PRIMARY CARE PSYCHIATRY POCKET GUIDE

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© Shawn Barton Hersevoort MD MPH

UCSF-Fresno Department of Psychiatry

TABLE OF CONTENTS

HOW TO USE THIS GUIDE 1

MOOD DISORDERS

Diagnosis, treatment, and adjuncts 2

Medications and safety 3

ANXIETY DISORDERS

Diagnosis, treatment, and adjuncts 4

Medications and safety 5

PSYCHOTIC DISORDERS

Diagnosis, treatment, and adjuncts 6

Medications and safety 7

SLEEP-WAKE DISORDERS

Diagnosis, treatment, and adjuncts 8

Medications and safety 9

SOURCES AND RESOURCES 10

HOW TO USE THIS GUIDE

<u>PURPOSE</u>: This pocket guide is intended for use as a treatment tool for primary care physicians and medical students in order to assist in the diagnosis and treatment of common psychiatric conditions. Although broad in scope and evidence-based, it is neither all-inclusive nor definitive in its recommendations.

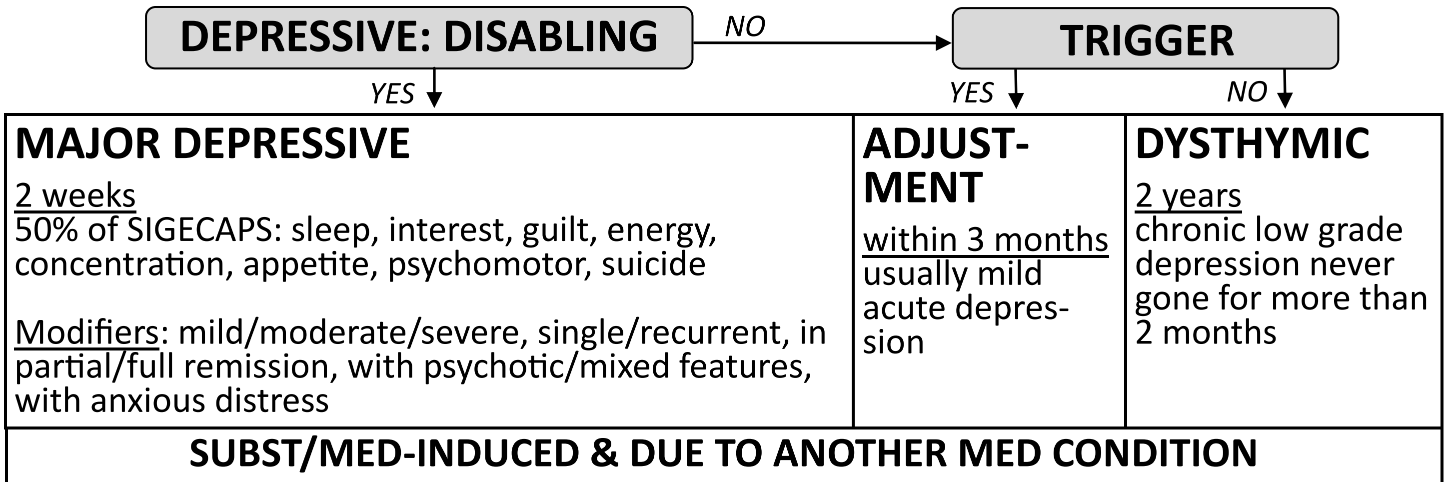
<u>MEDICATION CHOICE</u>: Start at the top of each page, using the safest and most tolerable medications for a given diagnosis (ex: SSRIs for major depression). Choose column based on patient profile (ex: weight/anxiety), increase dose at interval indicated (weekly/monthly), adjunct for partial effect, or cross-taper to lower agent if no benefit is evident after the stated number of days at non-starting dose, or intolerable because of side effects. This usually means attempting two medications in each class before moving on (ex: two SSRIs).

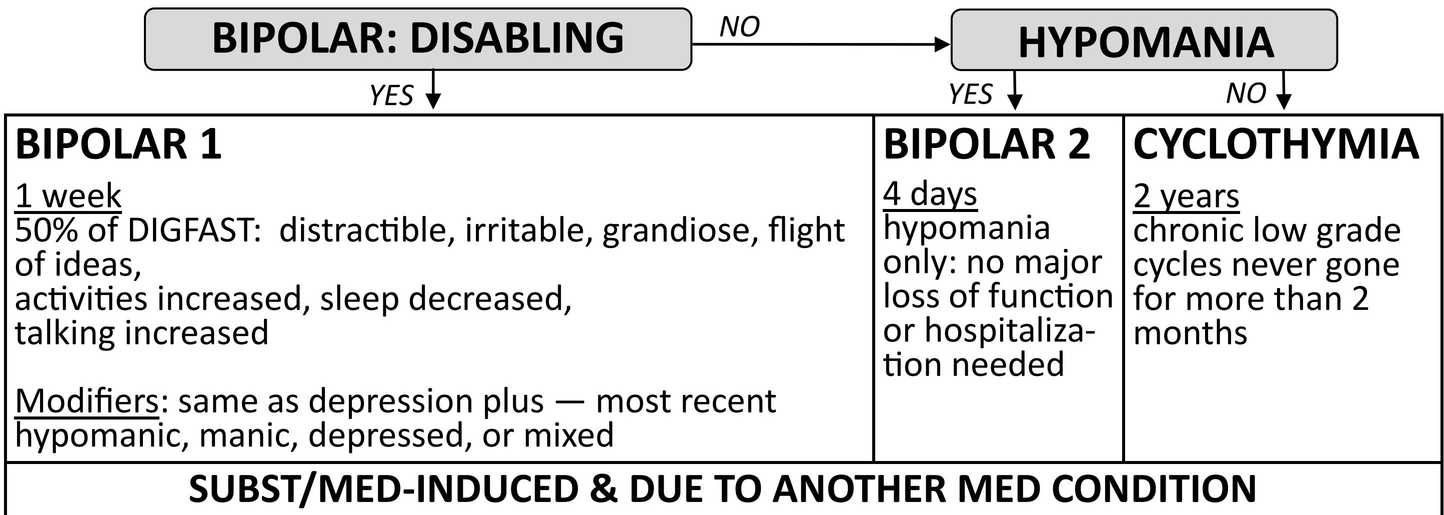
<u>OBESITY</u>: Of particular importance is weight gain and diabetes as they contribute so strongly to so many other medical conditions. For this reason they are given special attention and medications most associated with them are noted in italics throughout the guide.

<u>SAFETY</u>: Medications marked "worst choice" have either black-box warnings or well documented contraindications for use. Medications marked "best choice" for pregnancy are either category B or "safe" or "probably safe" for lactation. If there are none safer than category C or D then those listed are the safest agents according to research and formal treatment guidelines (ex: lithium and haloperidol). When a medication must be used, then these are the best first choices understanding that there are clear risks involved either way.

<u>CHILDREN</u>: Please note that the medications indicated for use in children are listed in the safety section for each diagnosis. All other medication use is off-label for psychiatric treatment.

MOOD DISORDERS





TREATMENT MODALITY & LABS

DEPRESSION: MILD: FIRST psychotherapy, **SEVERE:** FIRST medication
ALL BIPOLAR: Primary treatment is MEDICATION

BIPOLAR 1 LABS: Base/1/6/12 mo: CBC/CMP/TSH; Level: 1 wk/12 mo

ADJUNCTS & PRN adjust dose weekly

ANXIETY: MILD: buspirone 15 BID-30 BID, MODERATE-SEVERE: lorazepam (prn) or clonazepam (standing) 0.5 BID-1 BID, BZD
ALTERNATIVE: gabapentin (prn or standing) 100-300-600-900 up to TID
LOW ENERGY/HYPERSOMNIA: bupropion ER-12 100-200-300-400
SEX SIDE EFFECTS: bupropion/buspirone (above) or sildenafil 25-50-100
NEUROPATHIC PAIN: gabapentin (above) or TCA or use SNRI or TCA as primary agent (see mood d/o meds)

ALL BIPOLAR: LOW MOOD: FIRST bupropion ER-12 100-200-300-400, then SSRI or SNRI (NOTE: only use antidepressant with mood stabilizer)
BIPOLAR 2: MOOD CYCLING: valproic acid 500-1000 HS, or lithium 300-600 HS

ANTIDEPRESSANTS / MOOD STABILIZERS

Choose column, increase dose MONTHLY, adjunct for partial effect or cross-taper to lower agent if no benefit after 30 days or intolerable

OVERWEIGHT		HEALTHY		UNDERWEIGHT	
CALM	**ANXIOUS**	**CALM**	**ANXIOUS**	**CALM**	**ANXIOUS**
bupropion ER-12 100-200-300-400	fluoxetine 10-20-40-60-80 or sertraline 25-50-100-150-200	escitalopram 5-10-20 or citalopram 10-20-40	escitalopram 5-10-20 or citalopram 10-20-40	escitalopram 5-10-20 or citalopram 10-20-40	*paroxetine* *10-20-40 HS* *or mirtazapine* *7.5-15-30-45 HS*
fluoxetine 10-20-40-60-80 or sertraline 25-50-100-150-200	escitalopram 5-10-20 or citalopram 10-20-40	bupropion ER-12 100-200-300-400	fluoxetine 10-20-40-60-80 or sertraline 25-50-100-150-200	*paroxetine* *10-20-40 HS* *or mirtazapine* *7.5-15-30-45 HS*	escitalopram 5-10-20 or citalopram 10-20-40
SNRI: venlafaxine ER 37.5-75-150-225 or duloxetine 20-40-60-80-100-120					
TCA: desipramine 10-25-50-100-200		TCA: nortriptyline 10-25-50-100-150 HS		TCA: *amitriptyline* *10-25-50-100-150 HS*	

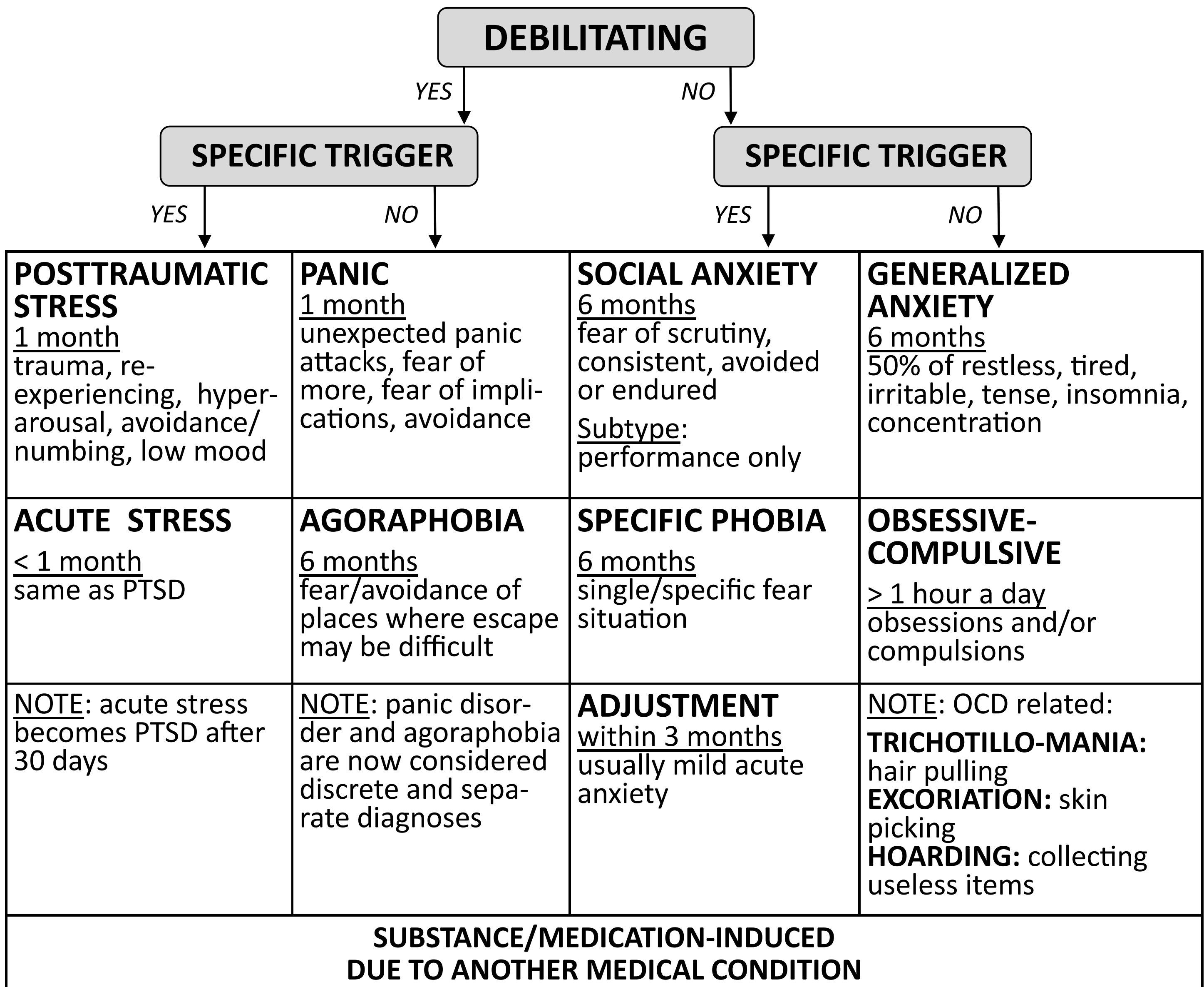
Choose column, increase dose WEEKLY, adjunct for partial effect or cross-taper to lower agent if no benefit after 1-2 weeks or intolerable

CLASSIC BIPOLAR 1	MIXED/RAPID BIPOLAR 1	BIPOLAR 2 & CYCLOTHYMIA
lithium 300 BID-600-900 BID (or try full dose at HS)	*valproic acid* *500-1000-1500 BID* (or try full dose at HS)	lamotrigine 25-50-100-200 HS
valproic acid *500-1000-1500 BID* (or try full dose at HS)	lithium 300 BID-600-900 BID (or try full dose at HS)	oxcarbazepine 300 BID-600-900 BID (or try full dose at HS)

SAFETY W/MEDICAL COMORBIDITIES

CONDITION	WORST CHOICE	BEST CHOICE
LIVER	duloxetine, TCA, *valproate*	*paroxetine*, gabapentin, lithium
KIDNEY	lithium	sertraline, fluoxetine, *valproate*
CARDIAC	TCA, bupropion	—
OBESITY/DM	*paroxetine, mirtazapine, valproate*	sertraline, fluoxetine, bupropion
ETOH/SEIZURE	duloxetine, bupropion, lithium, TCA	gabapentin, lamotrigine *valproate*, oxcarbazepine
PREGNANCY	*paroxetine*, BZD, TCA, *valproate*	sertraline, citalopram, buspirone, lithium/haloperidol
LACTATION	lorazepam, lithium, lamotrigine	sertraline, *paroxetine*, *valproate*
CHILDREN	only BEST have clinical indications for use	sertraline, fluoxetine, escitalopram, lorazepam, hydroxyzine, lithium

ANXIETY DISORDERS



POSTTRAUMATIC STRESS 1 month trauma, re-experiencing, hyper-arousal, avoidance/ numbing, low mood	**PANIC** 1 month unexpected panic attacks, fear of more, fear of impli-cations, avoidance	**SOCIAL ANXIETY** 6 months fear of scrutiny, consistent, avoided or endured Subtype: performance only	**GENERALIZED ANXIETY** 6 months 50% of restless, tired, irritable, tense, insomnia, concentration
ACUTE STRESS < 1 month same as PTSD	**AGORAPHOBIA** 6 months fear/avoidance of places where escape may be difficult	**SPECIFIC PHOBIA** 6 months single/specific fear situation	**OBSESSIVE-COMPULSIVE** > 1 hour a day obsessions and/or compulsions
NOTE: acute stress becomes PTSD after 30 days	NOTE: panic disor-der and agoraphobia are now considered discrete and sepa-rate diagnoses	**ADJUSTMENT** within 3 months usually mild acute anxiety	NOTE: OCD related: **TRICHOTILLO-MANIA:** hair pulling **EXCORIATION:** skin picking **HOARDING:** collecting useless items
SUBSTANCE/MEDICATION-INDUCED **DUE TO ANOTHER MEDICAL CONDITION**			

TREATMENT MODALITY

MILD: FIRST psychotherapy, **SEVERE:** FIRST medication

ADJUNCTS & PRN adjust dose weekly

STANDING	**PERSISTENT ANXIETY**: MILD: buspirone 15 BID-30 BID, MODERATE-SEVERE: clonazepam 0.5-1 up to BID, BZD ALTERNATIVE: gabapentin 100-300-600-900 up to TID **SEX SIDE EFFECTS**: buspirone (above) or sildenafil 25-50-100 **NEUROPATHIC PAIN**: gabapentin (above) or TCA or use SNRI or TCA as primary agent (see mood d/o meds)
PRN	**BREAKTHROUGH ANXIETY**: lorazepam or clonazepam (if already using standing) 0.5-1 up to BID, BZD ALTERNATIVE: gabapentin 100-300-600-900 up to TID or hydroxyzine 12.5-25-50-100 up to TID

ANXIOLYTIC MEDICATIONS

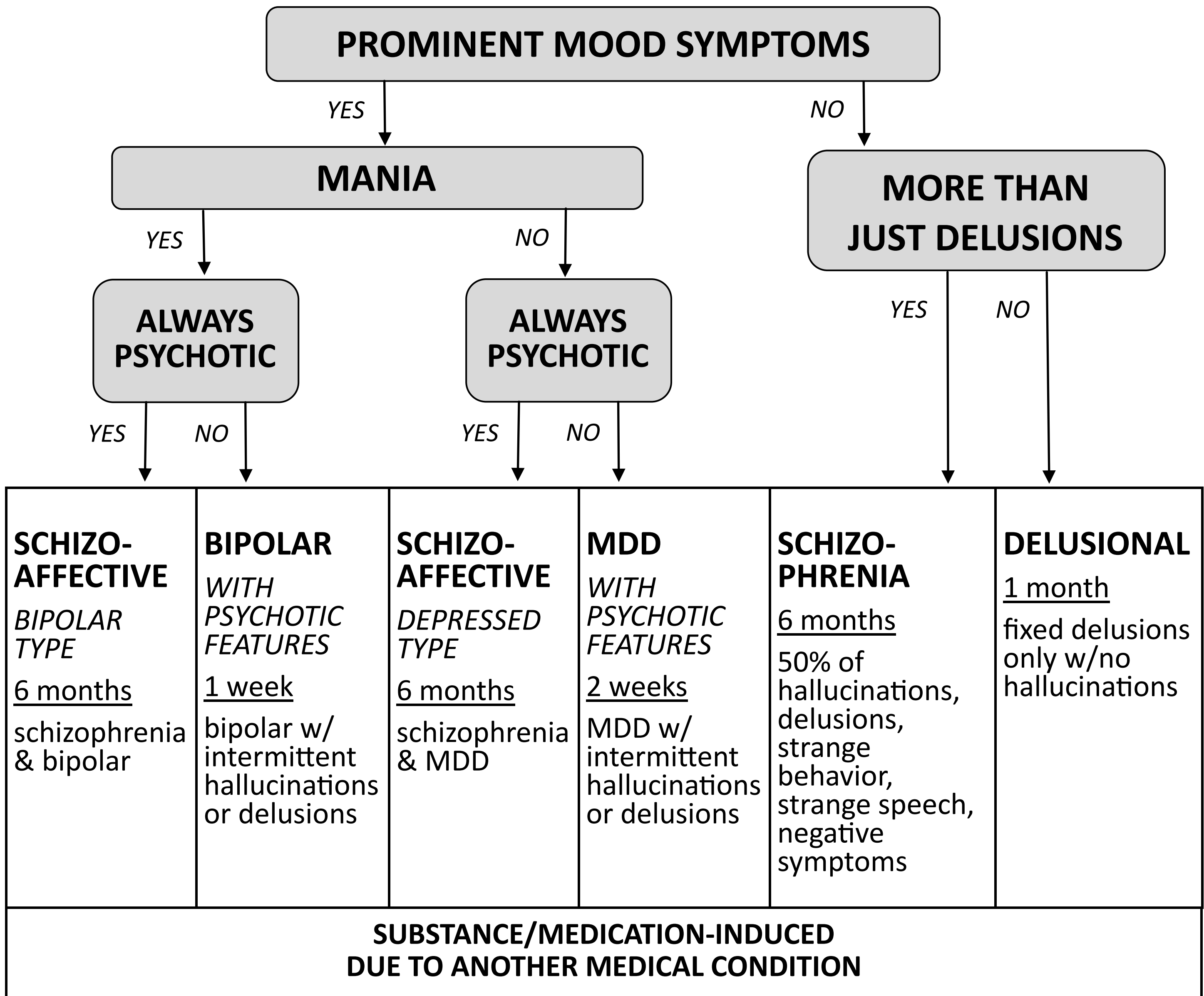
Choose column, increase dose MONTHLY, adjunct for partial effect or cross-taper to lower agent if no benefit after 30 days or intolerable

<table>
<tr><th colspan="2">GENERALIZED, SOCIAL, OCD, PANIC & PTSD</th></tr>
<tr><td colspan="2">buspirone 15 BID-30 BID only for mild-mod GAD/SAD</td></tr>
<tr><td colspan="2">citalopram 10-20-40
or escitalopram 5-10-20</td></tr>
<tr><td>too sedating / ineffective ↓</td><td>↓ too stimulating / ineffective</td></tr>
<tr><td>fluoxetine
10-20-40-60-80
or sertraline
25-50-100-150-200</td><td>paroxetine
10-20-40 HS
then mirtazapine
7.5-15-30-45 HS</td></tr>
<tr><td colspan="2">SNRI: venlafaxine ER 37.5-75-150-225
or duloxetine 20-40-60-80-100-120</td></tr>
<tr><th colspan="2">PERFORMANCE ANXIETY & SPECIFIC PHOBIA</th></tr>
<tr><td colspan="2">up to BID prn: propranolol 10-20-30-40 → lorazepam 0.5-1</td></tr>
<tr><th colspan="2">PTSD NIGHTMARE & HYPERAROUSAL</th></tr>
<tr><td colspan="2">HS/BID standing: prazosin 1-2-3-4-5-6 → clonazepam 0.5-1</td></tr>
</table>

SAFETY W/MEDICAL COMORBIDITIES

CONDITION	WORST CHOICE	BEST CHOICE
LIVER	duloxetine, TCA	*paroxetine*, gabapentin
KIDNEY	—	sertraline, fluoxetine
CARDIAC	TCA, bupropion	—
OBESITY/DM	*paroxetine, mirtzapine*	sertraline, fluoxetine, bupropion
ETOH/SEIZURE	duloxetine, bupropion, TCA	gabapentin
PREGNANCY	*paroxetine*, BZD, TCA	sertraline, citalopram, buspirone
LACTATION	lorazepam	sertraline, *paroxetine*
CHILDREN	only BEST have clinical indications for use	sertraline, *paroxetine*, buspirone, lorazepam, hydroxyzine

PSYCHOTIC DISORDERS



TREATMENT MODALITY & LABS

ALL PSYCHOSIS: Primary treatment is MEDICATION
SCHIZOAFFECTIVE: Use antipsychotic FIRST then add mood agent SECOND
BIPOLAR/MDD: Use mood agent FIRST then antipsychotic SECOND
PREGNANT: Continue effective treatment if already using when becoming pregnant. If not using — start single high potency typical antipsychotic (ex: haloperidol)

LABS: Base/1/3/6/12 mo: HA1C/glucose/fasting lipids

ADJUNCT adjust dose weekly

EXTRAPYRAMIDAL SIDE EFFECTS: benztropine 0.5-1-2 up to BID as needed or standing

ANTIPSYCHOTIC MEDICATIONS

Choose column, start second generation antipsychotic (SGA) at HS, increase dose every 2 WEEKS, adjunct for EPS or cross-taper to lower agent if no benefit after 2 weeks or intolerable

OVERWEIGHT BMI > 25	**HEALTHY** BMI 20-25	**UNDERWEIGHT** BMI < 25
aripiprazole 5-10-20-30 or ziprasidone 20-40-60-80 BID with food	risperidone 0.5-1-2-4-6	*olanzapine* *5-10-20-30* *or quetiapine* *25-50-100-200-300-400-500-600-700-800*
risperidone 0.5-1-2-4-6	*olanzapine* *5-10-20-30* *or quetiapine* *25-50-100-200-300-400-500-600-700-800*	risperidone 0.5-1-2-4-6
olanzapine *5-10-20-30* *or quetiapine* *25-50-100-200-300-400-500-600-700-800*	aripiprazole 5-10-20-30 or ziprasidone 20-40-60-80 BID with food	aripiprazole 5-10-20-30 or ziprasidone 20-40-60-80 BID with food

SAFETY W/MEDICAL COMORBIDITIES

CONDITION	WORST CHOICE	BEST CHOICE
LIVER	—	—
KIDNEY	—	—
CARDIAC	ziprasidone	—
OBESITY/DM	*quetiapine, olanzapine*	aripiprazole
ETOH/SEIZURE	—	—
PREGNANCY	—	haloperidol*, *SGA*
LACTATION	*all SGA*	—
CHILDREN	only BEST have clinical indications for use	aripiprazole, *quetiapine*, risperidone, *olanzapine*

* haloperidol 1-2-5-10: older first generation/typical antipsychotic similar to risperidone — can be used for psychosis or as an alternative to lithium for mood stabilization in pregnancy

SLEEP-WAKE DISORDERS

DYSSOMNIAS		PARASOMNIAS	
CENTRAL CAUSE		FEAR/AROUSAL	
YES	*NO*	*YES*	*NO*
PRIMARY INSOMNIA difficulty initiating or maintaining or non-restful sleep	**CIRCADIAN RHYTHM** mismatch b/w sleep-wake schedule required by environment and circadian pattern	**NIGHTMARE** recurrent awakening from sleep or naps, detailed recall of distressing content, rapid orientation in PTSD: can be re-experiencing event	**SLEEPWALKING** rising/walking, emotionless/ unresponsive, amnesia, delayed orientation upon awakening
HYPERSOMNELENCE prolonged/excessive sleep despite opportunity	**BREATHING-RELATED** sleep apnea/ hypopnea is cause of insomnia	**NIGHT TERROR** sudden awakening, intense fear/arousal, amnesia to content, delayed orientation	**REM SLEEP BEHAVIOR** arousals, vocalizations, or motor behaviors during REM
NARCOLEPSY short REM latency (transition hallucination, sleep paralysis) cataplexy (drop attacks) or low hypocretin	NOTE: apnea and hypopnea are serious medical conditions requiring evaluation and treatment by specialist	NOTE: **night terror** and **sleep-walking** are now both classified as individual symptoms of **NON-REM SLEEP AROUSAL DISORDER**	**RESTLESS LEGS SYNDROME** urge to move legs because of uncomfortable sensations—worse in PM, partially relieved by movement

SUBSTANCE/MEDICATION-INDUCED
MODIFIER: with another mental or medical comorbidity
NORMAL VARIANTS: long/short sleeper, snoring, sleep-talking/starts

TREATMENT MODALITY

ALL INSOMNIA: Primary treatment is NON-PHARMACOLOGICAL
FIRST: TREAT COMORBID psychiatric, substance, or medical illness
SECOND: BEHAVIORAL — CBTI, relaxation, sleep hygiene/stimulus control, sleep restriction, light, cognitive refocusing, imagery rehearsal
THIRD: PHARMACOLOGICAL beginning with safe/effective/time-limited

SPECIAL CONTRAINDICATIONS

PARASOMNIAS: ex: sleep-walking — do NOT use zolpidem/eszopiclone
SUBSTANCE AND BREATHING RELATED: do NOT use benzodiazepines
BREATHING-RELATED: do NOT use sleep aides or stimulants without CPAP or other airway support

SLEEP-WAKE MEDICATIONS

Start at top, increase dose WEEKLY, then combine for partial effect or change to lower agent if no benefit after 7 days or intolerable

GENERAL INSOMNIA

SHORT-TERM: INITIATION/EARLY EVENING
melatonin 1-2-5-10 or zolpidem 5-10
w/high anxiety: lorazepam 0.5-1 (if no use d/o)

SHORT-TERM: MID/LATE NIGHT OR MIXED
hydroxyzine/diphenhydramine 25-50-100 or zolpidem 5-10
w/high anxiety: clonazepam 0.5-1 or temazepam 15-30 (if no use d/o)

LONG-TERM
zolpidem 5-10 (if no non-REM sleep arousal d/o, ex: sleepwalking)

zolpidem ER 6.25-12.5 or eszopiclone 1-2-3

trazodone 25-50-100 or *mirtazapine* 7.5-15-30

TCA: *doxepin 10-25-50-100 or amitriptyline 10-25-50-100*

SGA: *quetiapine 12.5-25-50-100 or olanzapine 2.5-5-10*

PTSD NIGHTMARE

prazosin 1-2-4-6 BID or clonazepam 0.5-1 up to BID (if no use d/o)
SGA: *quetiapine* 12.5-25-50-100 or *olanzapine* 2.5-5-10

RESTLESS LEGS SYNDROME

ropinirole 0.25-0.5-1-2 or gabapentin 100-300-600-1200 HS

REM SLEEP BEHAVIOR & NON-REM SLEEP AROUSAL

clonazepam 0.5-1-2 (if no use d/o)

STIMULANTS/DAYTIME SEDATION

modafanil 50-100-200 or methylphenidate 5-10-20 (if no use/cards d/o)

SAFETY W/MEDICAL COMORBIDITIES

CONDITION	WORST CHOICE	BEST CHOICE
LIVER	TCA	gabapentin
KIDNEY	—	—
CARDIAC	TCA	—
OBESITY/DM	*mirtazapine, SGA*	—
ETOH/SEIZURE	BZD, TCA	gabapentin
PREGNANCY	BZD, TCA*, SGA*	diphenhydramine
LACTATION	TCA *(doxepin)*	diphenhydramine, hydroxyzine, trazodone
CHILDREN	Only BEST have clinical indication for use	hydroxyzine, diphenhydramine, lorazepam

SOURCES & RESOURCES

This pocket guide was developed by Dr. Shawn Hersevoort based primarily on the following sources:

1) Lippincott's Primary Care Psychiatry
2) Diagnostic and Statistical Manual-IV-TR
3) Diagnostic and Statistical Manual-5
4) International Classification of Sleep Disorders-2
5) Epocrates.com
6) American Psychiatric Association treatment guidelines

Please see my website for a digital copy of this guide as well as other valuable treatment tools including lectures, links, and handouts for providers and patients:

shawnhersevoortmd.com or imhfresno.com

Thank you to all of those who have helped me during the development of this tool as well as those who have contributed to my development as a physician and medical educator. These include my family, mentors, colleagues, residents, medical students, and patients.

Shawn Barton Hersevoort MD MPH 5/31/2014