

# Geriatric Psychiatry

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## ANTI-DEPRESSANTS

### SSRIs

#### (Selective Serotonin Reuptake Inhibitors)

(side effect of all: sexual dysfunction;  
all are qd dosing except Luvox)

Paroxetine (Paxil), (S)

- more anticholinergic
- OCD/social/panic phobia
- good for anxiety
  - ▶ 5-10 mg/d to start; can increase to 20-30 mg/d

Sertraline (Zoloft), (A)

- OCD/Panic
- PTSD
  - ▶ 25 mg/d to start;
  - ▶ effective dose: 50-150 mg/d

Fluoxetine (Prozac), (A)

- long half-life
  - ▶ 5-10 mg/d to start
  - ▶ effective dose: 20-30 mg/d
- more drug/drug interactions

Fluvoxamine (Luvox), (S)

- bid dosing
  - ▶ short half-life
  - ▶ OCD indication
  - ▶ 20 mg bid

Citalopram (Celexa), (S)

- 10 mg/d to start
- effective dose 40 mg/d, sometimes divided bid to minimize sedation

**A**=Activating **S**=Sedating

**OCD**=Obsessive Compulsive Disorder

**PTSD**=Post-traumatic Stress Disorder

#### Atypical modes of action

(less sexual dysfunction)

Bupropion (Wellbutrin)

- bid-tid
    - ▶ increased seizure risk
  - Dopaminergic/noradrenergic blockade
    - ▶ 75-100 mg to start
- effective dose: 200-450 mg/d

Nefazodone (Serzone), (S)

- bid
  - ▶ priapism caution
- 5HT<sub>1p</sub>/5HT<sub>2A</sub> blockade
- 50-100-150 mg to start
- effective dose: 300-600 mg/d

Venlafaxine (Effexor), (S)

- bid or qd with Effexor XR
- can cause hypertension or hypotension
- 5HT/ noradrenergic blockade
- useful in generalized anxiety disorder
- good in refractory depression
- 37.5-100 mg/d to start
- effective dose 150-225 mg/d

Mirtazapine (Remeron), (S)

- qhs dosing
- very sedating
- weight gain – good for elderly
- 5HT<sub>2A</sub>/5HT<sub>3</sub>/Noradrenergic blockade
- 7.5-15 mg/d to start
- effective dose: 30-45 mg/d

### **Can't use any SSRI's with MAOI's or Demerol**

All of the above “newer” agents have much less side effects than tricyclic antidepressants (TCA's) (not as sedating, no orthostasis, less anticholinergic side effects, safe in overdose, no QT interval prolongation).

Best TCAs = Desipramine, Nortriptylene (least sedating, anticholinergic).

## MOOD STABILIZERS

### Lithium

Target level ~0.8-1.2 g/ml

Most common side effects:

- tremor, polydipsia, polyuria,
- confusion and sedation in elderly

Most deadly toxicity:

- seizures, coma, death, renal failure

Monitor BUN, Cr, Lytes, thyroid function tests

### Depakote (Divalproex Sodium)

Good for agitation – clinically proven therapeutic level ~60-120 ug/ml

Most common side effects:

- sedation; nausea (rare with Depakote) but can be seen with valproic acid

hepatotoxicity is very rare

Monitor LFTs 2x/month, then 2x/year

Monitor CBC, platelets

Watch for thrombocytopenia

## ANTI-PSYCHOTICS

a.k.a. Neuroleptics

Typical agents work through dopaminergic blockade and are very good for stabilizing the positive (+) symptoms of psychosis including delusions, hallucinations and paranoia.

### Low Potency

Need more mg of drug

More anti-cholinergic properties

and more sedating, and with

Virtually NO Extrapyrmidal

Symptoms (EPS)

- Chlorpromazine (Thorazine)
  - ▶ 25 mg qd in aggressive elderly
- ▶ Thioridazine (Mellaril)
  - max 800 mg/d (because of chance of Retinitis)

Pigmentosum Syndrome

### Side Effects

Anti-cholinergic properties

dry eyes, mouth, blurry vision

constipation, urinary retention

Alpha adrenergic blockade

(dizziness, orthostatis)

Histaminergic blockade

(sedation)

### High Potency

Need less mg of drug

Less anti-cholinergic properties

and less sedating, but with

increased extrapyramidal

symptoms (EPS)

- Haloperidol (Haldol)
  - ▶ 0.5 mg to 2 mg/ d in elderly
  - ▶ Long acting (q 4weeks) decanoate 25-50 mg IM

Fluphenazine (Prolixin)

- 0.5 to 2 mg/ d in elderly

- Long acting (q 2 weeks)

decanoate 25-37.5 mg IM

- ▶ Triothexene (Navene)

- ▶ Trifluoperazine (Stelazine)

### Side Effects

EPS, dystonias, Parkinsonian (too much dopamine blockade)

treatment: anti-cholinergic agents

Benztropine (Cogentin)

0.5 mg qd or bid

Trihexyphenidyl (Artane)

Akathesia

treatment: Beta-blockers

## Atypical Agents: Dopaminergic and Serotonergic Blockade

Risperidone (Risperdal) - some EPS, no sedation, dose 0.5-2 mg/d

Clozapine (Clozaril) - seizures, anti-cholinergic except paradoxical hypersalivation, agranulocytosis, weekly CBC, dose 12.5-50 mg/d

Olanzapine (Zyprexa) - low EPS; sedation, increase prolactin; some anti-cholinergic side effects; dose 2.5-15 mg/d

Quetrapine (seroquel) - monitor for cataracts; some EPS; sedation, dose 100-300 mg/d

## SEDATIVE - HYPNOTICS

### Benzodiazepines

- safe in overdose (non-lethal)
- addictive potential
- agonist for GABA & chloride
  - ▶ withdrawal syndrome of anxiety, insomnia, fatigue, headache, irritability, tremor, sweating, nausea
- short half-life, quicker acting
  - ▶ Lorazepam (Ativan), Triazolam (Halcion), Estazolam (ProSom)
  - ▶ Quickest onset of action, very addictive: Alprazolam (Xanax) –don't use in elderly
- mid-range half life
- Clonazepam (Klonopin) 0.5 mg qd/bid – can use safely in elderly
- no euphoria rush, more stable blood levels
- longer half-life, very addictive, difficult to wean patients off, don't use in elderly
  - ▶ Chlordiazepoxide (Librium)
  - ▶ Diazepam (Valium), Flurazepam (Dalmane)
  - ▶ DEA IV (doesn't require triplicates)

### Chloral Hydrate

“Noctec”

- oldest agent still in use (1869)
- onset of action: 1/2 - 1 hr, lasts 4-8 hrs
- tolerance seen
- lethality w/ ETOH & other depressive agent
- side effects: GI symptoms, decreased heart rate

### Zolpiden (Ambien)/ Zaleplon (Sonata)

- agonist for GABA & chloride
- onset: 1-2 hrs & lasts 4-6 hrs
- less tolerance/addiction
- DEA IV (no triplicates)
- safe in overdose (non-lethal)

### Trazadone

anticholinergic but no EPS; caution for priapism; not addictive

- not scheduled

### Barbiturates

- lethal in overdose; Do not use
- phenobarbital (luminol)
  - ▶ still used to detox off barbiturates
- most DEA II & III (requires triplicates)