

❖❖ PSYCHIATRIC MEDS IN SPECIAL POPULATIONS

Visual Quick Reference for On-the-Go Prescribing

❖❖ DIALYSIS/ESRD PATIENTS

✓ SAFE FIRST-LINE CHOICES

- ❖❖ DEPRESSION/ANXIETY
- ❖❖ SERTRALINE
 - ❖❖ Dose: 25mg → 50mg daily (max 200mg)
 - ✓ NO renal adjustment needed
 - ✓ NO post-dialysis supplement
 - ❖❖ Preferred SSRI in ESRD (Kubaneck et al., 2021)
- ❖❖ INSOMNIA + DEPRESSION
- ❖❖ TRAZODONE
 - ❖❖ Dose: 25-50mg HS (max 100mg)
 - ✓ NO renal adjustment needed
 - ⚠ Monitor: Orthostatic hypotension

✗ MEDICATIONS TO AVOID

- ❖❖ LITHIUM → Toxicity risk with fluid shifts (Gupta & Khastgir, 2017)
- ❖❖ GABAPENTIN → Significant dose reduction needed (Zand et al., 2010)
- ❖❖ DULOXETINE → Limited ESRD data
- ❖❖ VENLAFAXINE → Active metabolite accumulation

❖❖ ANTIPSYCHOTICS

- ✓ PREFERRED: Risperidone, Olanzapine, Quetiapine
- ❖❖ DOSING: Start at 50% normal dose
- ⚠ AVOID: Amisulpride (renal elimination) (Sutar et al., 2021)
- ❖❖ MONITOR: Prolactin levels

⚖ MOOD STABILIZERS

💡💡 LAMOTRIGINE

✓ Standard dosing (hepatically metabolized)

⚠ Monitor **for** rash

💡💡 VALPROIC ACID

⚠ Use with caution

💡💡 Monitor free levels **if** available

💡💡 ANXIOLYTICS

✓ LORAZEPAM: 0.25-0.5mg BID (no active metabolites) ✗ AVOID:

Alprazolam, Clonazepam (active metabolites) (Kanofsky et al., 2011)

💡💡 STROKE PATIENTS

💡💡 POST-STROKE DEPRESSION (30-50% of patients)

💡💡 SERTRALINE

💡💡 Dose: 25-50mg daily

✓ Evidence **for** stroke recovery

✓ Lower bleeding risk

💡💡 CITALOPRAM

💡💡 Dose: 10-20mg daily

⚠ Monitor QTc (max 20mg **if** >60 years)

✗ STROKE-SPECIFIC AVOIDS

💡💡 TCAs → Anticholinergic effects, fall risk 💡💡 BUPROPION → Lowers seizure threshold

💡💡 TRAMADOL → Seizure risk, serotonin syndrome

💡💡 ANTIPSYCHOTICS - ⚠ BLACK BOX WARNING

⚠ INCREASED STROKE RISK in elderly with dementia ✓ **IF**

NECESSARY: Quetiapine 12.5-25mg

💡💡 Use: Lowest dose, shortest duration

💡💡 ANXIETY/AGITATION

- ❌ AVOID: Benzodiazepines (fall risk, cognitive impairment) ✅ PREFERRED:
- 💡💡 Trazodone 25-50mg HS
 - 💡💡 Buspirone 5mg BID (no fall risk)

💡💡 COGNITIVE SYMPTOMS

- ❌ AVOID: Anticholinergics (worsen recovery)
- ✅ CONSIDER: Donepezil if vascular dementia suspected 💡💡 MONITOR: Delirium vs depression vs cognitive impairment

💡💡 POST-MI PATIENTS

💡💡 POST-MI DEPRESSION (20-45% prevalence)

- 💡💡 SERTRALINE (SADHART Study)
 - 💡💡 Dose: 25mg → 50-100mg daily (Jiang et al., 2008)
 - ✅ Safe post-MI
 - ✅ No cardiac conduction effects
 - 💡💡 May improve cardiac outcomes
- 💡💡 CITALOPRAM (ENRICHD trial data)

❌ CARDIAC-SPECIFIC AVOIDS

- 💡💡 TCAs → Proarrhythmic
- 💡💡 QTc-PROLONGERS → Citalopram >20mg, Ziprasidone 💡💡
- STIMULANTS → Increase cardiac workload

💡💡 ANXIETY/PANIC

- ❌ AVOID: High-dose benzodiazepines
- ✅ PREFERRED: Sertraline (treats both depression + anxiety) ✅
- ALTERNATIVE: Buspirone 5-10mg BID

💡💡 SMOKING CESSATION (Critical post-MI)

- 💡💡 BUPROPION
 - 💡💡 Dose: 150mg daily × 3 days → 150mg BID ⚠️
 - Monitor BP (can increase)
 - ❌ Avoid if seizure history

💡💡 VARENICLINE

⚠️ Use with caution, cardiac monitoring

💡💡 SLEEP ISSUES

✅ TRAZODONE: 25-50mg HS (safe cardiac profile) ❌ AVOID:
Zolpidem (may affect cardiac recovery)

💡💡 DIABETES PATIENTS

💡💡 MEDICATIONS AFFECTING GLUCOSE

⬆️ HYPERGLYCEMIA RISK: (Holt, 2019)

💡💡 HIGH: Olanzapine, Clozapine

💡💡 MODERATE: Quetiapine

⬇️ HYPOGLYCEMIA RISK:

💡💡 RARE: MAOIs

⚖️ WEIGHT GAIN RISK:

💡💡 HIGH: Mirtazapine, Most Atypical Antipsychotics

💡💡 DEPRESSION IN DIABETES

💡💡 FIRST-LINE: Sertraline, Escitalopram

✅ Minimal weight gain

✅ No significant glucose effects

💡💡 CONSIDER: Bupropion (weight neutral/loss) ❌ AVOID:
Mirtazapine, Paroxetine (weight gain)

💡💡 ANTIPSYCHOTICS - METABOLIC MONITORING

💡💡 HIGHEST RISK: Olanzapine, Clozapine

💡💡 Baseline: Weight, BMI, glucose, lipids

💡💡 Monitor: 3 months, **then** annually

💡💡 LOWER RISK: Aripiprazole, Ziprasidone, Lurasidone 💡💡
MODERATE RISK: Risperidone, Quetiapine

💡💡 NEUROPATHIC PAIN

?? DULOXETINE

?? Dose: 30-60mg daily

?? Dual benefit: Depression + neuropathic pain ?? Monitor liver function

?? GABAPENTIN: 300mg TID, titrate up

?? PREGABALIN: 75mg BID, titrate up

CANCER PATIENTS

?? DEPRESSION/ANXIETY (25-50% prevalence) (Novin Nikbakhsh et al., 2014)

?? SERTRALINE

?? Dose: 25-50mg daily

- ✓ Fewer drug interactions
- ✓ Good evidence in cancer

?? ESCITALOPRAM: 5-10mg daily

✗ AVOID: Paroxetine (CYP2D6 inhibitor)

! MAJOR DRUG INTERACTIONS

?? SSRIs + TAMOXIFEN:

✗ Paroxetine, Fluoxetine reduce tamoxifen efficacy

?? ANTIDEPRESSANTS + CHEMOTHERAPY:

! Many CYP450 interactions

?? ST. JOHN'S WORT:

✗ Reduces chemotherapy levels

?? NAUSEA/VOMITING

?? MIRTAZAPINE: 15mg HS (antiemetic + antidepressant) ??

OLANZAPINE: 2.5-5mg for breakthrough nausea ✗ AVOID:

Metoclopramide long-term (tardive dyskinesia)

?? ANXIETY/PANIC

✓ LORAZEPAM: 0.5-1mg q6h PRN (short-acting) ✗ AVOID:
Long-acting benzodiazepines (accumulation)

❖❖ DELIRIUM

- ❖❖ HALOPERIDOL: 0.5-2mg q4h PRN
- ❖❖ QUETIAPINE: 12.5-25mg BID (less EPS)
- ❖❖ RULE OUT: Medication-induced, metabolic causes

❖❖ ELDERLY PATIENTS

❖❖ "START LOW, GO SLOW" DOSING

- ❖❖ SSRIs (Start 50% adult dose):
 - ❖❖ Sertraline: 12.5-25mg daily (Singh & Saadabadi, 2023)
 - ❖❖ Escitalopram: 2.5-5mg daily
- ❖❖ ANTIPSYCHOTICS (Start 25% adult dose):
 - ❖❖ Risperidone: 0.25mg daily
 - ❖❖ Quetiapine: 12.5mg daily

✗ BEERS CRITERIA - AVOID IN ELDERLY (American Geriatrics Society, 2023)

- ❖❖ BENZODIAZEPINES → Fall risk, cognitive impairment ❖❖
- ANTICHOLINERGICS → TCAs, Paroxetine
- ❖❖ HIGH-DOSE TRAZODONE → >50mg increases fall risk ❖❖
- ANTIPSYCHOTICS → Mortality risk in dementia

❖❖ DEPRESSION IN ELDERLY

- ❖❖ FIRST-LINE: Sertraline, Escitalopram
- ✗ AVOID:
 - ❖❖ Paroxetine (anticholinergic)
 - ❖❖ Fluoxetine (long half-life)
- ✅ CONSIDER: Mirtazapine if poor appetite/weight loss

❖❖ ANXIETY IN ELDERLY

- ✗ AVOID: Benzodiazepines (Beers criteria) ✅ PREFERRED: Buspirone 5mg BID, titrate slowly
- ✅ ALTERNATIVE: Low-dose Trazodone 25mg HS

?? SLEEP ISSUES

✓ TRAZODONE: 12.5-25mg HS (lower doses in elderly) ✗ AVOID: Zolpidem, Eszopiclone (fall risk) ?? CONSIDER: Sleep hygiene education first

?? LIVER DISEASE

?? CHILD-PUGH DOSING ADJUSTMENTS (Elmeliegy et al., 2020)

?? CHILD-PUGH A: Minimal reduction needed ??
CHILD-PUGH B: 50% dose reduction
?? CHILD-PUGH C: Avoid or use 25% dose

✓ PREFERRED MEDICATIONS

?? DEPRESSION: Sertraline (lower hepatic metabolism) ??
ANXIETY: Lorazepam (no active metabolites) ?? PSYCHOSIS:
Haloperidol (less hepatic metabolism)

✗ MEDICATIONS TO AVOID

?? VALPROIC ACID → Hepatotoxic
?? DULOXETINE → Significant hepatic metabolism ??
NEFAZODONE → Withdrawn due to hepatotoxicity

! HEPATOTOXIC MEDICATIONS

?? MONITOR CLOSELY: Carbamazepine, Lamotrigine, Phenytoin ??
BASELINE LFTs: Before starting mood stabilizers
?? DISCONTINUE IF: ALT >3× upper limit normal

?? ENCEPHALOPATHY CONSIDERATIONS

✗ AVOID: Sedating medications (benzos, high-dose antipsychotics) ✓ PREFERRED:
Low-dose Haloperidol for agitation
?? MONITOR: Mental status changes with new medications

?? HEART FAILURE

?? DEPRESSION (20-40% prevalence)

?? SERTRALINE (SADHART-CHF)

✓ Safe in heart failure

✓ No negative inotropic effects

?? Dose: 25mg → 50-100mg daily

✗ AVOID: TCAs (negative inotropic, proarrhythmic)

✗ MEDICATIONS TO AVOID

?? TCAs → Negative inotropic, proarrhythmic ?? LITHIUM → Fluid/sodium restrictions complicate ?? HIGH-DOSE ANTIPSYCHOTICS → May worsen heart failure

?? ANXIETY MANAGEMENT

✓ BUSPIRONE: Safe, no cardiac effects

✓ LOW-DOSE TRAZODONE: 25mg HS for anxiety/sleep

✗ AVOID: Benzodiazepines (respiratory depression risk)

?? SLEEP ISSUES

✓ TRAZODONE: 25-50mg HS (safe cardiac profile)

SLEEP HYGIENE: Elevate head of bed, avoid late fluids

?? EMERGENCY CONSIDERATIONS

?? SUICIDAL IDEATION

⚠ INCREASED RISK: All special populations

?? SAFETY PLANNING: Essential with medication initiation ?? FAMILY

INVOLVEMENT: Especially with cognitive impairment

❖❖ MEDICATION OVERDOSE RISKS

❖❖ DIALYSIS PATIENTS: Medications may not be dialyzable ❖❖ LIVER DISEASE: Reduced metabolism increases toxicity ❖❖ HEART FAILURE: Cardiac medications may interact

❖❖ WHEN TO CONSULT/REFER

❖❖ CARDIOLOGY: Before QTc-prolonging medications ❖❖
NEPHROLOGY: Complex dosing in renal disease ❖❖
ENDOCRINOLOGY: Diabetes + psychiatric medications ONCOLOGY: Chemotherapy interaction questions

❖❖ GENERAL PRESCRIBING PRINCIPLES

❖❖ BEFORE PRESCRIBING - ALWAYS ASSESS

❖❖ MEDICAL STABILITY: Acute medical issues first ❖❖
CURRENT MEDICATIONS: All Rx, OTC, supplements ❖❖
ORGAN FUNCTION: Renal, hepatic, cardiac status ❖❖
PREVIOUS TRIALS: What worked/didn't work

❖❖ MONITORING SCHEDULE

❖❖ WEEK 1-2: Safety and tolerability
❖❖ WEEK 4-6: Initial efficacy assessment
❖❖ WEEK 8-12: Full therapeutic trial
❖❖ ONGOING: Side effects, interactions, medical changes

❖❖ DOCUMENTATION ESSENTIALS

❖❖ MEDICAL COMORBIDITIES: How they affect treatment ⚠
DRUG INTERACTIONS: Checked **and** addressed ❖❖ DOSE
RATIONALE: Why this dose **for** this patient ❖❖ MONITORING
PLAN: What to check **and** when

❖❖ PATIENT EDUCATION PRIORITIES

⚠️ **DRUG INTERACTIONS:** Report to all providers ⚡️ **SIDE EFFECTS:** When to call, when to stop ⚡️ **MEDICAL MONITORING:** Importance of regular care ⚡️ **ADHERENCE:** How psychiatric meds help overall health

⚡️ QUICK REFERENCE SUMMARY

⚡️ SAFEST FIRST-LINE CHOICES BY CONDITION

CONDITION	DEPRESSION	ANXIETY	PSYCHOSIS	SLEEP
DIALYSIS/ESRD	Sertraline 25-50mg	Lorazepam 0.25-0.5mg	Risperidone 50% dose	Trazodone 25- 50mg
STROKE (Puckey, 2024)	Sertraline 25-50mg	Buspirone 5mg BID	Quetiapine 12.5-25mg	Trazodone 25- 50mg
POST-MI	Sertraline 25-50mg	Buspirone 5- 10mg	Avoid if possible	Trazodone 25- 50mg
DIABETES	Sertraline/Escitalopram	Buspirone	Aripiprazole	Trazodone 25- 50mg
CANCER	Sertraline 25-50mg	Lorazepam 0.5-1mg	Quetiapine 12.5-25mg	Mirtazapine 15mg
ELDERLY	Sertraline 12.5-25mg	Buspirone 5mg BID	Quetiapine 12.5mg	Trazodone 12.5-25mg
LIVER DISEASE	Sertraline	Lorazepam	Haloperidol	Trazodone (low dose)
HEART FAILURE	Sertraline 25-50mg	Buspirone	Avoid if possible	Trazodone 25- 50mg

⚡️ UNIVERSAL AVOIDS IN SPECIAL POPULATIONS

- ✗ TCAs in: Stroke, Post-MI, Heart Failure, Elderly
- ✗ Benzodiazepines in: Elderly, Stroke (long-term)
- ✗ QTc-prolongers in: Post-MI, Heart conditions
- ✗ Hepatotoxic drugs in: Liver disease
- ✗ Anticholinergics in: Elderly, Stroke, Cognitive impairment

❖❖ Optimized for mobile viewing • ❖❖ Updated June 2025 • 🩺 For healthcare providers only

⚠ **DISCLAIMER:** This guide is for educational purposes only. Always consult current prescribing information, consider individual patient factors, and use clinical judgment. Not a substitute for comprehensive psychiatric evaluation and ongoing medical care.

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