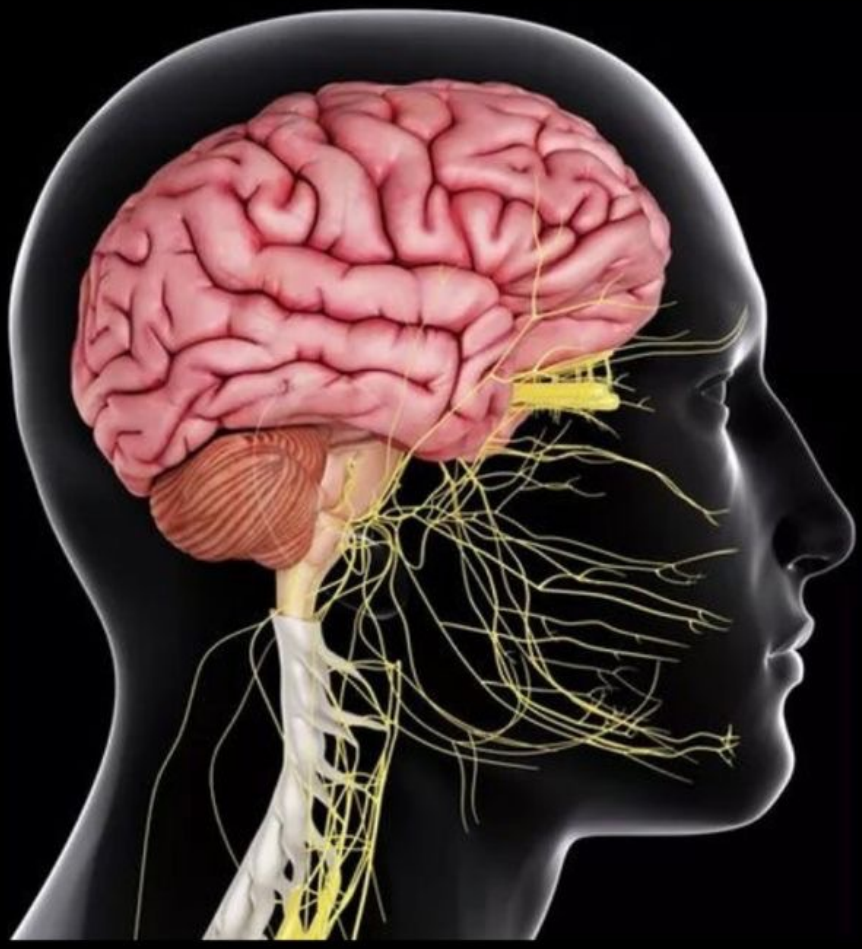
CENTRAL NERVOUS SYSTEM



SUBJECT : Pharmacology

LEC NO. : 3

DONE BY : Batool ALzubaidi

وقل رب زدني علماً

Antidepressants

Pharmacology and Toxicology

Central Nervous System Module

Third Year Medical Students

Tareq Saleh

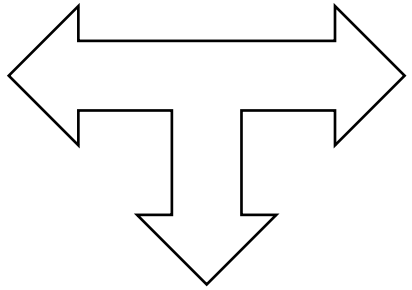
Faculty of Medicine

The Hashemite University

Textbook: pp. 128-138

Mood Disorders

Mood disorders



Major depressive disorder

- 2 weeks of at least **5** of the following symptoms:
  - Depressed mood — Main symptom
  - *Anhedonia* (diminished interest or loss of pleasure in almost all activities) — Mostly anorexia
  - Weight change or appetite disturbance
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation
  - Fatigue or loss of energy,
  - Feelings of worthlessness, diminished ability to think or concentrate;
  - suicidal ideation or a suicide attempt

Others

Bipolar disorder

- periods of prolonged depression that alternate with periods of an excessively elevated mood (mania)
- Manic episodes: 1 week of at least **3** of the following symptoms:
  - Grandiosity
  - Diminished need for sleep-excessive talking or pressured speech
  - Racing thoughts or flight of ideas-distractibility
  - Increased level of goal-focused activity at home, at work, or sexually
  - excessive pleasurable activities

Pathophysiology of Depression

- NOT fully understood.

There are so many theories thay range from biological factors to physiological problems it's a wild range of theories, mechanisms and contributing factors to depression, some start from the childhood some are secondary factors in adults

Pharmacological theory

Monoamine Theory of Depression:

- norepinephrine (NE), dopamine (DA) & serotonin (5-HT) are neurotransmitters responsible for mood.
- Depression is due to a deficiency in monoamines such as NE and 5-HT.

Very simplistic----fails to explain the long time course of most antidepressants.

Because many of the drugs that rapidly increase the level of serotonin and dopamine that can be used in the treatment of depression do not improve depression fast, they take a long time from weeks to months

اذا كان فعليا سبب ال depression هو ال deficiency in serotonin and dopamine ال rapid replacement الهم بال brain ليش ما صلح ال depression

Selective Serotonin Reuptake Inhibitors (SSRIs)

1.

Selective Serotonin Reuptake Inhibitors (SSRIs)

physiological , physco-social, behavior therapy علاج في pharmacological مش بس depression علاج ال

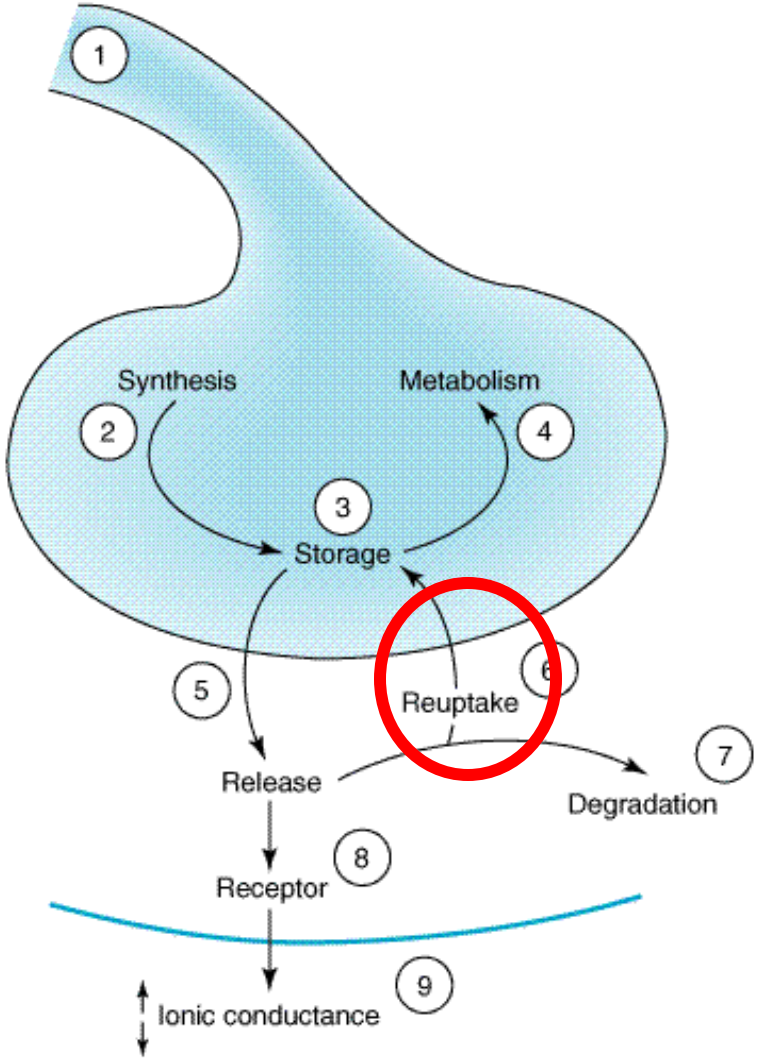
Mechanism of action

- SSRIs block the reuptake of serotonin →increase its concentrations in the synaptic cleft.

Increasing activity

DRUG	UPTAKE INHIBITION	
	Nor-epinephrine	Serotonin
Selective serotonin reuptake inhibitor		
Fluoxetine	0	++++
Selective serotonin/ norepinephrine reuptake inhibitors		
Venlafaxine	++*	++++
Duloxetine	++++	++++
Tricyclic antidepressants		
Imipramine	++++	+++
Nortriptyline	++++	++

Sites and Mechanisms of CNS Drug Action



NT reuptake:

•Antidepressants

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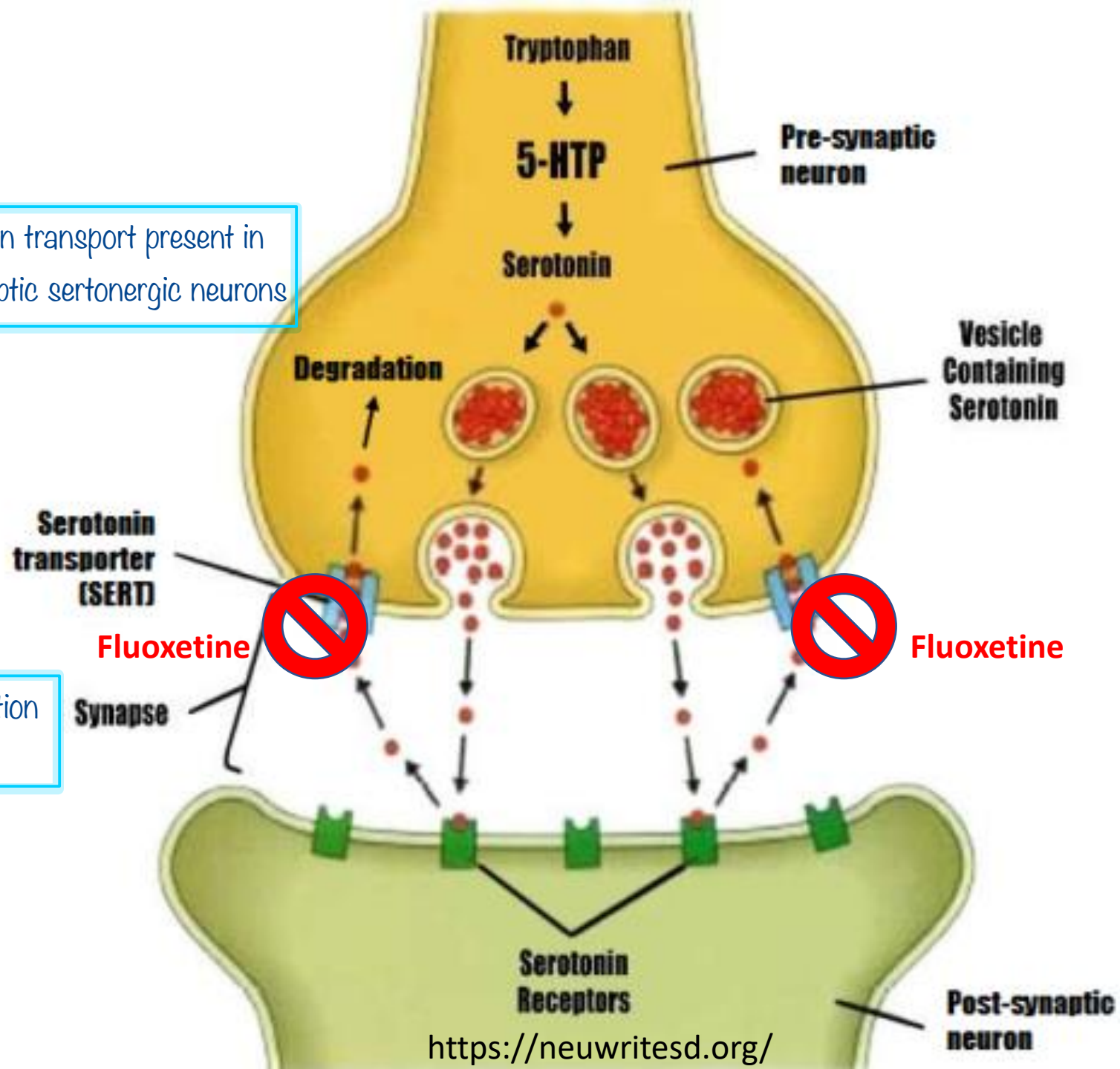
Selective Serotonin Reuptake Inhibitors (SSRIs)

- Fluoxetine inhibits SERT and interferes with serotonin reuptake.
- This results in increased serotonin availability in the synaptic cleft.

Serotonin transport present in presynaptic sertonergic neurons

Serotonin accumulation in synaptic cleft



https://neuwritesd.org/

Selective Serotonin Reuptake Inhibitors (SSRIs)

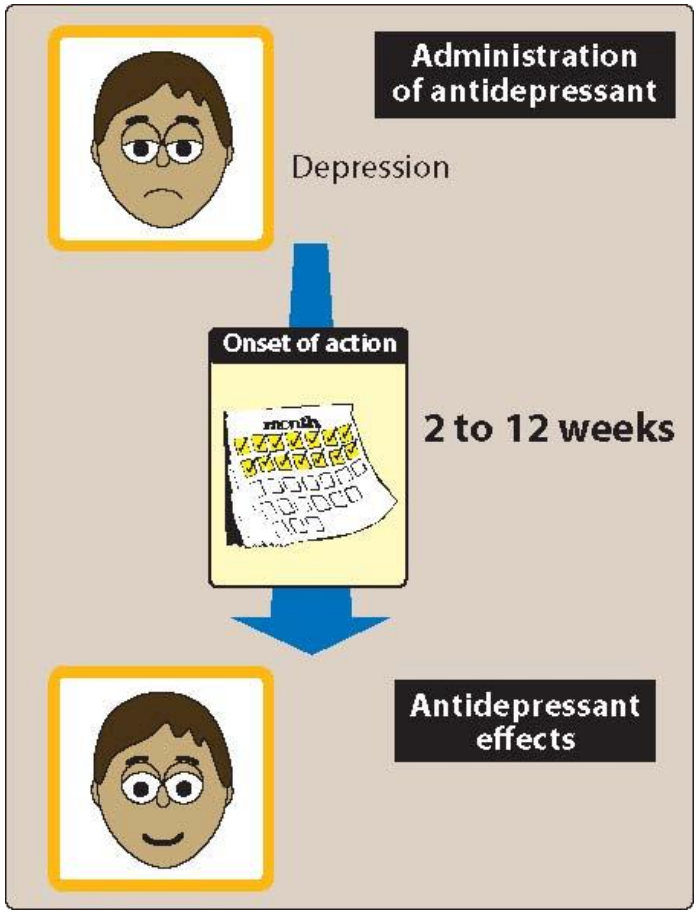
Therapeutic uses

First line for depression and anxiety disorders

- **Depression** (The primary indication)
- Obsessive Compulsive disorder (OCD)
- Panic disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Post-traumatic stress disorder
- Premenstrual dysphoric disorder
- Bulimia Nervosa (*Only fluoxetine*)

Therapeutic Effect

- SSRIs require 2 weeks to establish a significant alteration in mood (up to 12 weeks and more).



Selective Serotonin Reuptake Inhibitors (SSRIs)

Pharmacokinetics

- **Oral.**

  - Food has little impact on their absorption (*except for sertraline, for which food increases its absorption*).

- **Metabolized by CYP450 enzyme family**

Less dosing

- fluoxetine differs from the other members of the family in that it has a much longer half life (~50 hours), and the half life of its metabolite can be longer than 10 days.

  - fluoxetine and paroxetine are a potent inhibitors of *CYP2D6*

Can be associated with drug drug interaction

Selective Serotonin Reuptake Inhibitors (SSRIs)

One of the reasons why they became first line agents to treat depression » they're selective for serotonin reuptake inhibition, no effects on histamine or muscaranic receptors » less adverse effects

Adverse effects

- **Headache, sweating, nausea, vomiting and diarrhea.**
- **Sleep disturbances:**
  - -*Paroxetine* and *fluvoxamine* are sedative
  - -*Fluoxetine* and *sertraline* are more activating.

Given in case of depression with insomnia

Given in case of depression with hyper insomnia

- **Sexual dysfunction**: loss of libido, delayed ejaculation, anorgasmia.
  - Very common
  - Could require switching to another family of antidepressants

Results with incomplience

Selective Serotonin Reuptake Inhibitors (SSRIs)

Adverse effects

- **Overdose**: "*serotonin syndrome*" especially when used with another MAOi (includes seizures, hyperthermia, muscle rigidity, sweating, myoclonus, …)
- **Discontinuation syndrome**: occurs due to abrupt withdrawal (includes headache, malaise, flu-like symptoms, irritability, nervousness, sleep disturbances).

Must be stopped gradually

❑Particularly by the agents with the shorter half-lives.

❑SSRIs should be discontinued gradually.

Use of SSRIs in Children/Adolescents

- Used with caution.

[reports of suicidal ideation]

- ❑Fluoxetine and escitalopram are approved to treat childhood depression.
- ❑Fluoxetine, fluvoxamine and sertraline are approved to treat OCD in children

2. Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs)

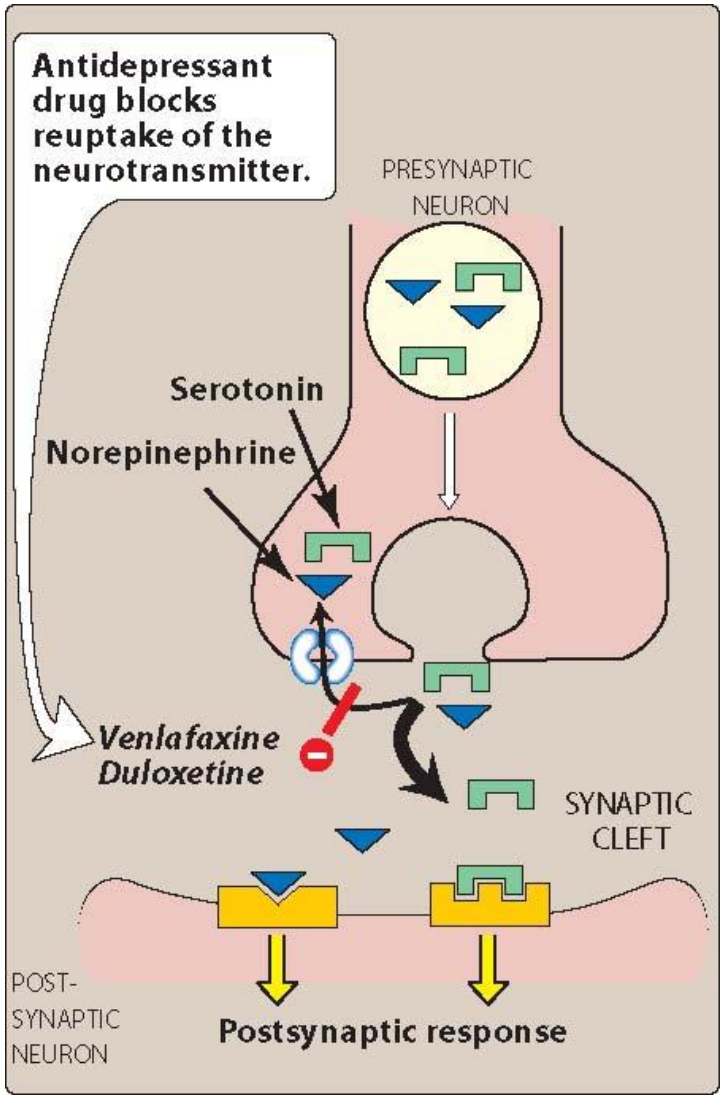
SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)
Desvenlafaxine PRISTIQ
Duloxetine CYMBALTA
Levomilnacipran FETZIMA
Venlafaxine EFFEXOR

Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs)

Widely used as first line treatment of depression

Mechanism of action

- SNRIs inhibit the reuptake of BOTH serotonin and norepinephrine

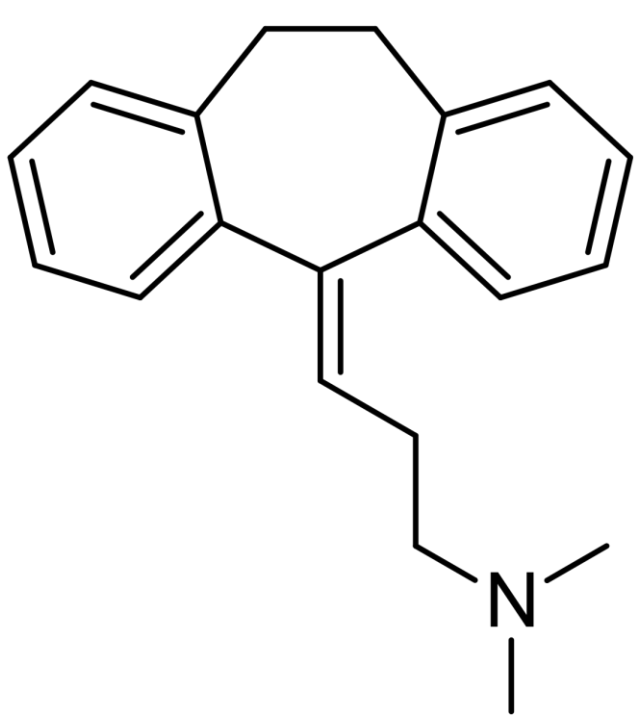


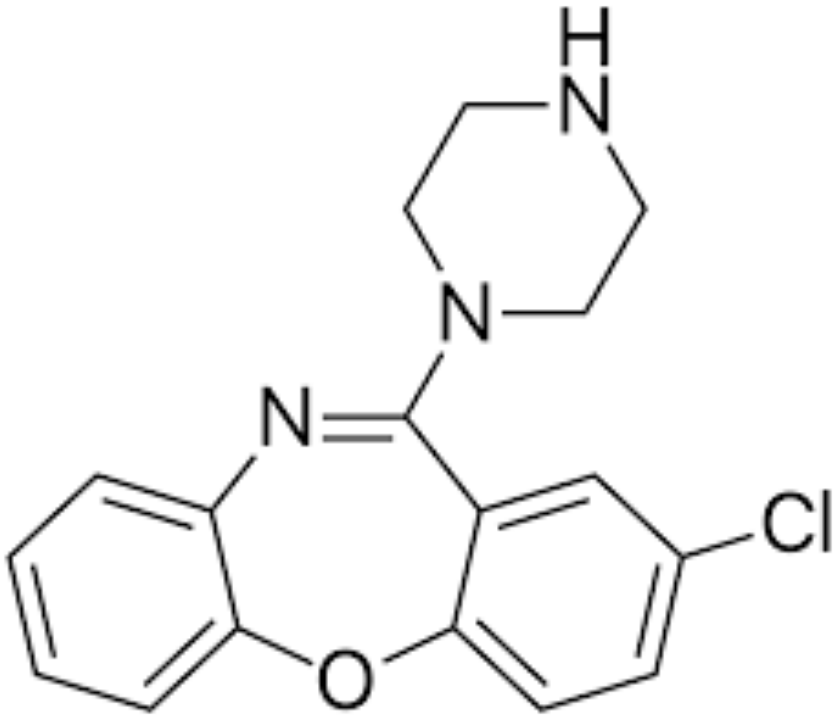
Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs)

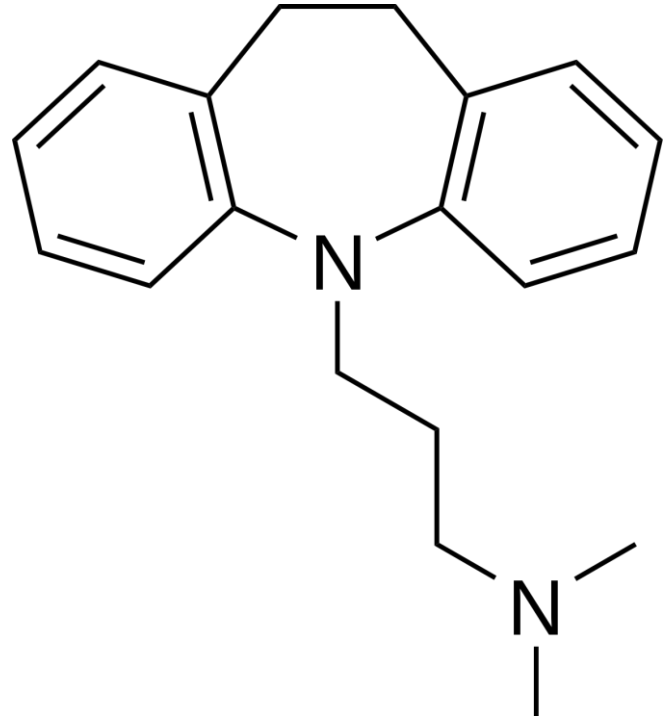
Therapeutic uses

1. **Depression** (when SSRIs are ineffective).
2. **Depression accompanied by a chronic painful condition.**
3. **Neuropathic Pain** (diabetic neuropathy, postherpetic neuralgia, fibromyalgia, etc.…)

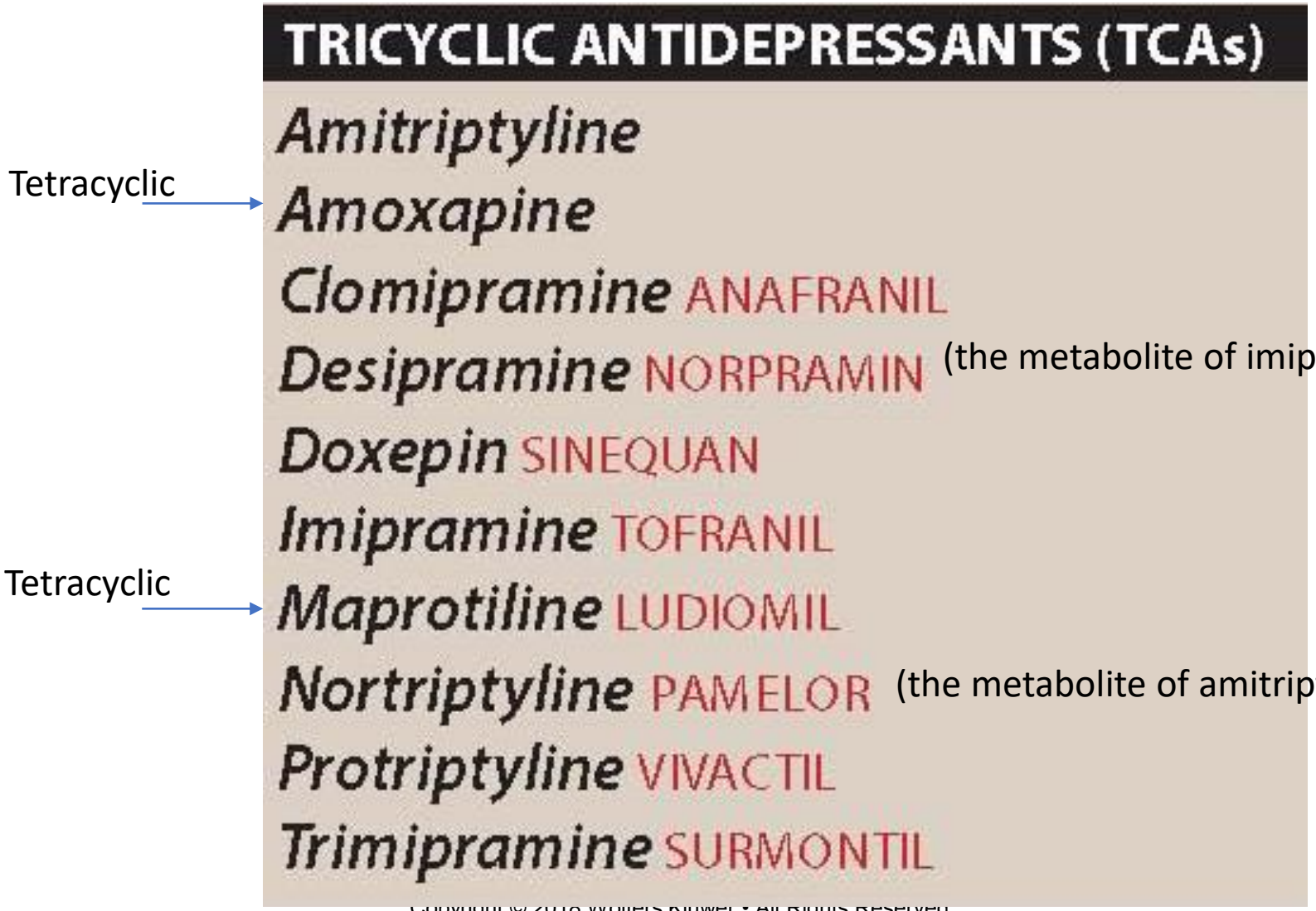
3. Tricyclic Antidepressants (TCAs)







Tricyclic Antidepressants (TCAs)



Tetracyclic →

Tetracyclic →

(the metabolite of imipramine)

(the metabolite of amitriptyline)

Tricyclic Antidepressants (TCAs)

Mechanism of action

- **Inhibition of neurotransmitter** (NE and 5-HT) **reuptake**:
- **Receptor antagonism**:

  - TCAs also block serotonergic, α-adrenergic, histaminic and muscarinic receptors.

  - Amoxapine also blocks 5-HT_2 and dopamine D_2 receptors.

many of the side effects of TCAs result from this non-selective receptor antagonism.

Wider profile of adverse effects

Tricyclic Antidepressants (TCAs)

Therapeutic uses

Not first line

- **Moderate to severe depression**
- Panic disorder
- Nocturnal enuresis (bedwetting): Imipramine (largely replaced by desmopressin).
- Migraine and chronic pain conditions: amitriptyline.
- Insomnia: doxepin.

Most sedative anti-depressant

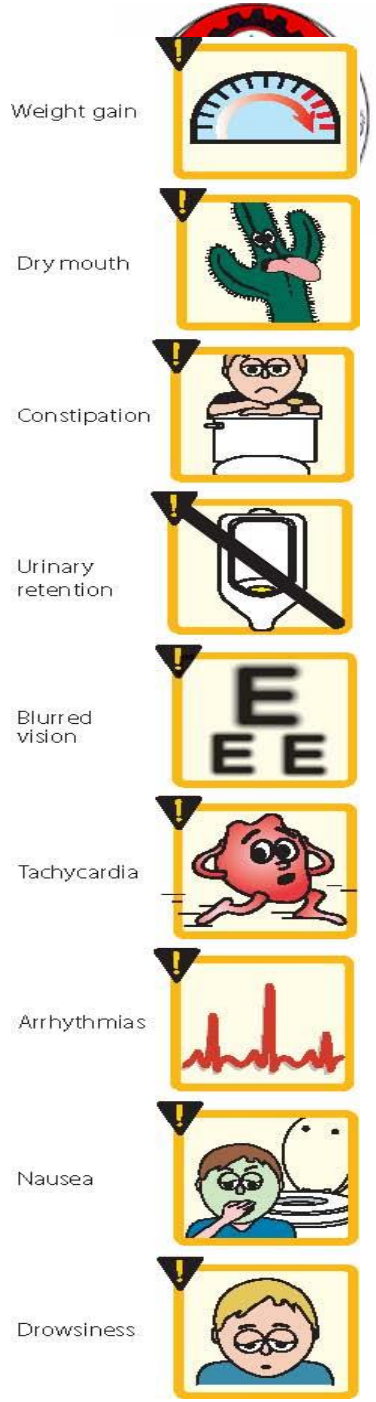
Tricyclic Antidepressants (TCAs)

Adverse effects

Mostly due to blocking of parasympathetic regulation

- **Muscarinic blockade:** blurred vision, xerostomia, urinary retention, sinus tachycardia, constipation and aggravation of angle-closure glaucoma.
- **α-adrenergic blockade:** orthostatic hypotension (imipramine), dizziness and reflex tachycardia.
- **H_1 histamine blockade:** sedation.
- **Overdose:** can be associated with life-threatening cardiac arrhythmias.
- **Sexual dysfunction:** less than SSRIs.

If SSRIs result with severe sexual dysfunction you can switch the patient to tricyclic antidepressants



4. Monoamine Oxidase Inhibitors (MAOi)

-Selective for MAO-B

-also used for the treatment of Parkinson's disease.

Monoamine Oxidase Inhibitors (MAOi)

The use of MAOi is limited (last line) due to the dietary restrictions required while taking these agents, toxicity and drug-drug interaction.

Monoamine Oxidase Inhibitors (MAOi)

Mechanism of action:

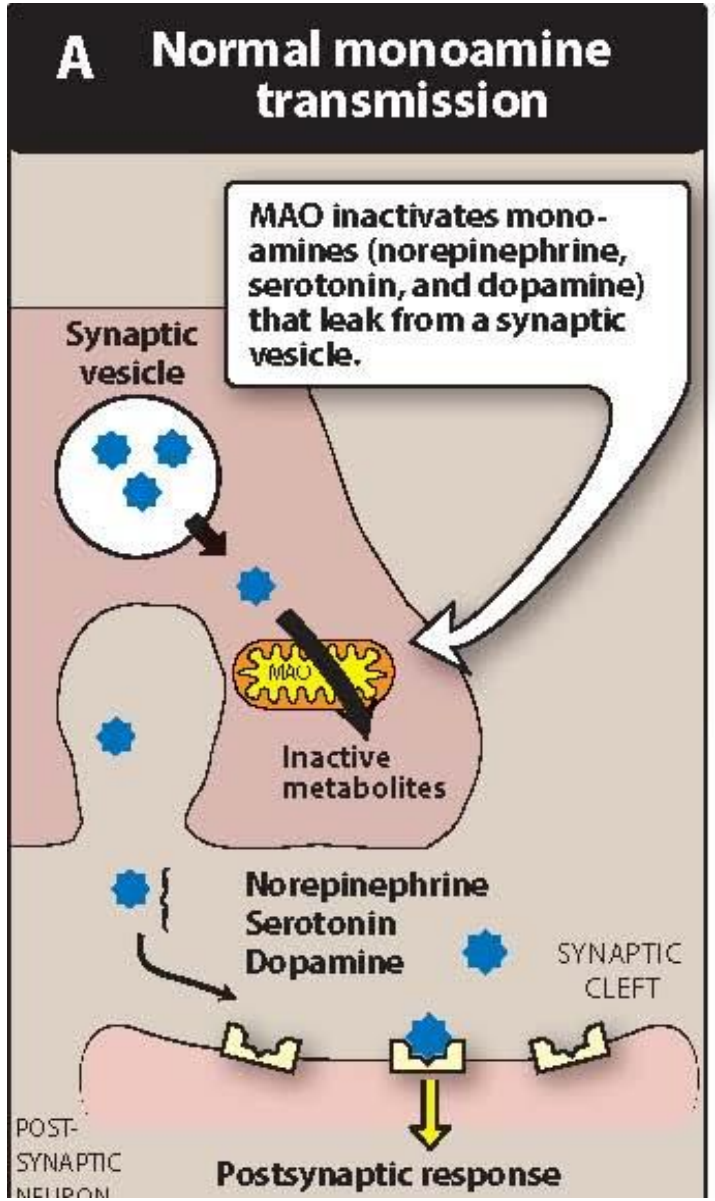
- MAO enzyme exists in 2 forms:

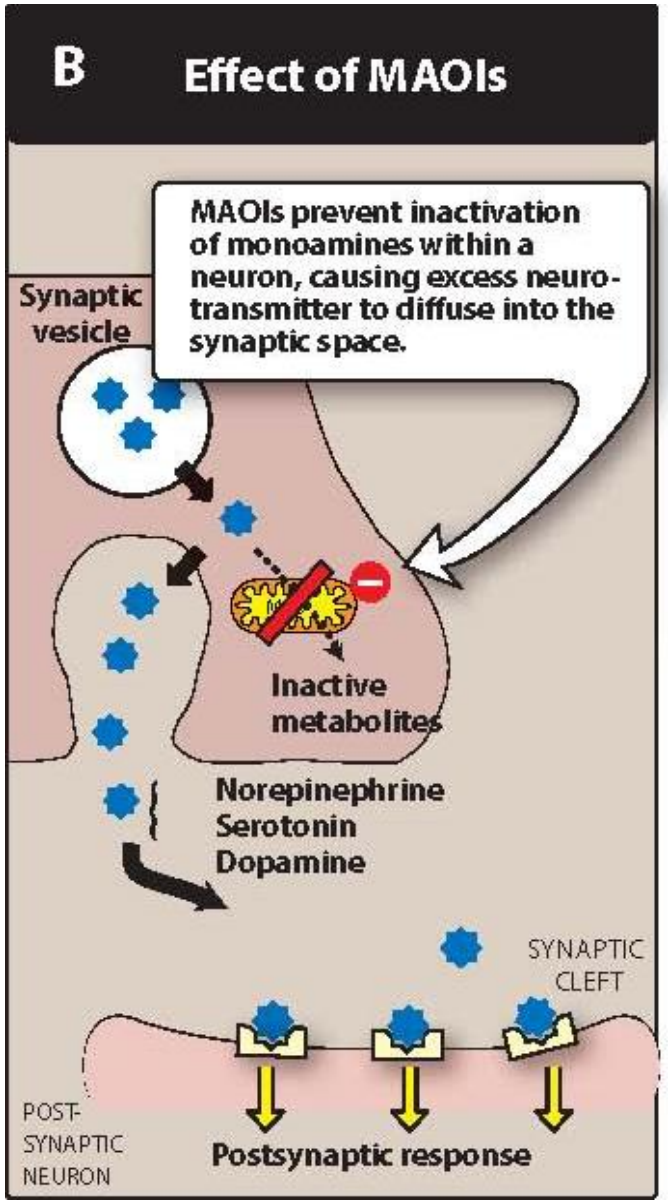
1- MAO-A: responsible for metabolism of NE and 5-HT.

2- MAO-B: more selective for dopamine (DA) metabolism.

- Most MAOis form stable complexes with the enzyme causing irreversible inactivation.
- **Inhibition of MAO results in ↑ NE + 5-HT + DA**

MAO enzyme is not only present in the brain it's also found in liver and gut, it's responsible for metabolism of dopamine peripherally in the circulation, if drug isn't selective for the enzyme centrally blocking it peripherally will result in a wide range of adverse effects





Monoamine Oxidase Inhibitors (MAOi)

Mechanism of action:

- The action of MAOi is delayed for several weeks.

MAOi also interfere with hepatic and intestinal isoforms of the enzyme which accounts for their high drug-drug and food-drug interactions.

Monoamine Oxidase Inhibitors (MAOi)

Therapeutic uses:

- **Last line for the treatment of depression:** for patients who are unresponsive to SSRIs or TCAs.
- **Atypical depression.**

Monoamine Oxidase Inhibitors (MAOi)

Adverse effects:

- Orthostatic hypotension, insomnia and convulsions.
- Hepatotoxicity (Phenelzine).
- **Serious food (tyramine-rich) and drug interactions.**

Seizures

Aged food

Monoamine Oxidase Inhibitors (MAOi)

Tyramine-rich diet and MAOi

- Tyramine is contained in foods such as aged cheese, meats, chicken liver, smoked fish and red wine.
- Tyramine is inactivated by hepatic and intestinal MAOs.
- MAOi interfere with the degradation of dietary tyramine.
- Tyramine accumulation results in the release of large amounts of stored catecholamines → Hypertensive crisis!!!
  - Epi & nor-epi

5. Atypical antidepressants

ATYPICAL ANTIDEPRESSANTS	
Bupropion	WELLBUTRIN, ZYBAN
Mirtazapine	REMERON
Nefazodone	
Trazodone	DESYREL
Vilazodone	VIIBRYD
Vortioxetine	BRINTELLIX

Bupropion

- **Mechanism of action**: Weak DA and NE reuptake inhibitor
- **Therapeutic uses:** Depression and smoking cessation (reduces cravings and attenuates nicotine withdrawal symptoms.
- **Adverse effects:** associated with a dose-dependent increased risk for seizures.

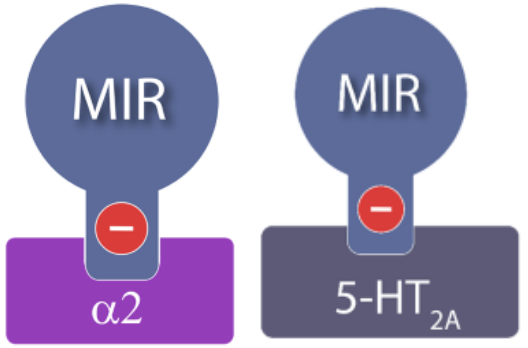
  -----*it has a very low incidence of sexual dysfunction.*

بديل ممتاز ل SSRIs

Mirtazapine

Selective a2 antagonist

- **Mechanism of action**: presynaptic α_2 antagonist and partially due to 5-HT_2 antagonism (enhances serotonin and norepinephrine neurotransmission)



Auto receptors present in postsynaptic neuron, function » auto regulation, negative feedback aiming to stop excessive release of norepinephrineupon activation of adrenergic pathway

- **Therapeutic uses:**

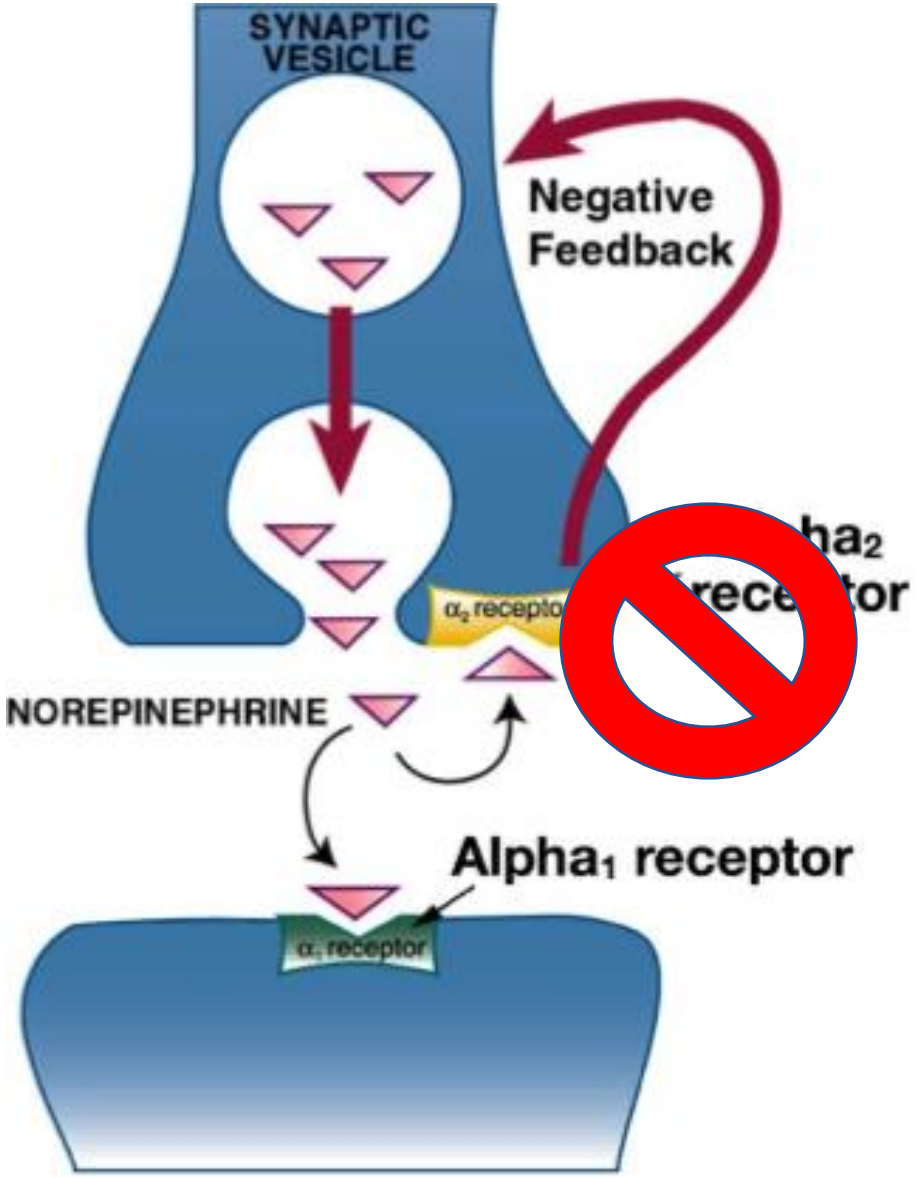
Second line treatment

-patients intolerant to TCAs or SSRIs.

-sedating antidepressant improve insomnia

- **Advantages:** No sexual dysfunction, nausea, anxiety of SSRIs.

بديل ممتاز ل SSRIs



Mirtazapine

Other atypical antidepressants

- **Nefazodone and trazodone**: weak serotonin reuptake inhibitors + 5-HT_{2a} antagonists + H_1-blocking + α_1 antagonism
- **Vilazodone**: serotonin reuptake inhibitor + 5-HT_{1a} partial agonism
- **Vortioxetine**: serotonin reuptake inhibitor + 5-HT_{1a} agonism + 5-HT_3 and 5-HT_7 antagonism

Novel therapies

- Brexpiprazole.
- Serotonin-dopamine activity modulator.
- Reading assignment:

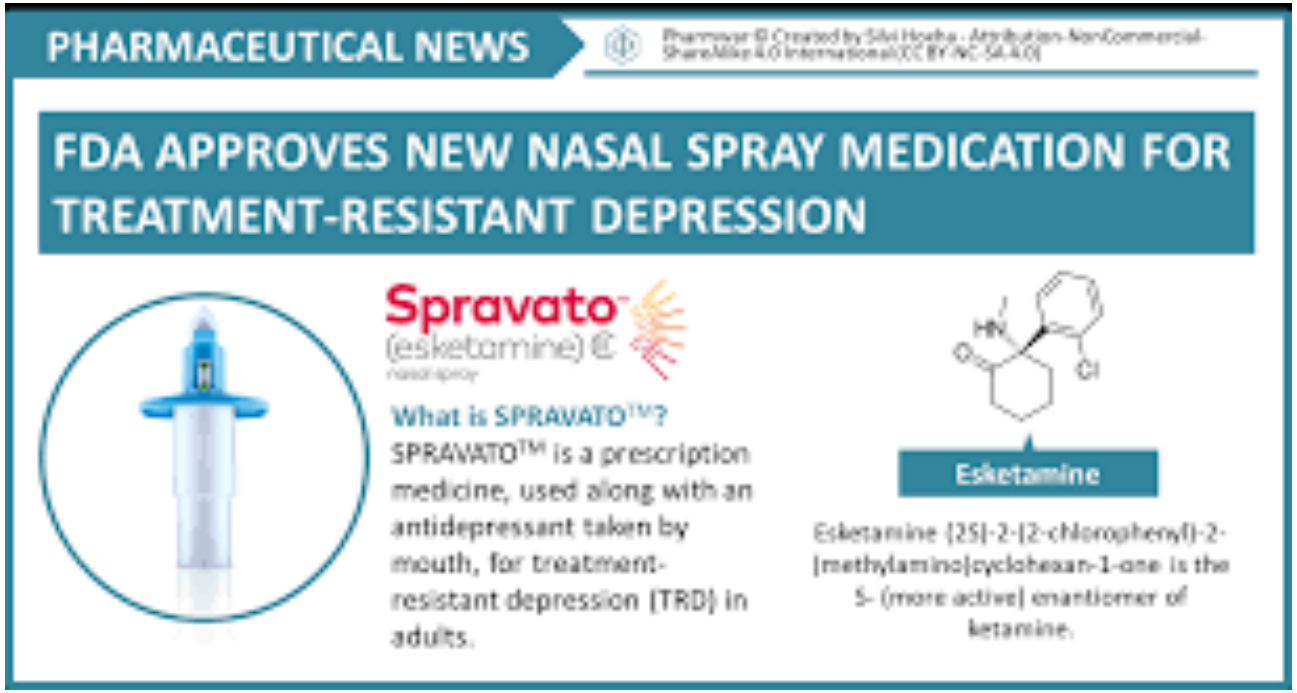
https://www.ncbi.nlm.nih.gov/pubmed/26849053

Good news?

NMDA receptor antagonists

- Esketamine

Nasal spray, providing very potent very efficacious antidepressants effct, approved for treatment of resistant depression



Drug class used as first-line therapy of major depressive disorder is SSRIs

Consuming aged cheese and meat is contraindicated while on MAOis for the treatment of depression

The antidepressant that interferes with negative feedback inhibition of norepinephrine release is Mirtazapine

How can you manage major depression in patients on SSRI that are suffering from persistent sexual dysfunction?

Switch to atypical antidepressants

Overall Therapeutic Strategy

- The **goal** of initial treatment for depression is symptom remission and restoring baseline functioning.
- The treatment strategy includes *combination of pharmacotherapy and psychotherapy* (based upon randomized trials that found combination treatment was more effective than either of these treatments alone).
- **First line treatment**: SSRIs
- **Alternatives**: second generation antidepressants: SNRIs, atypical antidepressants and serotonin modulators.
- TCAs and MAOis are typically **not** used as initial treatment because of concerns about safety and adverse effects.

Treatment of Bipolar Disorder

Mood Disorders

Major depressive disorder

- 2 weeks of at least **5** of the following symptoms:
  - Depressed mood — Main symptom
  - *Anhedonia* (diminished interest or loss of pleasure in almost all activities) — Mostly anorexia
  - Weight change or appetite disturbance
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation
  - Fatigue or loss of energy,
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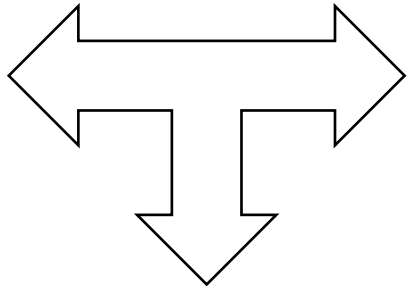
Mood disorders



Others

Bipolar disorder

- periods of prolonged depression that alternate with periods of an excessively elevated mood (mania)
- Manic episodes: 1 week of at least **3** of the following symptoms:
  - Grandiosity — Self inflated جنون العظمة
  - Diminished need for sleep-excessive talking or pressured speech — مش insomnia
  - Racing thoughts or flight of ideas-distractibility
  - Increased level of goal-focused activity at home, at work, or sexually
  - excessive pleasurable activities

Drugs Used to Manage Bipolar Disorder

Lithium

- Used acutely and prophylactically for managing bipolar patients. (effective in 60-80% of patients).
- **Mechanism of action**: Unknown.
- **Pharmacokinetics**:

  - very narrow therapeutic window (highly toxic).

  - entirely eliminated by renal clearance (best choice in patients with hepatic dysfunction)

- **Adverse effects:** headache, xerostomia, polyuria, polydipsia, polyphagia, dermatologic reactions and sedation.
- **Toxicity:** ataxia, slurred speech, confusion, seizures and thyroid dysfunction.

Symptoms consistent with cerebella dysfunction

Hypothyroidism especially in females

Tareq Saleh ©

Treatment of Bipolar Disorder

Other drugs

Mood enhancement effects

- **Antiepileptics:** Carbamazepine, valproic acid and lamotrigine.

- **Antipsychotics:** Chlorpromazine, haloperidol, risperidone, olanzapine, aripiprazole.

- Thank you

- Questions?

Please contact me tareq@hu.edu.jo