Antidepressant Handy Hints

journey to change

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

- Agomelatine
- Amitriptyline
- Bupropion
- Citalopram
- Clomipramine
- Dosulepin
- Doxepin
- Duloxetine
- Escitalopram
- Fluoxetine
- Fluvoxamine
- Imipramine
- Lofepramine
- Mirtazapine
- Nortriptyline
- Paroxetine
- Reboxetine
- Sertraline
- Trazodone
- Trimipramine
- Venlafaxine
- Vortioxetine

Not a comprehensive list of antidepressants.

The order of drugs listed does not imply an order of preference – please refer to the relevant treatment algorithm for specific recommendations on treatment choice.

Inclusion does not imply approval – please check local formulary status before prescribing:

North-East and North Cumbria Formulary

North Yorkshire and York Formulary

This guidance should be viewed in line with the respective TEWV depression and anxiety treatment pathways.

Click on the 'buttons' on this page to navigate to information about the drug you are interested in.

Use "Ctrl+F" and type in keywords to quickly search the document.

Links to the trust policies and guidance:

Medicines Optimisation – Interactive Guide

Title	Antidepressants Handy Hints		
Approved by	D&T Committee	Date approved	25th September 2025
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Selective Serotonin Reuptake Inhibitors (SSRIs) – (1)

ACTION: Delayed disinhibition of serotonin neurotransmission via 4 key pathways – the somatodendritic serotonin autoreceptors, neuronal impulse flow and postsynaptic serotonin receptors, and inhibition of the serotonin reuptake pump

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Citalopram **Escitalopram**	• ECG required before initiation in patients with cardiac disease to rule out pre-existing QT-prolongation – see Trust guidelines; maximum doses reduced by MHRA to minimise risk of dose-dependent QT-prolongation • More selective in the way they work and, therefore, generally have fewer side effects or secondary properties which may suit medically ill patients or those where there is polypharmacy	• Before initiating treatment, discuss the possibility of discontinuation symptoms when treatment is stopped. • Upon initiation – headache, nausea, insomnia, gastro-intestinal upset, sexual dysfunction* • Most common cause of poor compliance or stopping medication (especially in first 2 weeks). • Side effects self-limiting and occur usually in first 2 weeks. • Agitation and anxiety can increase / occur in first 2 weeks – if extreme use short term benzodiazepine (remember to discontinue) for approximately 2 weeks. **Continued on next page…..**
Fluoxetine	• Longer half-life – less discontinuation side effects; but more drug interactions; initiate other anti-depressants with caution for up to 5 weeks after discontinuing. • More likely to cause agitation and insomnia. • Causes activation of the central nervous system and may be more useful for patients with fatigue and apathy and hypersomnia. • Consider for atypical depression, the overweight patient, bulimia, or use in pregnancy. • Higher risk of drug interactions, avoid if taking other medications. • Watch for early and late onset side effects.	

Selective Serotonin Reuptake Inhibitors (SSRIs) – (2)

ACTION: Delayed disinhibition of serotonin neurotransmission via 4 key pathways – the somatodendritic serotonin autoreceptors, neuronal impulse flow and postsynaptic serotonin receptors, and inhibition of the serotonin reuptake pump

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Sertraline	• Causes activation of the central nervous system and may be more useful for patients with fatigue and apathy. • May be more useful for depressions with psychosis, the elderly/cognitively impaired and women. • Fewer clinically significant interactions. • Less suitable for patients with anxious and panicky presentation. • Avoid in agitated patients or those with gastrointestinal problems, higher incidence of diarrhoea than other SSRIs. • Drug of choice in pregnancy (lowest placental exposure), post-natal depression, breast-feeding (undetectable or low levels in infant) and in patients with cardiac disease.	**Continued from previous page….** • Increased risk of GI bleeds; consider co-prescription of PPI, especially in elderly and/or in combination with aspirin or NSAID. • May alter glycaemic control in diabetic patients – insulin and/or oral hypoglycaemic dosage may need to be adjusted. • Case report evidence suggests risk of pruritic rash is increased in high consumers of chocolate. Reduced consumption may avoid or ameliorate the problem without the need to change treatment. **consider providing Choice & Medication (TEWV) or NHS (primary care) patient information leaflet as part of shared decision making on treatment choice*
Fluvoxamine	**DO NOT PRESCRIBE:** • Can be continued in patient already prescribed or for patients coming into area already on them. • Can be used in exceptional cases by individual application for named patient.	
Paroxetine		

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Serotonin / Norepinephrine reuptake inhibitors (SNRIs)

ACTION: Acts as an SSRI, but with additional norepinephrine reuptake inhibition, and some dopamine reuptake inhibition.

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Venlafaxine	• Withdraw slowly – higher risk of discontinuation effects. • Venlafaxine MR – take in morning, less chance of insomnia. • Norepinephrine effect generally only seen in doses >150 mg so acts as SSRI in lower doses. • Doses >225 mg, of any preparation - secondary care initiation, monitoring and stabilisation, before transfer back to primary care. Monitor BP 6 monthly. • Be aware of higher toxicity in overdose so assess risk	• Similar side effects to SSRIs upon initiation – nausea / headache / insomnia / sexual dysfunction (see SSRI section). • Tend to be tolerated less well than SSRIs but better than TCAs. • Discontinuation effects more likely due to short half-life. • Sexual dysfunction – problematic, but less so with duloxetine.
Duloxetine (in all doses)	• May be of benefit to patients experiencing pain or frequency of micturition. • Lower starting dose (20 mg/day*) and slower titration improves tolerability and reduces dropouts. *20 mg & 40 mg capsules not licensed for depression • Use a combination of 30 mg & 60 mg capsules for doses >60 mg/day - more cost-effective than 90 mg/120 mg caps.	

Noradrenergic & Specific Serotonergic Antidepressant (NaSSA)

ACTION: Pre-synaptic alpha 2 adrenoreceptor antagonist - enhances both serotonin and norepinephrine neurotransmission, and has antihistamine properties

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Mirtazapine	• Monitor FBC if sign of infection. • Sedation – paradoxically lower dose more likely to cause sedation than higher doses	• Can cause weight gain and sedation. • Can cause blood dyscrasias. • Sexual dysfunction uncommon.

Multimodal Serotonergic Agent

ACTION: Inhibits re-uptake of serotonin, an antagonist at $5HT_3$ receptors and an agonist at $5\text{-}HT_{1A}$ receptors

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Vortioxetine	• Enhanced release of 5HT, norepinephrine, dopamine, acetylcholine and histamine could theoretically improve the efficiency of information processing in maladaptive brain circuits by facilitating long-term potentiation, synaptic plasticity, and enhanced pyramidal neuron activity leading to improvement not only of mood, but also of cognitive symptoms in major depressive disorder. • Glutamate action should help with anxiety, but trials in GAD have been variable	• Nausea seems to be particularly prevalent. • No cardiovascular effects • In SSRI/SNRI-resistant depression, switching to vortioxetine was superior to agomelatine and well tolerated. • Can be stopped abruptly, no need for gradual reduction in dose

Serotonin Antagonist Reuptake Inhibitors (SARIs)

ACTION: Similar to SSRIs but blocks serotonin receptors rather than stimulating them

DRUG	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Trazodone	• Low anticholinergic and cardiotoxicity. • Take after food to reduce peak blood levels/side effects. • Can add to SSRI to aid sleep; lower doses may be effective, but some may need full antidepressant dose	• Increased sedation (used off-licence as a hypnotic) and nausea. • Tremor, postural hypotension, tachycardia.

Selective Norepinephrine Reuptake Inhibitors (NRIs)

ACTION: Selective inhibition of norepinephrine reuptake

DRUG NAME	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Reboxetine	• Has also shown antinociceptive properties (reducing sensitivity to painful stimuli). • Reasonable alternative in patient's intolerant to serotonergic side effects from SSRI or TCA. • Reboxetine might be less effective than SSRI and SNRI • Use only in severe depression or if patient is unable to tolerate serotonergic medications.	• Side effects (less than with TCA) - insomnia, sweating, dizziness, dry mouth, constipation, tachycardia, urinary hesitancy may occur. • Sexual dysfunction uncommon. • Can cause hypokalaemia.

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Tri- and Tetra-cyclic Antidepressants (TCAs)

ACTION: Serotonin and norepinephrine reuptake inhibitor (therapeutic action), with anticholinergic properties, antihistamine and adrenergic antagonism (side effects).

DRUG NAME	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Amitriptyline	• Has shown additional effects on pain relief in low dose	• Antimuscarinic, sedation (often with hangover effects), weight gain. • Very cardiotoxic – arrhythmias, tachycardia / heart block. • Very toxic in overdose as they inhibit sodium channels. • Postural hypotension. • Women less tolerant of TCA side effects than men • Titrate to effective dose. • Caution in patients with cardiac disease. • Don't give to patients with suicide ideation or prescribe only a few days' supply at a time. • Studies demonstrated more rapid onset of action than with SSRI's especially in male patients
Lofepramine	• Less cardiotoxic than other TCAs and therefore less toxic in overdose. • May have increased risk of hepatic toxicity	
Doxepin	• Very sedating, good for patients with sleep problems	
Clomipramine	• More activating, has also demonstrated efficacy in anxiety; often used for depression with an obsessional component	
Imipramine	• Anxiolytic and sedative, reasonable choice in patients with sleep problems	
Nortriptyline	• Usually better tolerated than other TCAs with less cardiac and orthostatic side effects, often used in the elderly.	
Trimipramine	**DO NOT PRESCRIBE:** • Trimipramine deprescribing guidance • Dosulepin deprescribing guidance	
Dosulepin		

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Agomelatine

ACTION: Melatonin receptor agonist and a selective serotonin-receptor antagonist; does not affect the uptake of serotonin, noradrenaline or dopamine

DRUG NAME	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Agomelatine	• Green+ (Amber-SI in NYY) formulary status – see prescriber information sheet. • Melatonin activity useful if insomnia is a feature. • Agomelatine is **contraindicated** with concomitant use of potent CYP1A2 inhibitors (e.g. Fluvoxamine and Ciprofloxacin).	• Relatively free of side-effects. • Minimal cardiovascular effects. • Rare reports of liver damage & failure – LFT monitoring required before initiation and after 3, 6, 12 and 24 weeks (repeat after dose changes), then regularly thereafter when clinically indicated.

Bupropion

ACTION: Norepinephrine and dopamine reuptake inhibitor

DRUG NAME	DRUG-SPECIFIC INFORMATION	COMMON SIDE EFFECTS & ADVICE
Bupropion	• Green+ (Amber-SI in NYY) formulary status of prolonged release formulation (dose 150-300 mg/day) – see prescriber information sheet for more details: NENC, HNY • Higher doses require XL preparation – RED formulary status. • Low occurrence of sexual side effects and can reverse those caused by other medications. • May be useful for patients who develop hyponatraemia with other antidepressants. • Reduce hypersomnia and fatigue. • Used to reduce craving in smoking cessation and can help ADHD symptoms.	• May exacerbate tics. • May not be as effective for anxiety. • Bupropion does carry higher cardiovascular and pro-convulsive risk than serotonergic agents (dose > 400 mg/day increases seizure risk). • Caution in older patients and patients with renal or hepatic impairment, max dose: 150 mg/day.

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