How To Choose Medications for Major Depressive Disorder

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Patients who have never tried antidepressants

- Best first line antidepressants for most patients:
    - Sertraline (best combination of efficacy and tolerability)
    - Escitalopram (similar in tolerability to sertraline; citalopram can also be used)
    - Bupropion (best side effect profile, but less helpful for anxiety)
- Choice based on symptom profile/comorbidities
    - Comorbid anxiety disorder, bulimia, premenstrual dysphoric disorder: SSRIs
    - Comorbid ADHD or tobacco use disorder, or lethargy and poor concentration are prominent: Bupropion
    - Comorbid pain conditions, such as fibromyalgia, chronic musculoskeletal pain, and diabetic neuropathy: Duloxetine or amitriptyline
    - Insomnia and poor appetite are prominent: Mirtazapine
- Choice based on possible side effects
    - To avoid weight gain: Avoid paroxetine and mirtazapine.
    - To avoid sexual side effects: Use bupropion, mirtazapine, vilazodone
    - To avoid drug-drug interactions: Avoid paroxetine, fluvoxamine, and fluoxetine
    - To minimize seizure risk (e.g., in patients with alcohol use disorder): Avoid bupropion

Patients who have tried antidepressants in the past

- History of medication response
    - If the patient clearly responded to an antidepressant in the past, try it again.
    - If a patient reports that a close family member responded well to a particular antidepressant, it's reasonable to try that one.
- History of non-response to an SSRI
    - If patient has tried and failed one SSRI, you can try a different SSRI.
    - Optimize dose—increase to up to 4 times standard SSRI starting dose (eg., Zoloft 200 mg, Prozac 80 mg)
    - Switch to another class, eg., from SSRI to bupropion or duloxetine
- Treatment resistance: Patients who have tried and failed numerous antidepressants in the past.
    - Trial a less popular AD, eg., an MAOI or a tricyclic
    - Trial a newer AD, eg., vortioxetine, but make sure patients can financially access it after discharge
    - Augmentation. Adding another medication to an existing agent is often convenient and can yield a fairly rapid response.
        - Atypical antipsychotics.
            - Aripiprazole, 5-10 mg daily
            - Lurasidone, 20-120 mg daily
            - Quetiapine, 50-300 mg daily
        - Lithium. Usually 300-600 mg at bedtime.
        - Benzodiazepines. Though potentially addictive, they help speed up antidepressant response in patients with anxiety and insomnia.
            - Clonazepam, 0.5-1 mg BID
            - Lorazepam, 1-2 mg BID

- Bupropion. Add to SSRIs, especially in patients with lethargy.
- Stimulants. Methylphenidate can quickly mobilize patients with poor energy and concentration. Start at 5 mg and titrate upwards.
- Mirtazapine. Helpful for patients with insomnia and poor appetite, use 15-30 mg at bedtime.
- Thyroid. Start T3 (triiodothyronine, or Cytomel) at 12.5–25 mcg/day and increase gradually toward a dose of 50 mcg daily.