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Novel Therapeutics Treating the Adverse Events From SSRI and SNRI Monotherapy

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Ms. Sheahan:
Hello, my name is Catherine Sheahan. I'm a Nurse Practitioner dual certified in both Psychiatric and Family Health. I'm here today to talk with you about some novel therapeutics to treat adverse events found with traditional SSRI and SNRI effect - treatments.

Side effects can be measured with the Frequency, Intensity, and Burden Side Effect Scale, or the FIBSER, and it's very effective for monitoring side effects subjectively by the patients. It's important that patients understand the importance of reporting their side effects to the clinician. It's important for the clinician to do a very comprehensive education on what side effects they may potentially experience. Side effects are one of the primary reasons that people drop out of treatment. Having a heavy burden of adverse effects at 4 weeks is typically a very poor predictor of outcomes.

So pretreatment evaluations, it's important to understand where the patient is coming from even before you begin treatment because many of the side effects that can be attributed to SSRIs or SNRIs actually may exist even before treatment.

Common side effects of SSRIs and SNRIs can be grouped into the various symptoms, either psychiatric side effects, neuro, metabolic, Gi, coagulopathy, or sexual side effects. Some of the more serious side effects that need to be pointed out, and where patient education is critical, these can include EPS, extrapyramidal symptoms, rashes such as Stevens-Johnson syndromes, hyponatremia, or SIADH. These can all be - typically occur early in therapy, usually within the first 30 days and, you know, careful monitoring, and lab work are essential. It's especially important to discuss with the patients, treatment-emergent suicidality is most common with young adults and teenagers. And the only treatment for this is to stop the medication. And if necessary, to seek a higher level of care, even hospitalization should it occur.

It's important also to talk about congenital malformation risks in pregnancies. And that has to be weighed against the potential risk to the mother as a pregnant woman, or the risk to the fetus, and whether it's safe to continue therapy to keep the mom safe and therefore keep the baby safe. It's a case-by-case decision.

It's also important to note patients that cataracts could possibly happen, and they need regular eye exams. These are all variable and specific to the different SSRIs/SNRIs that are out there.

Some of the clinical pearls that are important to note for SSRI and SNRI side effects is that they do typically resolve after several weeks. That it's also important to note that they increase with the - incidence of side effects will increase with the dose. Many side effects are dose and time dependent. And sometimes you can backtrack, decrease the dose, and try to titrate it up again as tolerated if they're getting suboptimal relief. This is another point where it's helpful to track the treatment response and side effects over time using measurement-based cares and the self-reporting tools as previously discussed.

So what do we do about all these side effects? We can start the med at the lowest therapeutic dose. Those patients who have high anxiety sometimes it's effective to start them at a half dose, and titrate up much more slowly to minimize the risk of their side effects and, unfortunately, ending up with dropout. And it's important they understand watchful waiting, as sometimes you just have to kind of hang in there with it a little bit and see if it resolves. You can change the dosing time, you can switch between morning or night, you can go with food, without food, you can switch formulations from extended to immediate release, you can divide the dose over time.

It's also important to keep in mind that somebody becomes activated, overagitated, overactivated, you might have induced a bipolar state, especially if there's some mix dysphoria involved and suicidality and the treatment for that needs to be reevaluated because you may have induced bipolar disorder, or men may have.

So then it becomes, alright are we switching or are we augmenting, should we have notable side effects? The best approach for switching is if the patient has minimal relief and significant side effects, it's time to switch. And you can always try another SSRI. Duloxetine has a good effect for cognitive slowing, however it has a high side effect profile. Vortioxetine, on the other hand, is good for cognitive slowing, emotional blunting, and apathy, and sexual dysfunction. It has a very robust side effect profile. In those patients who are having suboptimal relief of their depressive symptoms and minimal side effects, so they're getting there but not quite there, bupropion and mirtazapine are excellent options for augmenting.

Thanks very much for your time with me reviewing some of this data and I wish you the best.

Announcer:
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