Geriatric Optimization

Tricyclic Antidepressants (TCA) and Paroxetine (Paxil®)

Selective Serotonin Reuptake Inhibitors (SSRIs)

Paroxetine (Paxil®)

Tricyclic Antidepressants (TCAs)

Amitriptyline (Elavil®)
Clomipramine (Anafranil®)
Doxepin (Silenor®)
Imipramine (Torfanil®)
Trimipramine (Surmontil®)
Amoxapine (Asendin®)
Desipramine (Norpramin®)
Nortriptyline (Pamelor®)
Protriptyline (Vivactil®)

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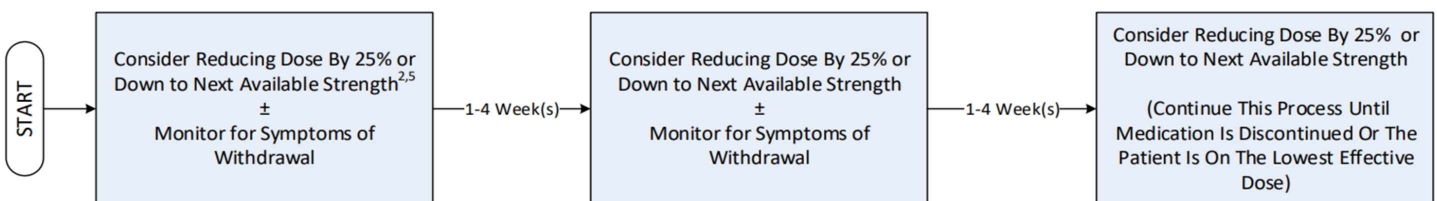
WHY ARE THESE MEDICATIONS INAPPROPRIATE?

- Older adults are at an increased risk of negative outcomes when taking TCAs and/or paroxetine due to the strong anticholinergic side effects and risk of hypotension.[1,2] Other side effects may include:
    - Sedation
    - Falls and fractures
    - Visual impairment
    - Hyponatremia
- One meta-analysis that included 248 studies showed that those taking TCAs **had higher odds of falling compared to placebo, especially during the first few weeks of therapy.**[2]
- Paroxetine is a major concern due to it having the **highest risk of anticholinergic side effects and hyponatremia compared to all other SSRIs.**
- These medications should be assessed for deprescribing and potentially replaced with alternatives.

APPROACH TO OPTIMIZATION

- Determine the indication(s) of the TCA or paroxetine including any off-label uses.
- Determine if an alternative medication is needed for the condition or if lifestyle changes can be made instead (see appendix for recommended alternatives if using to treat an off-label indication).
- When deprescribing the TCA or paroxetine, providers can consider the following methods[3,4]:
    1. Taper-off over several weeks with no alternative antidepressant to replace it
    2. Taper-off and add new antidepressant after taper is complete or after a washout period
    3. Cross-taper between both the TCA or paroxetine and the new antidepressant
- Deprescribing should be individualized based on treatment goals, side effects, fall risk, and severity of depression/anxiety. The diagram below provides guidance to deprescribing the TCA or paroxetine if any of the above methods are used.[3-5]



- Most tapering schedules last four weeks but can be shorter if member has been on antidepressant short term (≤3 weeks)[5]
    - Paroxetine has the highest likelihood of withdrawal effects and usually requires a longer taper (i.e., ≥6 weeks)[3-5]
- A taper can be extended if withdrawal symptoms occur (e.g., reduce dose every 2-3 weeks rather than every 1 week)
- Use caution if cross-tapering between antidepressants as there is an increased risk of adverse reactions (i.e., fractures, serotonin syndrome)[6]

GOAL: Full Discontinuation

- Providers may also choose to directly switch between the TCA or paroxetine to the new antidepressant as an option (see appendix for more details on all discontinuation/taper methods).[3-5]

ADDITIONAL BEST PRACTICES AND CONSIDERATIONS

Considerations If Switching to Other Antidepressants[1,2,7]

- All SSRIs and serotonin-norepinephrine reuptake inhibitors (SNRIs) are associated with falls and require monitoring. Use minimum effective dose.
- SSRIs and SNRIs also increase risk of hyponatremia and therefore Na+ should be monitored closely especially during initiation or dosage changes.
- The preferred SSRIs to use in older adults include citalopram (at 20 mg or less), escitalopram, and sertraline.

Antidepressant Discontinuation Syndrome: FINISH[4,8]

- **F**lu-like symptoms
- **I**mbalance
- **N**ausea
- **I**nsomnia
- **S**ensory disturbances (blurred vision)
- **H**yperarousal (increased anxiety/agitation)

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APPENDIX

ALTERNATIVE TREATMENT FOR OFF-LABEL USES

Off Label Uses	Alternative Therapies
Fibromyalgia/Neuropathic Pain[9,10]	• Cognitive behavioral therapy • Duloxetine (Cymbalta®) • Milnacipran (Savella®) (only FDA approved for fibromyalgia) • Gabapentin (Neurontin®) • Pregabalin (Lyrica®)
Abdominal Pain in Irritable Bowel Syndrome (IBS)[11]	• Gut-directed psychotherapy • Peppermint Oil • SSRIs may be used in IBS but do not demonstrate as much benefit in improving symptoms. • Other agents tailored to the specific symptoms (i.e., diarrhea or constipation) may also help with abdominal pain.
Sleep Disorders/Insomnia[12]	• Cognitive behavioral therapy • Melatonin

OVERVIEW OF ANTIDEPRESSANT TAPER METHODS

Taper Method	Additional Details[3-5]
Taper-Off (With No New Antidepressant)	• This method is preferred if member does not need an alternative antidepressant.
Taper Off and Add New Antidepressant After Taper	• This method is preferred when there is a concern of drug interactions between both antidepressants and if member wants to avoid side effects from taking both antidepressants at once. • Providers can consider adding new antidepressant immediately after taper is complete or after a washout period.
Cross-Taper (Between Old Antidepressant and New One)	• This method may be preferred in members who are at increased risk of relapse in depression or anxiety. • This method may have higher risk of side effects.
Direct Switch (Between Both Antidepressants)	• This method may be preferred if the member is having significant side effects from the TCA or paroxetine and prefers to be switched immediately. • This method may have higher risk discontinuation syndrome.

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