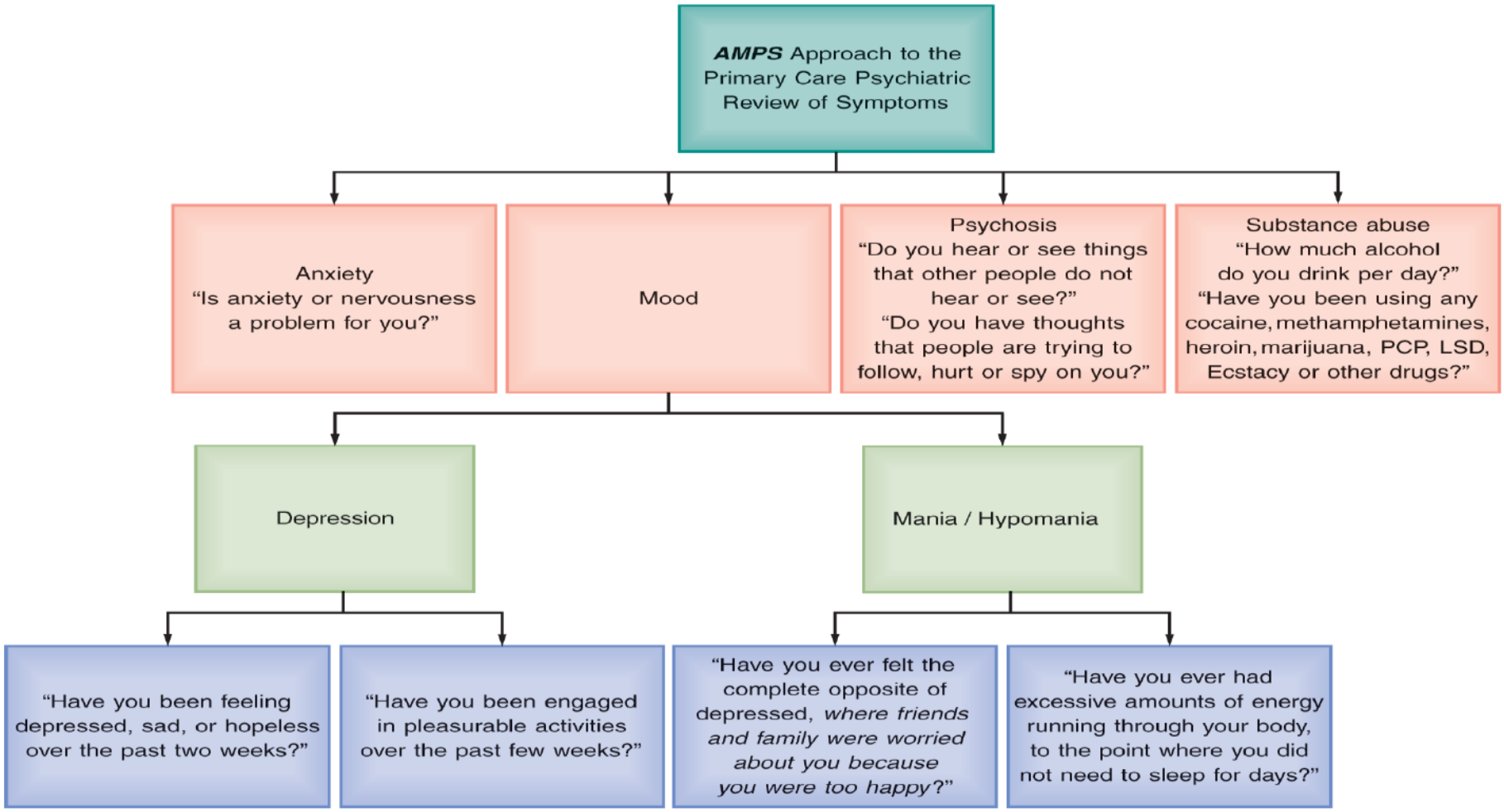
Honest Tips in Primary Care Psychiatry

MERCEDES BARRUTIA DODGE, MPAS, PA-C

Education and material collected from the Primary Care Psychiatry UCDavis/UCIrvine Fellowship, Book: Lippincott's Primary Care Psychiatry by Dr Robert McCarron, and UpToDate

CONTENTS: **PAGE**


AMPS Approach to the Primary Care Psychiatric Review of Symptoms
Anxiety
"Is anxiety or nervousness a problem for you?"
Mood
Psychosis
"Do you hear or see things that other people do not hear or see?"
"Do you have thoughts that people are trying to follow, hurt or spy on you?"
Substance abuse
"How much alcohol do you drink per day?"
"Have you been using any cocaine, methamphetamines, heroin, marijuana, PCP, LSD, Ecstacy or other drugs?"
Depression
Mania / Hypomania
"Have you been feeling depressed, sad, or hopeless over the past two weeks?"
"Have you been engaged in pleasurable activities over the past few weeks?"
"Have you ever felt the complete opposite of depressed, *where friends and family were worried about you because you were too happy*?"
"Have you ever had excessive amounts of energy running through your body, to the point where you did not need to sleep for days?"

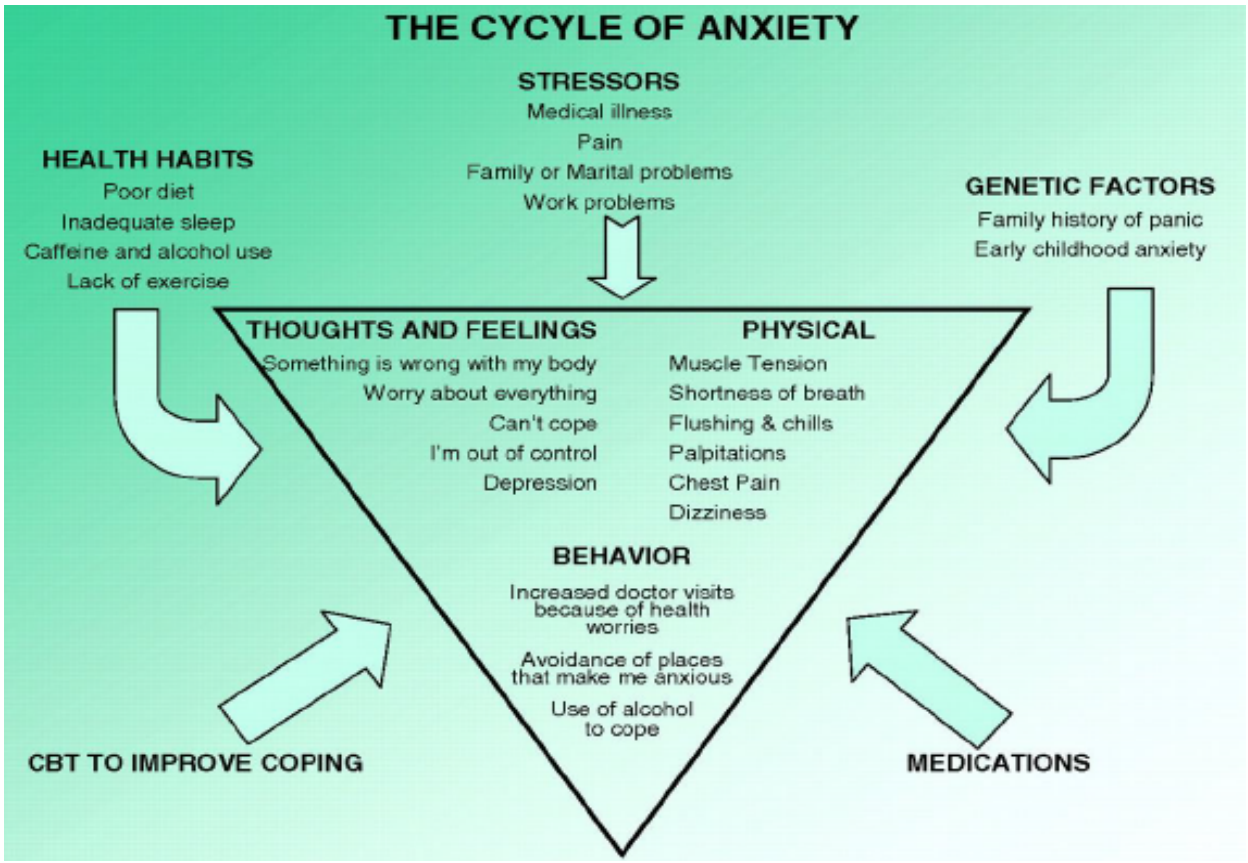
Commonly Prescribed Psychotropic Medications

NAME Generic (Trade)	DOSAGE	KEY CLINICAL INFORMATION
Antidepressant Medications*		
Bupropion (Wellbutrin)	Start: IR-100 mg bid X 7d, then ↑ to 100 mg tid; SR-150 mg qam X 7d then ↑ to 150 mg bid; XL-150 mg qam X 7d, then ↑ to 300 mg qam. Range: 300-450 mg/day.	SSRI; Contraindicated in seizure disorder and history of TBI because it decreases seizure threshold; stimulating; not good for treating anxiety disorders; 2nd line tx for ADHD; abuse potential. P: C L: Use caution. ¢ IR/SR/XL.
Citalopram (Celexa)	Start: 10 mg qday X 7d, then 20 mg. Range: 20-40 mg/d (Max 20 mg for > 55 y/o).	Well-tolerated SSRI; minimal CYP 450 interactions; good choice for anxious pt. Caution: QTc prolongation. P: C; L: Use caution. ¢
Duloxetine (Cymbalta)	Start: 30 mg qday X 7d, then ↑ to 60 mg qday. Range: 60-120 mg/day.	SNRI; TX neuropathic pain; need to monitor BP; 2nd line TX for ADHD. P: C; L: Safety unknown. $$
Escitalopram (Lexapro)	Start: 5 mg qday X 7d, then ↑ to 10 mg qday. Range 10-20 mg/d (~3X potent vs. Celexa).	Best tolerated SSRIs; minimal CYP 450 interactions. Good choice for anxious pt. P: C; L: Use caution. ¢
Fluoxetine (Prozac)	Start: 10 mg qam X 7d, then ↑ to 20 mg qday. Range: 20-60 mg/day.	More activating than other SSRIs; long half-life reduces withdrawal (t ½ = 4-6 d). P: C; L: Not recommended. ¢
Mirtazapine (Remeron)	Start: 15 mg qhs. X 7d, then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	Novel mechanism; Sedating and appetite promoting; Neutropenia risk so avoid in the immunosupressed. P: C; L: Safety unknown. ¢
Paroxetine (Paxil)	Start: 10 mg qhs X 7d, then ↑ to 20 mg qday. Range: 20-60 mg/day.	SSRI; Anticholinergic; sedating; significant withdrawal syndrome. P: D; L: Use caution. ¢
Sertraline (Zoloft)	Start: 25 mg qam X 7d, then ↑ to 50 mg qday. Range: 50-200 mg/day.	SSRI; limited CYP 450 interactions; mildly activating. P: C; L: Safest. ¢
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 7d, then ↑ to 75 mg bid; ER-75 mg qam X 7d, then ↑ to 150 qAM. Range: 150-375 mg/day.	SNRI. More agitation & GI side effects than SSRIs; tx neuropathic pain 225 mg and above; need to monitor BP; Significant withdrawal syndrome. P: C; L: Not recommended. ¢ ER $ IR.
Nortriptyline (Pamelor)	Start: 25 mg qhs X 7d, then ↑ 25 mg qhs - q weekly to 75 mg qhs. Range: 75-150 mg/day.	TCA; Sedating; Helpful in neuropathic pain; Baseline EKG; Max dosing 100mg in elderly; Lethal in overdose. P: D; L: Not recommended. ¢
*Warnings/precautions: 1) Potential increased suicidality in first few months, 2) Long term weight gain likely (except venlafaxine & bupropion), 3) Sexual side effects common (except bupropion & mirtazapine), 4) Withdrawal syndrome frequently occurs with abrupt cessation (especially with SSRIs and SNRIs), Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 5) Risk for Serotonin Syndrome (except bupropion), especially with combination of drugs effecting serotonin metabolism, 6) Hyponatremia sometimes seen with SSRIs and SNRIs especially in elderly.		
Antianxiety and Sleep (Hypnotic) Medications		
Alprazolam (Xanax)	Start: IR-0.25-0.5 mg tid. Usual MAX: 4 mg/d. ER-0.5-1mg qAM Usual MAX:3-6 mg/d	Equiv. dose: 0.50 mg. Onset: intermediate (1-2 hrs). T½: 11 hrs. More addictive than other benzos and has uniquely problematic withdrawal syndrome. Try to avoid as 1st line tx. Significant withdrawal syndrome. P: D; L: Use caution. ¢
Amitriptyline (Elavil)	Start: 10 mg qhs X 7d, then consider ↑ 25 mg qhs Range: 10-50mg/qhs	TCA; Sedating; Helpful in neuropathic pain; Lethal in overdose. P: C; L: Compatible. ¢
Clonazepam (Klonopin)	Start: 0.25 mg bid Usual MAX: 4 mg/day.	Equiv. dose: 0.25 mg. Onset: intermediate (1-4 hrs). T½: 30-40 hrs. Helpful in TX mania. P: D; L: Not recommended.¢
Diazepam (Valium)	Start: 5 mg bid. Usual MAX: 40 mg/day.	Equiv. dose: 5 mg. Onset: immediate. T½: 50-100 hrs. Caution with liver disease P: D; L: Contraindicated ¢
Lorazepam (Ativan)	Start: 0.5-1 mg bid to tid. Usual MAX: 6 mg/day. Insomnia: 0.5-2 mg qhs.	Equiv. dose: 1 mg. Onset: intermediate. T½: 12 hrs. No active metabolites, so safer in liver dz. P: D; L: Use caution. ¢
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like drug FDA approved for anxiety. May take 4-6 weeks to become fully effective. P: B; L: Not recommended ¢
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg/day.	Non-benzo Antihistamine FDA approved for anxiety. P: C (Not recommended in 1st trimester); L: Not recommended ¢
Prazosin (Minipress)	Start: 1 mg qhs. Increase q 2-3 d until symptoms abate. Usual MAX: 10 mg qhs.	Old BP med used to TX nightmares. Warn about orthostasis in AM after first dose and after each new dosage change. P: C; L: Use caution.¢
Trazodone (Desyrel)	Start: 25-50 mg qhs. Range: 50-150 mg qhs.	Commonly used as sleep aid; inform about priapism risk in men. P: C; L: Use caution ¢
Temazepam (Restoril)	Start: 15 mg at bedtime. MAX: 45 mg qhs.	T½: 8.8 hrs. Older benzo hypnotic. No P450 metabolism. More potential for physical dependence. P: X; L: Use caution. ¢
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 20 mg qhs.	T½: 2.6 hrs. Potential for sleep-eating and sleep-driving. P: C; L: Compatible ¢ Available in longer acting form (CR $)
Mood Stabilizers		
Lithi	Start: 300 mg bid or 600 mg qhs. Target plasma level: acute mania & bipolar depression: 0.8-1.0 meq/L; Maintenance: 0.6-0.8 meq/L. Available in ER form dosed once daily (usually at HS, Lithobid & Eskalith). Plasma levels related to renal clearance.	Black box warning for toxicity. Teratogenic (cardiac malform.) and will need to inform women of childbearing age of this risk. Check Ca^{2+}, TSH and BMP before starting and q6-12 months thereafter. Advise pt about concurrent use of NSAIDS and HTN meds acting on the kidney as can decrease renal clearance. Lithium strongly anti-suicidal. P: D (Not recommended in 1st trimester); L: Not recommended ¢
Divalproex (Depakote)	Start: 500 mg/day (bid, DR; qday, ER); increase dose as quickly as tolerated to clinical effect. Target plasma level: 75 to 100 mcg/mL (DR) & 85-125 mcg/ml (ER).	Multiple black box warnings including for hepatotoxicity, pancreatitis, and teratogenicity (need to inform women of childbearing age of this risk). Need to monitor LFTs, platelet counts, and coags initially and q3-6 mo. Weight gain common. P: D/X; L: Compatible $
Lamotrigine (Lamictal)	Start: 25 mg daily for weeks 1 & 2, then 50 mg daily for weeks 3 & 4, then 100 mg qday for week 5, and finally 200 mg qday for week 6+ (usual target dose). Dosage will need to be adjusted for patients taking enzyme-inducing drugs or Depakote.	Black box warning for serious, life-threatening rashes requiring hospitalization and d/c of TX (Stevens Johnson syndrome @ approx. 1:1-2000). No drug level monitoring typically required. Need to strictly follow published titration schedule. Fewer cognitive and appetite stimulating side effects. No evidence that doses above 200 mg more effective for mood. P: C; L: Not recommended ¢
Antipsychotic/Mood Stabilizers**		
Aripiprazole (Abilify)	**Mania.** Start: 15 mg qday; Range: 15-30 mg/day. **MDD adj tx.** Start: 2-5 mg/day; adjust dose q1+ weeks by 2-5 mg. Range: 5-10 mg/day. MAX: 15 mg qday. **Schizophrenia.** Start: 10-15 mg/day; ↑ at 2 week intervals; Range: 10-15/day; MAX: 30 mg/day.	EPS: Mild; TD Risk: Mild; Sedation: Mild; Metabolic Effects: Mild. Very long half-life: 75 hrs. Least amount of sexual side effects. FDA indication for adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. P: C; L: Use caution. $$
Olanzapine (Zyprexa)	**Mania.** Start: 10 mg qhs; Range: 10-20 mg/qhs. MAX: 20 mg/day. **Schizophrenia.** Start: 5 mg qhs; ↑ by 5 mg qhs per week; Range: 10-15 mg qhs: MAX: 20 mg/day.	EPS: Mild; TD Risk: Mild; Sedation: Moderate; Metabolic Effects: Severe. Do not prescribe to diabetics. Need to screen glucose and lipids regularly. P: C; L: Not recommended. ¢
Quetiapine (Seroquel)	**Bipolar Dep:** Start: 50 mg qhs; Initial target: 300 mg qhs; Range: 300-600 mg/d. **Mania.** Start: 50 mg bid; Initial target: 200 mg bid. Range: 400-800 mg/d. **MDD adj tx.** Start: 50 mg qhs; Initial target: 150 mg qhs. Range: 150-300 mg/day. **Schizophrenia.** Start: 25 mg bid and increase by 50-100 mg/d (bid/tid). Initial target: 400 mg/d. Range: 400-800 mg/d.	EPS: Mild; TD Risk: Mild; Sedation: Moderate; Effects: Moderate. FDA indication for bipolar depression and adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. Abuse potential. Available in an extended release form: Seroquel XR. Avoid or use alternative in combination with methadone due to QTc prolongation. P: C; L: Use caution. IR $/XR $$
Risperidone (Risperdal)	**Mania.** Start: 1-2 mg qhs;↑ by 1-2 mg/day per week. Range: 3-4 mg/day. MAX: 6 mg/day. **Schizophrenia.** Start: 1 mg qhs;↑ by 1 mg/day per week; Range: 3-4 mg/day: MAX: 6 mg/day.	EPS: Moderate; TD Risk: Moderate; Sedation: Moderate; Metabolic Effects: Moderate. Hyperprolactinemia and sexual side effects common. Need to screen glucose and lipids regularly. P: C; L: Use caution. ¢
Ziprasidone (Geodon)	Start: 40 mg bid titrating quickly to 60–80 mg bid. Needs to be taken w/ food (doubles absorption). Lower dosages can be more agitating than higher dosages.	EPS: Moderate; TD Risk: Mild; Sedation: Moderate; Metabolic Effects: Mild. Need to screen glucose and lipids regularly. Contraindicated in combination with methadone due to QTc prolongation. P: C; L: No data/Not recommended. $
**Antipsychotic/mood stabilizer warnings/precautions: 1) Increased risk of death related to psychosis and behavioral problems in elderly patients with dementia, 2) Increased risk of QTc prolongation and risk of sudden death (especially in combination with other drugs that are known to prolong the QTc).		

po = by mouth; prn = as needed; qday = 1x/day; bid = 2x/day; tid = 3x/day; qid = 4x/day; qod = every other day; qhs = at bedtime; qac = before meals. P= pregnancy risk category L= lactation. ¢ = <$20. $ = $20-$50. $$ >$50. SSRI = Selective Serotonin Reuptake Inhibitor. SNRI = Serotonin Norepinephrine Reuptake Inhibitor. Initially developed by Stephen Thilke, MD, MPH & Alex Thompson, MD, MPH in 2008. Subsequent revisions by David A. Harrison, MD, PhD & Anna Ratzliff, MD, PhD ©University of Washington V3.2 Sept 2013.

NOTICE: This guide, updated September 2013, is a reference tool. It is the provider's responsibility to verify the information is current before use in a clinical setting. FDA labeling information available at www.accessdata.fda.gov/scripts/cder/drugsatfda/.

Online: https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications



The Anxiety Cycle

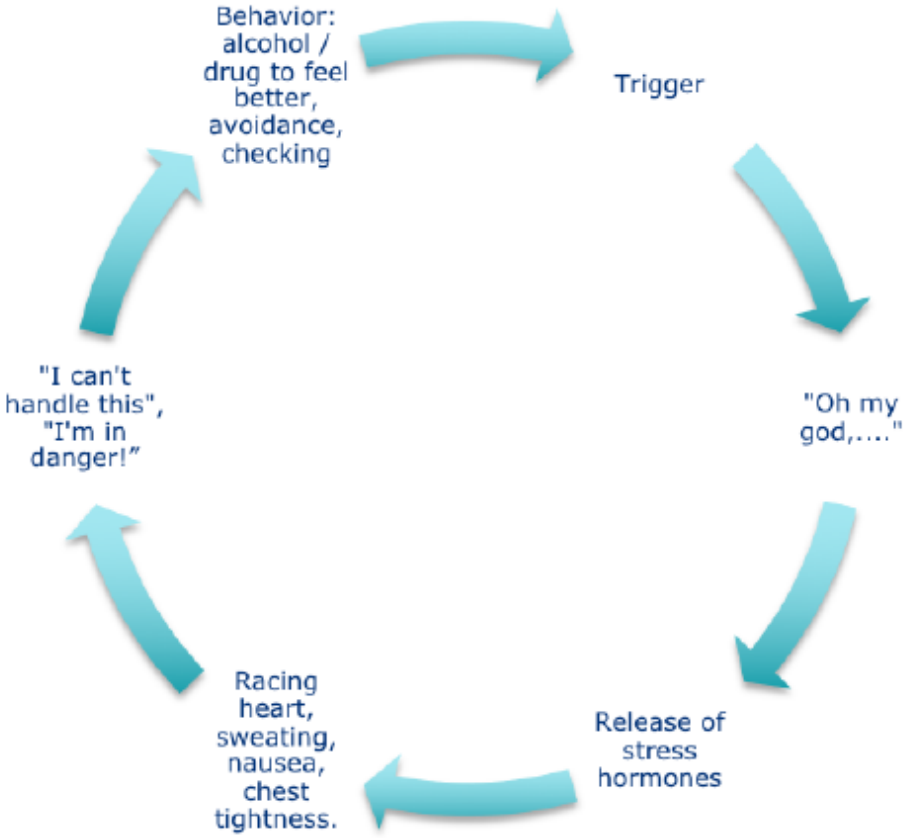


TABLE 8-4 First-Line Antidepressant Medications

CLASS	INITIAL DOSE (mg/day)[a]	THERAPEUTIC DOSE (mg/day)	PRACTICAL POINTERS FOR THE PCP[b]
Selective serotonin reuptake inhibitors (SSRIs)			
Sertraline (Zoloft)	50	50-200	Serotonin and dopamine reuptake inhibition Possible early and temporary diarrhea and dyspepsia Relatively low risk for drug interactions
Paroxetine Paroxetine CR (Paxil, Paxil CR)	20 12.5-20	20-60 25-75	High anticholinergic and antihistamine side effect profile Risk for sedation, weight gain, and dry mouth Short half-life with more risk for discontinuation syndrome High chance for drug interactions Unsafe during pregnancy—class D
Fluoxetine (Prozac)	20	20-60	Long half-life and ideal for intermittently compliant patients Relatively inexpensive High chance for drug interactions
Fluvoxamine (Luvox)	50	50-300	Rarely used owing to high side effect profile
Citalopram (Celexa)	20	20-60	Structurally similar to escitalopram Low risk for drug interactions
Escitalopram (Lexapro)	10	10-20	Structurally similar to citalopram Low risk for drug interactions
Serotonin norepinephrine reuptake inhibitors (SNRIs)			
Venlafaxine XR (Effexor XR)	37.5	75-300	Structurally similar to desvenlafaxine (do not use concurrently) Dual action on serotonin and norepinephrine receptors *Not* consistently "activating" but usually does not cause sedation Sometimes used as an adjunct for chronic pain Not to be used in those with difficult-to-treat hypertension May increase blood pressure and heart rate, especially at higher dosing range (>150 mg/day) Non-XR formulation is rarely used due to side effect profile and twice-per-day dosing Short half-life with more risk for discontinuation syndrome Reduce dose with renal insufficiency
Desvenlafaxine (Pristiq)	50	50-100	Structurally similar to venlafaxine (do not use concurrently) Dual action on serotonin and norepinephrine receptors *Not* consistently "activating" but usually does not cause sedation Not to be used in those with difficult-to-treat hypertension Short half-life with more risk for discontinuation syndrome Reduce dose with renal insufficiency
Duloxetine (Cymbalta)	30	30-60	Dual action on serotonin and norepinephrine receptors *Not* consistently "activating" but usually does not cause sedation FDA approved for fibromyalgia and diabetic peripheral neuropathic pain Sometimes used for chronic neuropathic pain Short half-life with more risk for discontinuation syndrome Increased risk for drug interactions
Other			
Bupropion	75-150	300-450	
Bupropion SR (Wellbutrin SR)	100	300-400	Given twice per day Likely dual action on dopamine and norepinephrine receptors Contraindicated with seizure and eating disorders
Bupropion XL (Wellbutrin XL)	150	300-450	Increased risk for seizures in those with alcohol withdrawal Not used for anxiety disorders May worsen anxiety associated with depression No serotonin activity and no related sexual side effects XL formulation is supposed to have slower release and lower side effect profile (permits higher dosing and lower seizure risk) Less frequently used owing to side effect profile
Mirtazapine (Remeron)	15	15-45	Increases central serotonin and norepinephrine activity (possibly through presynaptic α_2-adrenergic receptor inhibition) Decreased frequency of sexual side effects Increased sedation and sleepiness at mainly *lower* doses Although not indicated for anxiety disorders, it may be helpful Remeron Soltab is orally dissolving for patients who cannot swallow

[a] *Initial dose should be decreased by half when treating an anxiety disorder or an elderly person.*

[b] *Drug interactions refer to commonly used medications that are principally metabolized by the P450 2D6 pathway.*

FDA, Food and Drug Administration; PCP, primary care physician.

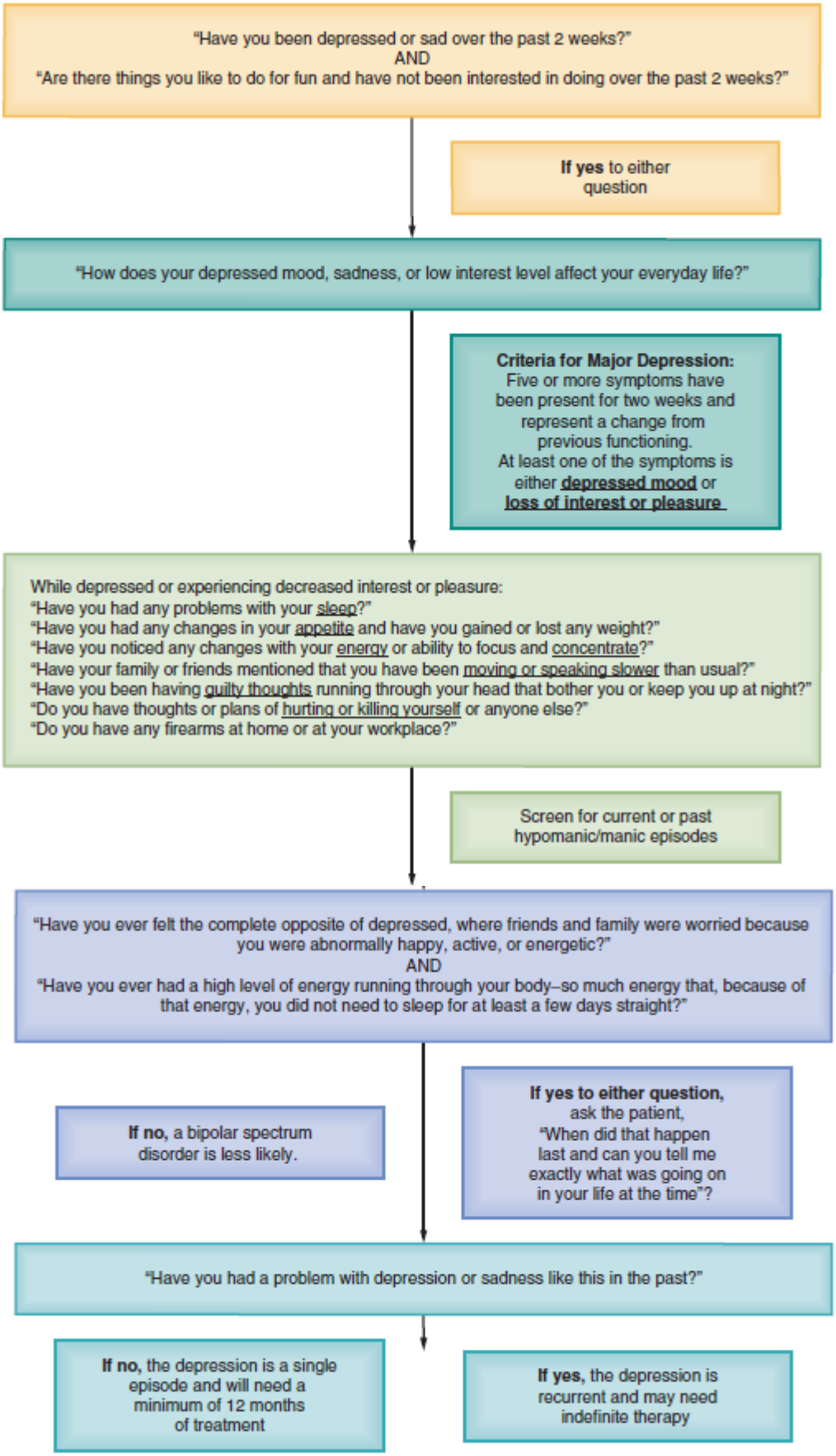


Figure 2.1 Diagnosing depression in the primary care setting.

CROSS TAPER/SWITCHING	Recommendations	Notes or Exceptions
Between SSRI	Direct immediate switch to equivalent*	*You may start the new SSRI lower dose, but close follow up as may be sub therapeutic
SSRI to SNRI	Direct immediate switch	*If high SSRI then cross-taper *If switching from Fluoxetine or paroxetine to duloxetine or venlafaxine then should start SNRI at low doses (but direct switch)
Between SNRI	Direct immediate switch if at low doses Cross-taper if at high doses	*low dose = <150 mg venlafaxine, <60 duloxetine)
SSRI to other atypical antidepressants or serotonin modulators	Cross-taper	*If switching to bupropion Cross-taper for 1-3 weeks *If switching from Fluoxetine Cross-taper for ≥ 2 weeks
SNRI to other atypical antidepressants	Cross-taper for 1-4 weeks	* If switching from Duloxetine or Venlafaxine Cross-taper for ≥ 2 weeks
Bupropion to SSRI, SNRI, TCA or other atypical antidepressants, serotonin modulators	Cross-taper 1-3 weeks	*Recommend avoid rx high dose Bupropion with Fluoxetine or Paroxetine
Mirtazapine to SSRI, SNRI, TCA, other atypical antidepressants, serotonin modulators	Cross-taper	
Serotonin modulators to SSRI, SNRI, TCA, atypical antidepressants, or serotonin modulators	Cross-taper 1-2 weeks	Serotonin modulators are Vortioxetine, nefazodone, trazodone. Vilazodone

*See equivalent dose table on UpToDate labelled: **Unipolar depression in adults: Antidepressant doses**

Table 2.6 Sample Dysfunctional Thought Record (DTR)

EMOTIONS	AUTOMATIC DYSFUNCTIONAL THOUGHTS	RECONSTRUCTED THOUGHTS	OUTCOME
Specify feeling Rate 1–10 (10 rated as most intense)	"What is running through your head?" (NOT an emotion or feeling)	"Why is the automatic thought inaccurate (be specific)?"	Respecify feeling Rerate feeling using 1–10 scale
"Sad" 9/10	"*No one* will ever really care about me."	"Not true — my parents and wife love me even when I am irritable and unhappy."	"Sad" 3/10
"Depressed" 8/10	"I will never amount to anything."	"I actually have a great job and my kids see me as a great dad.... I think I am just feeling low today."	"Depressed" 2/10
"Really down" 9/10	"I would be much better off dead." "I'm worthless and have no energy."	"Who would take care of my family if I were actually dead?" "The depression makes my energy lower but I can still function." "I feel worthless at this moment but I know my boss relies on me."	"Down" 5/10

Dysfunctional Thoughts Record (DTR) Date_____

EMOTIONS Specify feeling Rate 1-10 (10 rated as most intense)	**ATUOMATIC DYSFUNCTIONAL THOUGHTS** "What keeps running through your head?" (NOT an emotion or feeling)	**RESCONSTRUCTED THOUGHTS** "Why is this automatic though wrong or inaccurate" "How else can you explain the obj. situation?"	**EMOTIONS AFTER REFLECTION (or OUTCOME)** Re-specify feeling Re-rate feeling using 1-10 scale