## Key Messages

- Antidepressants should be prescribed in a step-wise approach and reviewed in a timely manner.

- Patients should be assessed for adverse effects at 1 or 2 weeks, depending on risk.

- Assess concordance, dose and therapeutic response over 2-4 weeks
  - Consider assessment for longer for older people.

- If partial response, continue for further 2-4 weeks.

- Do not persist with treatment that is ineffective or not tolerated. Instead, move to the next step.

- After recovery:
  - First episode: Continue for at least 6 months (12 months in older people)
  - Subsequent episodes: For those experiencing more than one episode in the recent past who experienced significant functional impairment during episodes, advise continuing for 2 years after recovery
  - Patients on maintenance treatment should be re-evaluated after 2 years, taking into account age, co-morbidity and other risk factors.
  - Withdraw antidepressants cautiously.

- Antidepressant discontinuation syndrome (stopping/ tapering antidepressant) – Generally if an antidepressant has been taken for 8 weeks or more, a gradual taper over 4 weeks avoids problems. See table on p.6 for further detail.
Antidepressants in moderate and severe unipolar depression
Guidelines for selecting and reviewing in adults aged 18 or over, including older people\textsuperscript{1,2}

If an antidepressant is indicated\textsuperscript{3}, use a stepwise approach and review in a timely manner\textsuperscript{4}

Assess for adverse effects at 1 or 2 weeks, depending on risk\textsuperscript{5}

Assess concordance, dose and therapeutic response over 2-4 weeks\textsuperscript{6}
Consider longer after step 1 for older people
If partial response, continue for further 2-4 weeks\textsuperscript{7}

Do not persist with treatment which is ineffective or not tolerated, move to the next step

After recovery:
First episode: continue for at least 6 months (12 months in older people)
Subsequent episodes: for those experiencing more than one episode in the recent past who experienced significant functional impairment during episodes, advise continuing for 2 years after recovery
Patients on maintenance treatment should be re-evaluated after 2 years, taking into account age, co-morbidity and other risk factors.
Withdraw antidepressants cautiously\textsuperscript{12}, see further advice on p.5/6

Choose from\textsuperscript{8}
- SSRI\textsuperscript{9,10} at standard dose
- Mirtazapine

Consider sertraline if MI in past 4 weeks, unstable angina or QT prolongation risk
Consider mirtazapine if high risk of bleed\textsuperscript{9} (esp GI) or concurrent NSAID, antiplatelet, anticoagulant or corticosteroid.

Choose from\textsuperscript{8}
- Alternative SSRI\textsuperscript{9,10}
- Mirtazapine (if not already tried)
- Lofepramine
- Moclobemide

Specialist initiation only\textsuperscript{8,15}:
- Lithium augmentation (see shared care)
- Mirtazapine + SSRI
- Mirtazapine + Venlafaxine
- Vortioxetine (RED: DHCFT prescribing only)\textsuperscript{16}

Specialist initiation only\textsuperscript{8,16}:
- Atypical antipsychotic augmentation
- MAOI monotherapy
- Lamotrigine augmentation
- Liothyronine (T3) augmentation (RED: DHCFT prescribing only)\textsuperscript{17}

Step 1

Step 2

Step 3

Step 4

Re-evaluate diagnosis
Treatment Resistance\textsuperscript{11}

Re-evaluate diagnosis
Treatment Resistance\textsuperscript{11}

Re-evaluate diagnosis
Treatment Resistance\textsuperscript{11}
Notes

1. **Scope:** This guideline is based upon guidance contained in NICE Clinical Guidelines CG90 and CG91 (2009). The guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families or carers. The guideline considers the choice, sequencing and review of pharmacological treatments for the treatment of depression and requires that appropriate steps have been taken in assessing the diagnosis and the appropriateness of antidepressant medication. It is recommended that prescribers are familiar with the appropriate NICE guideline(s).

2. **Other patient groups:** For children and young people under 18 contact your local CAMHS. For other special clinical situations such as pregnancy or possible bipolar disorder, seek specialist advice.

3. **Do not** use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression, because the risk-benefit ratio is poor but consider them for people with a past history of moderate or severe depression or an initial presentation of subthreshold depressive symptoms that have been present for at least 2 years or subthreshold depressive symptoms or mild depression that persist(s) after other interventions.

4. **A stepwise approach** to sequencing antidepressant medications is the most effective method to achieve treatment that is effective and tolerated. The aim of antidepressant symptoms is a meaningful improvement in the patient’s functioning, in a timely manner. Moving through the suggested steps will generally increase the risk of adverse effects. When prescribing an antidepressant explore any concerns the patient has about taking the medication and provide information about taking antidepressants including the gradual onset of the full antidepressant effect and the importance of taking medication as prescribed. A return to a previous step or treatment should only be considered if it was inadequately delivered or inadequately adhered to.

5. **The risk of self-harm** is greatest around the time of presentation and might increase in the early stages of treatment as antidepressant medicines can increase anxiety and agitation in the short-term. Careful and frequent monitoring is important in the early stages of treatment and when doses are increased, particularly in young adults and where any patient experiences worsening of symptoms when starting a new antidepressant or a new dose.

6. **When assessing therapeutic response** consider use of a rating scale such as Patient Health Questionnaire PHQ-9 or Geriatric Depression Scale-15, appropriate to the patient. If a patient’s depression shows no improvement after 2-4 weeks, check the medicine has been take regularly and at the prescribed dose. If response is absent or minimal at 3-4 weeks of treatment with a therapeutic dose of an antidepressant consider increasing the dose or switching antidepressant in line with the stepwise approach suggested in this guideline and with the patient’s preference.

7. **Partial response:** If the patient’s depression shows some improvement by 4 weeks, continue treatment for another 2 to 4 weeks. Consider moving to the next step of treatment if the response is still not adequate after this time, or there are side effects or the patient prefers to change treatment.

8. **Discuss antidepressant treatment options with the patient,** covering their perception of the efficacy and tolerability of any antidepressants they have previously taken and any anticipated adverse events or potential interactions associated with the suggested
options. Take into account toxicity in overdose when choosing an antidepressant with a patient at significant risk of suicide. Tricyclic antidepressants (excluding lofepramine) are associated with the greatest risk on overdose. Compared with other equally effective antidepressants recommended for routine use, venlafaxine is associated with a greater risk of death on overdose. Information to support conversations and informed decision-making can be found at https://www.derbyshirehealthcareft.nhs.uk/getting-help/understanding-your-medication/choosing-medicine

9. **SSRIs are associated with an increased risk of bleeding**, especially in older people or in those taking other medicines with the potential to interfere with clotting or damage the GI mucosa. Consider a PPI in older people already taking a non-steroidal anti-inflammatory drug (NSAID) or aspirin. SSRI-induced platelet dysfunction may manifest as bruising, nose bleeds, peri-operative bleeding or even haemorrhagic stroke. It is therefore recommended that SSRIs are avoided if at all possible in patients with a high risk of bleeding such as a previous history of bleed or concurrent medication. Additive factors include being aged over 80, smoking and excessive alcohol use. Co-prescribing gastro-protection alongside an SSRI in a high risk patient where no alternative antidepressant is suitable seems advisable but there is no evidence that this will reduce the haemorrhagic risk and it represents unlicensed use.

10. **SSRI choice:** Escitalopram is not currently recommended for routine use in Derbyshire. Paroxetine has a short half-life and is more often associated with problematic withdrawal syndromes than other SSRIs. Fluoxetine, fluvoxamine and paroxetine are associated with a greater propensity for drug-drug interactions than other SSRIs. If prescribing citalopram or escitalopram consider the QTc prolongation risk that is explained in more detail below.

11. **Treatment Resistant Depression (TRD) usually denotes a failure to respond to 2 or more single antidepressants given at adequate dose for an adequate time sequentially.** Level of service user concordance should be investigated in any apparent antidepressant failure. There is significant variation in the level of evidence supporting the options listed in Steps 3 and 4. The options therefore represent a guide only and it is anticipated that the Specialist would consider seeking further opinion for individual service users e.g. for concordance and thorough medication history assessment, consideration for tertiary referral service, review of diagnosis (e.g. possibility of hitherto undiagnosed bipolar depression, co-morbid anxiety etc.)

12. **Antidepressant discontinuation syndrome** – onset is usually within 5 days of stopping (or sometimes tapering) antidepressant. This can also occur following a missed dose of an antidepressant with a particularly short elimination half-life such as paroxetine or venlafaxine. Symptom severity varies and although often mild and self-limiting can be severe or prolonged. Evidence suggests symptom severity is worse if service user is not forewarned of possibility. Generally if an antidepressant has been taken for 8 weeks or more, a gradual taper over 4 weeks (not necessary with Fluoxetine) avoids problems. Paroxetine and Venlafaxine may need a longer taper. Further information can be found in the Maudsley Prescribing Guidelines and in the Psychotropic Drug Directory.

13. **Venlafaxine** should not be prescribed to a patient with uncontrolled hypertension. If higher doses are prescribed, blood pressure should be routinely monitored. Venlafaxine is also contraindicated in conditions associated with a high risk of cardiac arrhythmia.

14. **Tricyclic Antidepressants** are contraindicated in patients with significant cardiac problems such as arrhythmias, heart block or in the immediate recovery period following myocardial infarction. Do not switch to, or start, Dosulepin because evidence supporting its tolerability compared to other tricyclics is outweighed by the increased cardiac risk and toxicity in overdose (NICE CG90, 2009).

15. **Augmentation:** Be aware that using a single antidepressant rather than a combination or augmentation regimen is usually associated with a lower side-effect burden. Augmentation can increase the risk of serotonin syndrome (see below).
16. **Vortioxetine** is currently “RED” on the Derbyshire traffic-light list. For this reason it is currently sequenced in step 3 for specialist initiation and continuation. This does not reflect any additional complexity in prescribing or monitoring this antidepressant when compared to equivalent “green” options.

17. **Liothyronine (T3)** is currently “RED” on the Derbyshire traffic-light list following advice received from the Regional Medicines Optimisation Committee (South) regarding the prescribing of this medication in all contexts. The evidence base arising from STAR*D is supportive of liothyronine as an option in Treatment Resistant Depression (STAR*D (Sequenced Treatment Alternatives to Relieve depression) Level 2 Rush AJ, Trivedi MH et al Bupropion – SR, Sertraline or Venlafaxine XR after failure of SSRIs for depression. NEJM; Mar 2006; 354 (12); 1231 – 1242). Advice on prescribing and monitoring liothyronine for depression is available to DHCFT staff on the Trust's intranet.

**Switching between antidepressants** can also prove hazardous and useful tables with recommendations for method and speed of switch are available such as the Maudsley Prescribing Guidelines.

- Few studies have specifically examined the optimum strategy for switching between antidepressants. Advice is based on available information, theoretical concerns and clinical experience. For patients with complex medical or drug histories, specialist advice should be sought. Whichever strategy is adopted, patients should be closely monitored for relapse and adverse effect.

<table>
<thead>
<tr>
<th>When switching antidepressants, individual patient circumstances should be assessed taking into account the following factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>The urgency</strong> of the switch. In severely depressed patients who have failed to respond to one antidepressant or in cases of a severe adverse drug reaction it might be necessary to accelerate the process of switching. With less urgency a more cautious approach can be used.</td>
</tr>
<tr>
<td>- The patient’s <strong>physical condition</strong>. Caution is required in older people and those with co-morbid conditions.</td>
</tr>
<tr>
<td>- The <strong>current dose</strong> of the antidepressant being switched from and how easily this can be withdrawn.</td>
</tr>
<tr>
<td>- The <strong>duration of antidepressant treatment</strong>. Long-term treatment should be stopped or switched more slowly. Likewise treatment of a few weeks’ duration might be stopped more rapidly.</td>
</tr>
<tr>
<td>- The risk of <strong>serotonin syndrome</strong>. See the notes below under “other considerations”.</td>
</tr>
<tr>
<td>- Any <strong>history</strong> of discontinuation reactions.</td>
</tr>
<tr>
<td>- The severity of any <strong>previous depressive episodes</strong>.</td>
</tr>
<tr>
<td>- The risk that the switching regimen will <strong>confuse</strong> the patient and result in a medication error.</td>
</tr>
</tbody>
</table>
The following table provided general advice about switching more commonly-used antidepressants and is adapted from information presented in the Maudsley Prescribing Guidelines in Psychiatry, 13th Edition:

<table>
<thead>
<tr>
<th>From</th>
<th>Citalopram or Escitalopram or Sertraline</th>
<th>Fluoxetine (Notably long elimination half-life)</th>
<th>Mirtazapine</th>
<th>Moclobemide</th>
<th>Tricyclics other than clomipramine</th>
<th>Clomipramine (TCA with predominantly serotonergic pharmacology)</th>
<th>Venlafaxine (Notably short elimination half-life)</th>
<th>STOPPING or CROSS TAPERING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram or Escitalopram or Sertraline</td>
<td>Cautious cross taper starting with low dose</td>
<td>Reduce and stop then wait for 4-7 days before starting SSRI</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then wait for 1 week before starting moclobemide</td>
<td>Cross-taper cautiously with low-dose TCA</td>
<td>Reduce and stop, then start low dose clomipramine</td>
<td>Cross-taper cautiously with low-dose venlafaxine</td>
<td>Over 4 weeks</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Reduce and stop then start fluoxetine from 10mg/day</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then wait for 5-6 weeks before starting moclobemide</td>
<td>Great care for 4-weeks</td>
<td>Reduce and stop, then wait 2 weeks before starting low dose clomipramine</td>
<td>Reduce and stop, then start low dose venlafaxine</td>
<td>At 20mg/day just stop At higher doses reduce and stop over 2 weeks</td>
<td></td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Careful cross taper</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then wait for 1 week before starting moclobemide</td>
<td>Careful cross taper</td>
<td>Careful cross taper</td>
<td>Careful cross taper</td>
<td>Over 4 weeks</td>
<td></td>
</tr>
<tr>
<td>Moclobemide</td>
<td>Reduce and stop, then wait 24 hours before starting SSRI</td>
<td>Reduce and stop, then wait 24 hours before starting fluoxetine</td>
<td>Reduce and stop, then wait 24 hours before starting mirtazapine</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then wait 24 hours before starting TCA</td>
<td>Reduce and stop, then wait 24 hours before starting clomipramine</td>
<td>Reduce and stop, then wait 24 hours before starting venlafaxine</td>
<td>Over 4 weeks</td>
</tr>
<tr>
<td>Tricyclics other than clomipramine</td>
<td>Halve dose, then add SSRI before slowly withdrawing TCA</td>
<td>Halve dose, then add fluoxetine before slowly withdrawing TCA</td>
<td>Careful cross taper</td>
<td>Reduce and stop TCA then wait 1 week before starting moclobemide</td>
<td>Careful cross taper</td>
<td>Careful cross taper</td>
<td>Cross-taper cautiously starting with low dose of venlafaxine</td>
<td>Over 4 weeks</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>Reduce and stop, then start low dose SSRI</td>
<td>Reduce and stop, then start fluoxetine 10mg/day</td>
<td>Careful cross taper</td>
<td>Reduce and stop clomipramine then wait 1 week before starting moclobemide</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then start low dose clomipramine</td>
<td>Reduce and stop, then start low dose venlafaxine</td>
<td>Over 4 weeks</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Cross taper cautiously, starting SSRI at a low dose</td>
<td>Reduce and stop, then start fluoxetine 10mg/day</td>
<td>Careful cross taper</td>
<td>Reduce and stop, then wait for 1 week before starting moclobemide</td>
<td>Cross-taper cautiously with low-dose TCA</td>
<td>Reduce and stop, then start low dose clomipramine</td>
<td>Over at least 4 weeks or longer. Significant propensity for withdrawal syndrome</td>
<td></td>
</tr>
</tbody>
</table>
Other considerations:

Hyponatraemia – any antidepressant may be associated with this. Recommendation is for baseline serum sodium and repeat within first month. Risk is greater in older adults or those taking concurrent natriuretic medicines e.g. diuretics or with low body weight or in warm weather. Management - consider other cause of hyponatraemia, stop antidepressant and monitor serum sodium. Consider switching to another class e.g. from SSRI to TCAD or a MAOI or mirtazapine if appropriate. See further advice from SPS.

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Risk of hyponatraemia</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>SNRI</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>TCAD</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>MAOI</td>
<td>Low</td>
<td>Weak</td>
</tr>
<tr>
<td>NaSSA (mirtazapine, mianserin)</td>
<td>Low</td>
<td>Strong</td>
</tr>
<tr>
<td>Bupropion</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Agomelatine</td>
<td>Low</td>
<td>Weak</td>
</tr>
</tbody>
</table>

Serotonin syndrome and toxicity – This is often predictable from serotonergic drug combinations; including single serotonergic agents in highly susceptible individuals, lithium, some atypical antipsychotics and non-psychiatric medicines e.g. tramadol, sumatriptan. The level of severity ranges from milder chronic symptoms of akathisia, tremor, agitation, sweating and shivering to rapid onset of potentially fatal metabolic acidosis, seizures and rhabdomyolysis. Stopping serotonergic agent(s) is key as this usually results in rapid symptom resolution within 24 – 72 hours.

Serotonergic antidepressant combination options (see Steps 3 and 4) are an obvious risk for developing toxicity, in particular the combination of a tricyclic and an MAOI. For this reason, the relatively safer combination of Mirtazapine with a SSRI is put forward as an option but, as a minimum, the service user is expected to be informed of possible symptoms to look out for and should ideally be monitored frequently over the first few days.


Co-morbid conditions requiring careful consideration of the choice of antidepressant include:
Diabetes, glaucoma, epilepsy, bleeding disorders (especially gastro-intestinal bleeding - see above) and cardiovascular disease (including hypertension, postural hypotension, arrhythmias, known QT prolongation, congenital QT syndrome and conditions that pose a risk of Torsade de Pointes including medication known to be associated with QT prolongation). There is perhaps a greater association of QT prolongation with Citalopram than with other SSRIs and safeguards in terms of appropriate patient selection and consideration of concomitant medication should be taken as detailed below and in the Citalopram SPC.
Cognitive Behavioural Therapy (CBT) and other intervention options

The use of antidepressants should be considered within the overall framework of managing depression where other intervention options may also be appropriate e.g. in moderate depression. CBT should also be considered for those service users who do not take, refuse or are unable to tolerate antidepressant treatments or have shown an inadequate response to them. In severe depression, a combination of antidepressants and individual CBT has been shown to be more cost effective than either treatment alone. Other options to consider are Interpersonal Psychotherapy (IPT), couple-focused therapy and occupational therapy.

Electro-Convulsive Therapy (ECT)

Should be considered as an emergency treatment in life-threatening situations. It may also be considered in severe depression where a trial of antidepressants up to and including Step 3 of the above algorithm (where feasible) has produced inadequate response or has been poorly tolerated, depending on the individual clinical situation.

Citalopram - MHRA Usage and Maximum Dose Recommendations

1. Whilst Citalopram remains a treatment option in Derbyshire, the MHRA has warned of dose-dependent QT prolongation associated with Citalopram (MHRA Drug Safety Update Citalopram and Escitalopram: QT interval prolongation Dec 2011 Vol 5 Issue 5). Therefore licensed prescribing recommendations changed in October 2011.
   - Citalopram is contraindicated in people:
     - with a known QT prolongation or congenital long QT syndrome
     - taking other medicines known to prolong QT interval (see individual Summary of Product Characteristics for the relevant product at www.medicines.org.uk or check QTc risk at www.crediblemeds.org). The table below also lists some medicines and substances associated with QT prolongation:
     - Citalopram should only be used with caution in people with higher risk of developing Torsades de Pointes e.g. CHF, recent MI, bradyarrhythmias, hypokalaemia, hypomagnesaemia, other disturbances of electrolytes or concomitant illness predisposing to lengthened QT interval. A useful summary is available from the UK Specialist Pharmacy Service: https://www.sps.nhs.uk/wp-content/uploads/2017/09/QA237_2_DruginducedQTprolongation-2017-update.pdf
   - Citalopram should not be used above 40mg/d in adults
   - Citalopram should not be used above 20mg/d in older adults and people with reduced hepatic function
   - Patients on Citalopram at high risk of QT prolongation should be offered ECG monitoring.
   - Patients on Citalopram should be advised to contact a health care professional immediately if they experience signs or symptoms of an abnormal heart rate or rhythm, such as fast or irregular heartbeat, shortness of breath, fainting, collapse or dizziness.

In addition, Cimetidine may inhibit the metabolism of Citalopram and caution is therefore advised when co-administering (the FDA recommend not exceeding 20mg/day for such patients).

The following flowchart provides guidance on appropriate steps when reviewing patients who are prescribed citalopram.
Citalopram Use and Maximum Dose Recommendations

MHRA recommendations for citalopram due to a dose-dependent risk of QTc prolongation:
- Maximum dose 40mg in adults
- Maximum dose 20mg in older people
- Maximum dose 20mg in people with reduced hepatic function
- Contraindicated with known QT prolongation, congenital long QT syndrome or taking other QT-prolonging medicines
- Caution with higher risk of developing Torsades de Pointes

A QTc interval beyond 500ms is generally considered to present an unacceptable level of risk, necessitating prompt review and/or change of medicine regimen.

Switch to an appropriate alternative for the given indication

NO

YES

NO

YES

Does the patient taking citalopram have known QTc prolongation, congenital long QT syndrome, higher risk of Torsades de Pointes or concomitant QT-prolonging medication?

NO

YES

Discuss MHRA contraindications with patient. Is there a compelling reason not to reduce the dose to one within the license?

NO

YES

Is citalopram above the maximum licensed dose?

Discuss with the patient and reduce stepwise (usually over 4 weeks) to within maximum licensed dose for patient's diagnosis. Review patient within 2-4 weeks.

Patient remains clinically stable?

Perform ECG if new QT-prolonging medicines are co-prescribed and considered essential

Repeat regular ECG monitoring, e.g. 6-monthly or after any dose or relevant medicine changes

MHRA contraindications with patient. Is there a compelling reason not to reduce the dose to one within the license?

Continue citalopram

Perform ECG and check U&Es to exclude electrolyte imbalance

Is QTc ≥ 500ms?

Seek psychiatrist +/− cardiologist opinion

Switch to an appropriate alternative for the given indication

Perform ECG after dose stabilisation and after any relevant medicine or dose changes

Call patient for review. Check for further risk factors such as citalopram prescribed above the licensed maximum dose. Discuss MHRA contraindications, seek patient view of switching to a suitable alternative. Is there a compelling reason to remain on citalopram (e.g. previous treatment-resistant depression)

Having obtained specialist opinion and considered other options, if it is felt to be in the patient’s best interests to continue using citalopram outside of its product license, this should be discussed fully with the patient. Patient consent should be clearly documented and the prescriber takes full responsibility for unlicensed dose or off-label use. Tell patient to report heart-rhythm disturbance or fainting.

YES

NO

Repeat regular ECG monitoring, e.g. 6-monthly or after any dose or relevant medicine changes

Perform ECG after dose stabilisation and after any relevant medicine or dose changes

Switch to an appropriate alternative for the given indication

MHRA contraindications with patient. Is there a compelling reason not to reduce the dose to one within the license?

Continue citalopram

Perform ECG if new QT-prolonging medicines are co-prescribed and considered essential

Repeat regular ECG monitoring, e.g. 6-monthly or after any dose or relevant medicine changes

Call patient for review. Check for further risk factors such as citalopram prescribed above the licensed maximum dose. Discuss MHRA contraindications, seek patient view of switching to a suitable alternative. Is there a compelling reason to remain on citalopram (e.g. previous treatment-resistant depression)

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