Guidance on swapping and stopping antidepressants (Quick Guide for primary care)

Avon and Wiltshire NHS Mental Health Partnership NHS Trust

Approved by Bath Clinical Area Partnership Prescribing & Therapeutics Committee September 2016

Purpose

The purpose of this guidance is to advise clinicians about strategies to swap or stop antidepressants in primary or secondary care. It is a guide only and does not replace clinical judgement or a thorough assessment of the individual circumstances. It is based on the data in the Summary of Product Characteristics (SPC) of the individual antidepressants and also published reference sources.

1. General guidelines

People swapping or stopping antidepressants should be carefully monitored. People should be advised what effects to be mindful of when swapping and when to seek help.

Clinicians should review the switch regularly while it is occurring; in people under the age of 25 years this review should take place within a week in line with NICE clinical guidelines 90 and 91 to check for any signs of emergent or increased suicide risk and symptoms as detailed below.

1.1 Serotonin syndrome

This generally occurs if high doses are used or the use of two agents that both increase levels of serotonin. Symptoms can occur on a spectrum and the effects seen and severity is usually dose related. Symptoms include –

- **Psychiatric effects** – agitation, excitement, confusion, restlessness, lack of coordination
- **Neuromuscular activity** –tremor, clonus, myoclonus, hyper-reflexia and pyramidal rigidity, shivering
- **Autonomic activity** – diaphoresis, fever, mydriasis, tachycardia, tachypnoea, diarrhoea, vomiting, hypertension

Onset of symptoms is usually rapid within a few doses of the second drug being introduced. Severe symptoms will need urgent management in an acute care setting such as Emergency Departments. The causative agents should be stopped and the switch re-assessed.

1.2 Antidepressant discontinuation symptoms

As a rough rule of thumb the shorter the elimination half-life of the antidepressant then the more likely discontinuation symptoms are to occur. They are more common with paroxetine, venlafaxine, amitriptyline, imipramine and MAOIs. Symptoms usually occur within a few days of stopping or reducing the dose of an antidepressant. Left untreated most discontinuation symptoms will resolve in 1-21 days; however some can be markedly unpleasant and disabling. Symptoms will usually resolve within 24hours if the original antidepressant is reintroduced.

Slow tapering of the antidepressant can lessen the occurrence of discontinuation symptoms

Symptoms include –

- **SSRI / SNRI discontinuation** – numbness, paraesthesia, electric-shock like sensations, rushing noise (in head), dizziness, light-headedness, vertigo, ataxia, lethargy, headache, tremor, sweating, anorexia, insomnia, nightmares, nausea, vomiting, diarrhoea, irritability, anxiety, agitation, tearfulness, flu like symptoms, movement disorders.
- **TCA discontinuation** – as for SSRIs although the first 7 symptoms are less likely and the rest more likely than with the SSRIs
- **MAOI discontinuation** – symptoms can be severe especially with tranylcypromine (due to its partial metabolism to amphetamine), confusion, paranoid delusions and hallucinations, anxiety, agitation, irritability, insomnia, vivid dreams, cognitive impairment, depersonalisation and rapid worsening of depressive symptoms
- **Mirtazapine discontinuation** – anxiety, insomnia, nausea

Methods of swapping

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1.3 Cross taper

The half-life of the agents involved is important, it takes approximately 5 half-lives to reach a steady state when a medicine is introduced and around 5 half-lives to excrete a medicine until it is below the therapeutic range. Usually cross tapering is done over several weeks and may be done in a series of steps.

1.4 Taper and stop then wait and start

Sometimes co-administration of two agents is contraindicated and due to the long half-life or the mode of action of the first antidepressant there should be a 'drug free period' before a second agent is introduced. This is common with the MAOI antidepressants due to their prolonged effect on the enzyme monoamine oxidase, it is also recommended in some switches involving fluoxetine or fluvoxamine.

1.5 Abrupt switch or stop

When changing from one agent to another with a very similar mode of action it may be possible to do an abrupt switch, for example changing from one SSRI to another.

2. Advice for swapping from one agent to the next

The tables on the following pages give some advice on how to switch between individual or certain classes of antidepressants and at the bottom of the table how they should be stopped.

3. References

- SPC for specific antidepressants accessed via www.medicines.org.uk accessed April 2016
- Adverse syndromes and psychiatric drugs: a clinical guide, Peter Haddad, Serdar Dursun, Bill Deakin. Oxford University Press. 2004 Kings Lynn
- Psychotropic drug directory 2014: the professionals pocket handbook and aide memorie, Stephen Bazire. Loyd-Reinhold Communications. 2014 Norwich
- The Maudsley Prescribing guidelines 12th edition. David Taylor, Carol Paton, Shitij Kapur. Wiley Blackwell. 2015 Oxford
- AWP guidance on swapping and stopping antidepressants – Graham Parton

4. Abbreviations used

- **MAOI** – monoamine oxidase inhibitor type of antidepressant
- **SNRI** – serotonin and noradrenalin reuptake inhibitor type of antidepressant
- **SSRI** – specific serotonin reuptake inhibitor type of antidepressant
- **TCA** – tricyclic type of antidepressant
- **NICE** – National Institute for Health and Care Excellence

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from⇓ to⇒	Citalopram / escitalopram	Fluoxetine	Paroxetine	Sertraline	Votioxetine	Trazodone	Venlafaxine	Duloxetine	Tricyclics	Clomipramine	Mirtazapine	Phenelzine / isocarb	Tranylcypromine	Mocobamide	Agomelatine	Bupropion
How to stop	Reduce dose over at least 4 weeks (longer may be required)	Reduce over 2weeks until dose is 20mg daily then stop	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce over one week to 10mg then stop	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Reduce dose over at least 4 weeks (longer may be required)	Can be stopped abruptly	Reduce dose over at least 4 weeks (longer may be required)
Citalopram / escitalopram		D (alt. days 1/52)	B	B	**B**	B	B	I	B	C	A	G – wait 1/52	G – wait 1/52	G – wait 1/52	A	B
Fluoxetine	H - wait 4-7 days		H - wait 4-7 days	H - wait 4-7 days	H - wait 4-7 days	B	C	C	H - wait 4-7 days , ↑ slowly	H - wait 4-7 days , ↑ slowly	A	H - wait 5-6 weeks	H - wait 5-6 weeks	H - wait 5-6 weeks	A	B
Paroxetine	B – 10mg	D – 20mg		B – 25mg	B	B	B	B - 60mg	B	B	A	G – wait 1–2 weeks	G – wait 1–2 weeks	G – wait 1/52	A	B
Sertraline	B – 10mg	D – 20mg	B- 10mg		B	B	B – 37.5mg	B - 60mg	B	C	A	G – wait 1–2 weeks	G – wait 1–2 weeks	G – wait 1/52	A	B
Votioxetine	B	C - 20mg alt die	B	**B**		B	B	B - 30mg	B	C	A	G – wait 1/52	G – wait 1/52	G – wait 1/52	A	B
Trazodone	A	A	A	A	A		A	A	B	B	A	G – wait 1/52	G – wait 1/52	G – wait 1/52	A	A
Venlafaxine	B	D – 20mg	CB	B	B	A		A	B	B	A	G – wait 1/52	G – wait 1/52	G – wait 1/52	A	B
Duloxetine	B – 10mg	D – 20mg	B – 10mg	B – 25mg	B	A	A		B	B	A	G – wait 1/52	G – wait 1/52	G – wait 1/52	A	B
Tricyclics	Taper to half dose then A	Taper to half dose then A	Taper to half dose then A	Taper to half dose then A	Taper to half dose then A	Taper to half dose then A	B	B (30mg daily)		A	A	G – wait 2/52 (3/52 if imipramine)	G – wait 2/52 (3/52 if imipramine)	G – wait 1/52	A	Taper to half dose then A
Clomipramine	C - 10mg	C - 20mg alt die	C	C	C	B	C – 37.5mg	C - 30mg	A		A	G – wait 3/52	G – wait 3/52	G – wait 1/52	A	A
Mirtazapine	A	A	A	A	A	A	A	A	A	A		G – wait 2/52	G – wait 2/52	G – wait 1/52	A	A
Phenelzine / isocarb	G - wait 2/52	G - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52		H - wait 2/52	H - wait 2/52	A	H - wait 2/52
Tranylcypromine	G – wait 2/52	G – wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52	H - wait 2/52		G – wait 2/52	A	H - wait 2/52
Mocobamide	G – wait 24 hours	H – wait 24 hours	H – wait 24 hours	H – wait 24 hours	H – wait 24 hours	H – wait 24 hours	G – wait 24 hours	G – wait 24 hours	G – wait 24 hours	G – wait 24 hours	G – wait 24 hours	G – wait 24 hours	G – wait 24 hours		A	G – wait 24 hours
Agomelatine	I	I	I	I	I	I	I	I	I	I	I	I	I	I		I
Bupropion	A	A	A	A	A	A	A	A	B	B	A	G – wait 2/52	G – wait 2/52	G – wait 1/52	A	

	Key		
A	Cross taper cautiously	**E**	Taper and stop original drug then wait 24 hours to start the start new drug
B	Cross taper cautiously and start new drug at low dose	**F**	Taper and stop original drug then wait 24 hours to start the start new drug at low dose
C	Taper and stop original drug then start new drug at low dose	**G**	Taper and stop original drug then wait ** period of time ** to start the start new drug
D	Taper and stop original drug then start new drug on alternate days	**H**	Taper and stop original drug then wait ** period of time ** to start the start new drug at low dose
		I	Stop original and start new drug (no delay)