About the Compendium of Therapeutic Choices

The *Compendium of Therapeutic Choices*, formerly *Therapeutic Choices*, is a trusted Canadian source for evidence-based treatment information for all health care practitioners involved in therapeutic decision-making. Practical, bottom-line, clinical information covering more than 200 common medical conditions is referenced and organized in a concise format by therapeutic condition. More than 72 chapters cover drug therapy during pregnancy and breastfeeding. The content is based on the best available evidence, subject to a rigorous peer review process.

**CANADIAN**

The *Compendium of Therapeutic Choices* contains unparalleled Canadian-specific content available in both official languages written and reviewed by Canadian expert physicians and pharmacists and managed by CPhA editors.

**CURRENT**

Digital content is updated every two weeks. The latest print edition has been completely revised and features three new chapters (obsessive-compulsive disorder, post-traumatic stress disorder and menorrhagia).

**CONTINUOUS IMPROVEMENT**

The content undergoes continuous review and improvement. In addition to our own ongoing surveillance of the evidence, our partnership with McGill University provides direct feedback from physicians and pharmacists through the IAM questionnaire. McGill researchers select potentially actionable feedback, provide it to CPhA editors for consideration, and track the rate of content change prompted by the feedback.

**CONVENIENT**

With the e-Suite bundle, you have easy access to recommended treatment information for more than 200 conditions on multiple platforms designed to suit the way you work. Now you can access therapeutic information whenever, wherever and however you want it.
Chapter 1

Obsessive-Compulsive Disorder

R. P. Swinson, MD, FRCPsych, FRCPC

Obsessive-compulsive disorder (OCD) is now classified separately from anxiety disorders in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5). Related conditions in the same classification include body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation disorder, and OCD that is substance/medication-induced or related to another medical condition.

OCD frequently starts early in life and often becomes a chronic condition. The mean age of onset is about 20 years with 25% of cases beginning by age 14. On average the onset is earlier in males. The defining symptoms are obsessions and compulsions. Obsessions are thoughts, images or urges that provoke anxiety and are unwanted, repetitive and difficult to control. Compulsions consist of repetitive behaviours that may be visible, such as washing or turning a light switch on and off, or may be mental actions such as counting or repeating a phrase in a precise manner. In severe OCD these ritualistic behaviours may occupy hours each day and can be extremely disabling.

Goals of Therapy

- Eliminate or decrease symptoms of OCD
- Eliminate or decrease OCD-associated disability
- Prevent recurrence
- Treat comorbid conditions

Investigations

- Thorough history with attention to:
  - nature and onset of symptoms
  - nature and extent of disability
  - presence of comorbid medical or psychiatric conditions

Note: Treat comorbid mood disorders, especially depression, as the primary condition.

- Criteria and interview questions assist in obtaining an accurate diagnosis (Table 1, Table 2)
- Physical examination to exclude endocrine or cardiac disorders and to look for signs of substance use
- Laboratory tests:
  - CBC, liver function tests, gamma-glutamyl transpeptidase (GGT to screen for alcohol use), thyroid indices (supersensitive TSH), ECG

Note: Treat physical disorders of recent onset before making a definitive diagnosis of an OCD.

Therapeutic Choices

Cognitive behavioural therapy (CBT) and pharmacotherapy with SSRIs or SNRIs are considered to be first-line treatments for OCD. The efficacy for both modalities is supported by a significant number of high-quality studies. A combination of these 2 modalities may help to increase the clinical response or reduce the risk of relapse when medication is discontinued.
Psychiatric Disorders

Table 1: Diagnosis Criteria

- Presence of obsessions (persistent, disturbing thoughts that cannot be reasoned away) or compulsions (uncontrollable impulses to do something against one’s conscious will)
- Patient has recognized that the obsessions or compulsions are excessive or unreasonable
- Obsessions/compulsions cause distress, are time consuming or interfere with patient's routine, occupation, or academic or social functioning
- Obsessions/compulsions are not due to substance abuse or another medical or mental disorder

Table 2: Interview Questions to Identify Presence of Obsessions or Compulsions

<table>
<thead>
<tr>
<th>Obsessions</th>
<th>Is patient experiencing disturbing thoughts, images or urges that recur or are difficult to ignore? For example, “Do troubling thoughts or images come into your mind without you wanting to have them and are they difficult to get rid of?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsions</td>
<td>Does patient feel compelled to do something that doesn't make sense to them or that they don't want to do? For example, “Do you feel that you have to count, wash, clean or check things repeatedly when you know that it isn't really necessary?”</td>
</tr>
</tbody>
</table>

Nonpharmacologic Choices

Two psychological treatments for OCD, exposure and response prevention (ERP) and cognitive therapy (CT), have been shown repeatedly to be more effective than no treatment or supportive therapies. Some studies have found that ERP is more effective than medication. In one randomized trial in an outpatient setting, ERP, clomipramine, and a combination of both were found to be significantly more effective than placebo in 122 adults with OCD. ERP and ERP plus clomipramine were superior to clomipramine alone. ERP reduced the Yale Brown Obsessive Compulsive scale (YBOCS) score by 55% and the Clinical Global Impression improvement scale (CGI-I) by 32%. The ERP in this study was intensive and may be difficult to replicate in regular clinical practice.

Brain stimulation therapies have recently been investigated in the treatment of OCD. Transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS) have been used to treat OCD that has not responded to the usual first-line therapies. TMS consists of the application of magnetic stimulation to targeted areas of the brain. In a small study of 17 patients, DBS reduced YBOCS scores by 25% after 12 months of stimulation in the ventral capsule/ventral striatum area. A review of 90 patients receiving DBS in the internal capsule/ventral striatum showed a 50% decrease in YBOCS scores in the first 3 months of treatment. The limited number and low quality of available clinical trials keeps this technique from being recognized as a standard treatment. However, DBS is available as an alternative prior to selecting an ablative technique.

Pharmacologic Choices

Drug therapy is indicated for many patients and is often more readily available than CBT. First-, second- and third-line options are listed in Figure 1, Table 3 and Table 4.

The SSRIs citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine and sertraline, in usual antidepressant doses, are recommended as first-line treatment for OCD. It may take up to 12 weeks of therapy to produce a significant change in symptoms; a trial at full dosage for at least 6 weeks is required to assess the potential benefit of each SSRI. A recent study demonstrated that a 20% reduction in baseline YBOCS score at week 4 predicted response at week 12. Subjects who had less than 20% improvement had only a 20% chance of response at week 12 compared to 55% for those with greater improvement. There is no strong evidence to suggest that SSRIs vary in efficacy, but patients may
Chapter 1: Obsessive-Compulsive Disorder

respond to or tolerate one drug better than others in the same class. Second-line options include clomipramine, venlafaxine and mirtazapine. Clomipramine and venlafaxine are effective, but use is limited by their respective side effect profiles; mirtazapine is less effective and causes significant weight gain. Although SSRIs and SNRIs are better tolerated than clomipramine, some patients may experience agitation early in therapy leading to discontinuation of these drugs. To minimize early adverse effects, initiate SSRIs or SNRIs with lower doses and titrate slowly to an effective dose.

If successful, treatment should continue for a minimum of 6 months in acute therapy and may continue for years. When stopping any antidepressant, taper gradually to minimize discontinuation effects and warn patients to report any early signs of relapse. For more information about antidepressant discontinuation syndrome, see .

It is estimated that 40–60% of patients do not respond adequately to SSRIs. In these instances consider increasing the dose or augmentation with another mode of therapy. If available, CBT can be used to augment pharmacologic treatment response. First- (i.e., haloperidol) and second-generation (i.e., olanzapine, quetiapine, risperidone, aripiprazole) antipsychotics have been studied in this setting. A systematic review and a meta-analysis have concluded that antipsychotic augmentation of SSRI treatment will benefit about 30% of patients. While olanzapine was not shown to be better than placebo, limited data support the addition of quetiapine or risperidone to SSRIs to increase the response in OCD. There is insufficient evidence to guide the use of one over the other. Adverse effects (e.g., sedation) will affect the tolerability of this group of drugs and must be weighed carefully against the limited benefits they provide.

In a 12-week placebo-controlled study, topiramate plus an SSRI improved patient compulsion scores, but not obsessions. Some other agents such as riluzole, tramadol, gabapentin and pindolol have shown some benefit as augmentation therapy in patients who were refractory to other treatments. The efficacy of other agents affecting glutamatergic systems, such as ketamine and memantine, are being investigated for their ability to reduce OCD symptoms when combined with an SSRI.

Benzodiazepines alone are not usually helpful in treating OCD.

In DSM-5, hoarding disorder and body dysmorphic disorder (BDD) have been separated from OCD and now have their own diagnostic category. Standard treatment for hoarding disorder consists of CBT and serotonergic medications; for nonresponders augmentation with second-generation antipsychotics or haloperidol may be beneficial. BDD also responds to the same treatment regimens as OCD and hoarding disorder.

Figure 1: Drug Therapy for Obsessive-Compulsive Disorder

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Add on to first- or second-line monotherapy.

Abbreviations: CBT = cognitive behavioural therapy

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Psychiatric Disorders

Choices during Pregnancy and Breastfeeding

OCD and Pregnancy

During pregnancy, obsessive-compulsive symptoms, particularly obsessional ideas about causing harm to the baby, may worsen and can be extremely disturbing. These ideas are often accompanied by marked guilt and depression. Many people with psychiatric disorders do not bring their distress to the attention of healthcare providers.

Whenever possible, it is important to screen for the presence of OCD or other psychiatric symptoms before conception occurs. Screening can be repeated during the pregnancy and particularly postpartum. If a woman is suffering from marked psychological distress related to pregnancy and breastfeeding, it is imperative to screen for the presence of mood symptoms and suicidality.

When a woman experiences severe psychiatric symptoms during pregnancy or postpartum, referral to a psychiatrist may be necessary. In major centres, women's mental health programs are usually available and are attuned to responding to consultation requests quickly.

Preconceptional treatment can be offered for disorders that are producing significant distress or are interfering with functioning. Obsessive-compulsive disorder with high fear of contamination may prevent a woman from entering settings where there is a perceived high risk of coming into contact with infections.

Management during Pregnancy

There is good evidence to show that psychological treatments can have beneficial effects for more than half of those who persist with a treatment program. CBT can be administered without restriction throughout pregnancy. Therapies based in meditative or relaxation techniques may be more acceptable than pharmacologic approaches.24

If symptoms are severe and producing significant impairment, medications can be appropriate and effective.25 SSRIs, SNRIs and TCAs are initial treatment options for OCD in the pregnant patient.

SSRIs and SNRIs may cause agitation, sweating, nausea, GI distress and weight gain. There have been reports of a slightly higher (but still low) risk of congenital abnormalities involving the heart or cleft lip/palate.26 Use of these drugs in the 3rd trimester may be associated with neonatal withdrawal symptoms such as tremors, increased muscle tone, feeding or digestive problems or respiratory distress.

The use of SSRIs and SNRIs may be warranted in patients with severe symptoms that could affect fetal or maternal safety or health. In general, the lowest effective dose should be used for the shortest time necessary. General principles for management of depression during pregnancy are applicable to the management of OCD disorders.26,27 See also for information on management of depression during pregnancy and breastfeeding.

OCD and Breastfeeding

In the postpartum period, severe anxiety can impede the mother's sleep and erode her confidence in caring for her child. A woman with severe OCD can be so tormented by thoughts of potentially harming her child that she may refuse to be involved with caring for it. In such cases a psychiatric consultation is urgently required, and treatment consideration should include admitting the mother and child to hospital.

As in pregnancy, nonpharmacologic options should be used whenever possible in the postpartum period, particularly in breastfeeding women. If drug therapy is necessary, consider paroxetine and sertraline, since both have low concentrations in breast milk.28
A discussion of general principles on the use of medications in these special populations can be found in and . Other specialized reference sources are also provided in these appendices.

**Therapeutic Tips**

- If response to initial therapy is not adequate, optimize the dose and assess adherence before switching agents.
- If the first antidepressant at optimal dosage is not effective or not tolerated, switch to another first-line antidepressant.
- If the second antidepressant is not effective consider switching to clomipramine or add risperidone as adjunctive therapy.
<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dose</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors</strong></td>
<td>citalopram</td>
<td>Initial: 10–20 mg/day po</td>
<td>Agitation (on initiation of therapy), nausea, anorgasmia, insomnia, headache, increased appetite, diarrhea, increased risk of GI bleeding. Dose-related QTc prolongation.</td>
<td>Serotonin syndrome with MAOIs (hypertension, tremor, agitation, hypomania); caution with other serotonergic drugs including amphetamine derivatives, dextromethorphan, dihydroergotamine, linesolid, lithium, meperidine, pentazocine, seleliline, St. John's wort, trazodone, triptans, tryptophan (increased risk of serotonin syndrome); increased risk of GI bleeding with NSAIDs, antiplatelet agents. SSRIs are substrates and inhibitors of several cytochrome P450 isoenzymes. This may result in decreased clearance of many drugs (e.g., clozapine, methadone, mexiteline, phenytoin, pimozide, propafenone) or reduced enzymatic conversion of a prodrug to its active form (e.g., clopidogrel, codeine, tamoxifen). Avoid combined use with drugs associated with prolonged QTc interval/torsades de pointes, such as amiodarone, azithromycin, clarithromycin, domperidone, erythromycin, haloperidol, methadone, pimozide, quinine, sotalol, ziprasidone.</td>
<td>May take 2–3 months for maximum effect. Discontinue gradually.</td>
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<tr>
<td></td>
<td>escitalopram</td>
<td>Cipralex, Cipralex MELTZ</td>
<td>Initial: 10–20 mg/day po</td>
<td></td>
<td>See citalopram.</td>
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<td></td>
<td>fluoxetine</td>
<td>Prozac, generics</td>
<td>Initial: 10–20 mg/day po</td>
<td>Agitation (on initiation of therapy), nausea, anorgasmia, insomnia, headache, increased appetite, diarrhea, increased risk of GI bleeding.</td>
<td>See citalopram.</td>
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<td></td>
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<td>Target: 20–40 mg/day po</td>
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<td>See citalopram.</td>
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<td>Maximum: 40 mg/day po</td>
<td></td>
<td>See citalopram.</td>
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<tr>
<td>Class</td>
<td>Drug</td>
<td>Initial Dose</td>
<td>Target Dose</td>
<td>Maximum Dose</td>
<td>Adverse Effects</td>
<td>Drug Interactions</td>
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<td></td>
<td>fluvoxamine</td>
<td>50–100 mg/day po</td>
<td>200–300 mg/day po</td>
<td>300 mg/day po</td>
<td>See fluoxetine.</td>
<td>See citalopram.</td>
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<td></td>
<td>Luvox, generics</td>
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<td></td>
<td>paroxetine</td>
<td>10–20 mg/day po</td>
<td>40–60 mg/day po</td>
<td>60 mg/day po</td>
<td>See fluoxetine.</td>
<td>See citalopram.</td>
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<td></td>
<td>immediate-release</td>
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<td></td>
<td>Paxil, generics</td>
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<td></td>
<td>paroxetine</td>
<td>25–50 mg/day po</td>
<td></td>
<td></td>
<td>See fluoxetine.</td>
<td>See citalopram.</td>
</tr>
<tr>
<td></td>
<td>controlled-release</td>
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<td></td>
<td>Paxil CR</td>
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<td></td>
<td>sertraline</td>
<td>50–100 mg/day po</td>
<td>200 mg/day po</td>
<td>200 mg/day po</td>
<td>See fluoxetine.</td>
<td>See citalopram.</td>
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<tr>
<td></td>
<td>Zoloft, generics</td>
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</tbody>
</table>

* Cost of 30-day supply of mean dosage; includes drug cost only.

Dosage adjustment may be required in renal impairment; see .

Abbreviations: MAOI = monoamine oxidase inhibitor; NSAID = nonsteroidal anti-inflammatory drug; SSRI = selective serotonin reuptake inhibitor

Legend: $ < $30  $$ $30–60  $$$ $60–90  $$$$ $90–120
### Table 4: Drugs for Second- and Third-line Management of Obsessive-Compulsive Disorder

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dose</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants, noradrenergic and specific serotonergic</td>
<td>mirtazapine Remeron, Remeron RD, generics</td>
<td>30–60 mg QHS po</td>
<td>Somnolence, increased appetite/weight gain, dizziness.</td>
<td>Do not use with MAOIs. Additive sedation with other CNS depressants such as alcohol, benzodiazepines; substrate of CYP1A2, 2D6 and 3A4—caution with inhibitors or inducers of these isoenzymes.</td>
<td>Second-line monotherapy when SSRIs fail. Orally disintegrating tablets can be taken without water.</td>
<td>$</td>
</tr>
<tr>
<td>Antidepressants, serotonin-norepinephrine reuptake inhibitors</td>
<td>venlafaxine Effexor XR, generics</td>
<td>Initial: 37.5–75 mg/day po Usual: 112.5–225 mg/day po High: 300–375 mg/day po</td>
<td>Nausea, sleep disturbance, drowsiness, nervousness, dizziness, dry mouth. Dose-related hypertension occurs rarely, particularly at doses ≥225 mg/day.</td>
<td>Use with MAOIs may lead to potentially fatal reaction initially presenting with tremor, agitation, hypomania, hyperthermia and/or hypertension. Inhibitors of CYP2D6 or CYP3A4 may increase venlafaxine levels.</td>
<td>Second-line monotherapy when SSRIs fail.</td>
<td>$</td>
</tr>
<tr>
<td>Antidepressants, tricyclic</td>
<td>clomipramine Anafranil, generics</td>
<td>100–250 mg/day po Adjunctive: 10–50 mg/day po</td>
<td>CNS effects (agitation on initiation of therapy, confusion, drowsiness, headache), anticholinergic effects (dry mouth, blurred vision, constipation, etc.), weight gain, nausea, cardiovascular effects (tachycardia, arrhythmias, orthostatic hypotension), anorgasmia, erectile dysfunction.</td>
<td>May increase effect of anticholinergic drugs, CNS depressants, warfarin; do not use MAOIs concurrently.</td>
<td>Second-line monotherapy when SSRIs fail. Third-line augmentation therapy with SSRI or SNRI. May take 2–3 months for maximum effect.</td>
<td>$$$</td>
</tr>
<tr>
<td>Antipsychotics, First-generation</td>
<td>haloperidol generics</td>
<td>5–10 mg daily po</td>
<td>Sedation, parkinsonism, akathisia, EPS, neuroleptic malignant syndrome, QTc prolongation.</td>
<td>Additive effects with other CNS depressants, antagonism of dopamine agonists.</td>
<td>Third-line augmentation of SSRI or SNRI. Use only if second-generation antipsychotics not effective or not tolerated.</td>
<td>$</td>
</tr>
</tbody>
</table>
### Chapter 1: Obsessive-Compulsive Disorder

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dose</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antipsychotics,</strong> Second-generation</td>
<td>olanzapine</td>
<td>2.5 mg daily po</td>
<td>Initial: 2.5 mg daily po; titrate gradually to desired effect, usually 2.5–5 mg daily po. May need to increase to a maximum of 10 mg per day po.</td>
<td>Sedation with CNS depressants, weight gain, dizziness, orthostatic hypotension, increased risk of diabetes and dyslipidemia, EPS (especially akathisia), QTc prolongation.</td>
<td>Third-line augmentation of SSRIs or SNRIs. May need to increase dose to maximum of 10 mg per day po. May decrease dose to 2.5 mg daily po if needed.</td>
</tr>
<tr>
<td></td>
<td>quetiapine</td>
<td>50 mg daily po</td>
<td>Initial: 50 mg daily po; titrate to 150 mg daily po, or higher if necessary. Usual maximum: 400 mg daily po.</td>
<td>Sedation, dizziness, weight gain, orthostatic hypotension, increased risk of diabetes and dyslipidemia, possible increased risk of cataracts; may decrease thyroid hormone levels, QTc prolongation.</td>
<td>Third-line augmentation of SSRIs or SNRIs.</td>
</tr>
<tr>
<td></td>
<td>risperidone</td>
<td>0.5–3 mg daily po</td>
<td>Initial: 0.5–3 mg daily po; titrate to desired effect.</td>
<td>Insomnia, headaches, weight gain, lipid and glucose dysregulation, orthostatic hypotension, rhinitis, anxiety, dose-related hyperprolactinemia, EPS and QTc prolongation. Risk of intraoperative floppy iris syndrome in patients undergoing cataract surgery who are taking olanzapine or risperidone.</td>
<td>Second-line augmentation of SSRIs or SNRIs or clomipramine.</td>
</tr>
<tr>
<td><strong>GABA Derivatives</strong></td>
<td>gabapentin</td>
<td>300 mg/day po</td>
<td>Initial: 300 mg/day po; may increase to 1200 mg/day po in 2 divided doses.</td>
<td>Headache, dizziness, somnolence, ataxia, blurred vision changes.</td>
<td>Third-line augmentation of SSRIs or SNRIs.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dose</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monoamine Oxidase Inhibitors</td>
<td>phenelzine (Nardil)</td>
<td>45–90 mg/day po</td>
<td>Insomnia, dizziness, orthostatic hypotension, edema, sexual dysfunction.</td>
<td>Concurrent use with sympathomimetic agents, tyramine or levodopa may result in hypertensive crisis; do not use with serotonergic drugs such as SSRIs, SNRIs, TCAs, meperidine, tryptophan (increased risk of serotonin syndrome).</td>
<td>Only for refractory cases. Stringent dietary restrictions (tyramine-containing foods) are necessary.</td>
<td>$$$$$$</td>
</tr>
<tr>
<td></td>
<td>tranylcypromine (Parnate)</td>
<td>20–60 mg/day po</td>
<td>See phenelzine.</td>
<td>See phenelzine.</td>
<td>See phenelzine.</td>
<td>$$$$$</td>
</tr>
<tr>
<td>Other Antiepileptic Drugs</td>
<td>topiramate (Topamax, generics)</td>
<td>Initial: 15–25 mg daily po Increase by 15 mg/day at weekly intervals or 25 mg/day every 1–2 wk Range: 50–400 mg/day in 2 divided doses po(^\text{10})</td>
<td>CNS effects (e.g., dizziness, ataxia, tremor, sedation, cognitive impairment), GI symptoms (e.g., nausea, dyspepsia, constipation), weight loss (can be beneficial in some patients). Possible increased risk of oral clefts if used during the first trimester; avoid topiramate for migraine prophylaxis during pregnancy.</td>
<td>Additive depressant effects with other CNS depressants. May decrease effectiveness of oral contraceptives; use oral contraceptives containing at least 35 μg estrogen and add barrier contraceptive protection (condoms). Inhibitors of CYP2C19 may increase topiramate levels (e.g., SSRIs, isoniazid, omeprazole, moclobemide). Phenytoin and carbamazepine can decrease topiramate levels.</td>
<td>Third-line augmentation of SSRI or SNRI. May raise risk of nephrolithiasis; maintain adequate hydration during therapy; avoid in patients with renal stones. May cause acute myopia, with consequent angle closure glaucoma that responds to drug discontinuation; advise patients to consult an ophthalmologist or emergency room immediately if they have acute painfilled eyes or decreased/blurred vision. Warn patients about CNS depressant effects; possible risk associated with driving, other hazardous activities.</td>
<td>$$$$</td>
</tr>
</tbody>
</table>

\(^{a}\) Cost of 30-day supply of mean dosage; includes drug cost only.
\(^{10}\) Dosage adjustment required in renal impairment; see .

Abbreviations: EPS = extrapyramidal symptoms; GABA = gamma-aminobutyric acid; MAOI = monoamine oxidase inhibitor; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant

Legend: $ < $15 $15–30 $$$ $30–45 $$$\$ $45–60
Suggested Readings


References


Why do nurses and nurse practitioners use CTC when making therapeutic decisions?

Because it is . . .

• The Canadian source for evidence-based treatment information based on Canadian guidelines
• Written and reviewed by expert physicians and pharmacists
• Practical, bottom-line, clinical information that covers more than 200 common medical conditions
• Referenced and organized in a concise format by therapeutic condition in print
• Available in English and in French online
• Updated every two weeks online
• Used by all Canadian health care practitioners

Because CTC provides . . .

• Concise, comparative drug tables including dosing, drug interactions, adverse effects and cost for each condition
• Drug therapy during pregnancy and breastfeeding for 72 conditions
• Excellent decision-making tools to help you make better decisions

Because it covers . . .

• Blood Disorders
• Cardiovascular Disorders
• Dosage Adjustment in Renal Impairment
• End-of-Life Care
• Endocrine and Metabolic Disorders
• Eye Disorders
• Fluid and Electrolyte
• Gastrointestinal Disorders
• Genitourinary Disorders
• Infectious Diseases
• Musculoskeletal Disorders
• Neurologic Disorders
• Nutritional Supplements
• Psychiatric Disorders
• Renal Disorders
• Respiratory Disorders
• Sexual Health
• Skin Disorders
• Thermoregulatory Disorders in Adults
• Thyroid Disorders

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