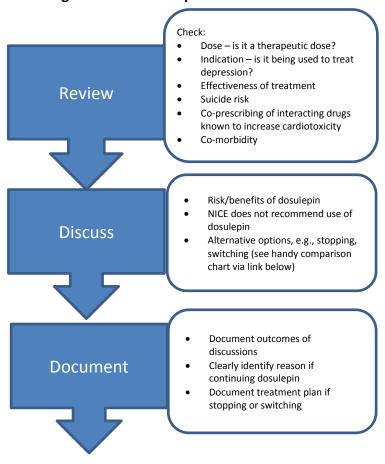


### **Dosulepin Prescribing Guidance**

Dosulepin, a tricyclic antidepressant, is licensed for the treatment of depression, particularly where sedation is required. In December 2007 the MHRA advised that as dosulepin has a narrow safety margin its use in new patients should be avoided; the BNF marks it as a drug considered to be "less suitable for prescribing". NICE and Cumbria Partnership recommend that it is not used. Although often prescribed to aid sleep, it disrupts REM sleep and there is no evidence that it has sleep promoting effects. Nevertheless, dosulepin continues to be prescribed. Every year, up to 200 people in England and Wales fatally overdose with dosulepin. Of these about 20% are accidental.

## Reducing risks with dosulepin



Licensed dose: 75-225mg/day (elderly 50mg/day initially) Toxicity in overdose is rated as HIGH – less than 1 weeks' supply likely to cause serious toxicity or death. Never prescribe if a risk of suicide identified

Interacting medicines:

Anti-arrhythmics, atomoxetine – increased risk of ventricular arrhythmias;

Antipsychotics and SSRIs – plasma concentration of dosulepin increased, possible increased risk of ventricular arrhythmias

Medicines with a potential to cause electrolyte imbalance, e.g., diuretics – may indirectly affect cardiac conduction

Dosulepin should be avoided in patients with cardiac disease, diabetes, epilepsy, hepatic impairment, renal impairment, Parkinson's disease and Alzheimer's disease

Dosulepin has an established link with a number of adverse cardiovascular effects (hypotension, tachycardia/arrhythmia and QTc prolongation) Relative incidence and severity of side effects is higher than other antidepressants.

It is extremely toxic in overdose – warn about accidental overdose

Information on Medicines may be found at: http://www.choiceandmedication.org/cumbria/

# Stopping dosulepin

Dosulepin should not be stopped abruptly unless serious side effects have occurred. There is a lack of evidence to support any particular regime for reduction, although there are published regimes that suggest withdrawal over 3 to 4 weeks. However, a more gradual tapering of the dose seems prudent. In general after long-term maintenance treatment, expert opinion suggests reducing the dose by about 25% every 4 to 6 weeks.

## Switching to another antidepressant

The choice of antidepressant should be discussed with the patient. Considerations include:

- Depressive symptoms
- Relative side effects
- Physical illness
- Interactions with other prescribed medication

Written by:	Jeanette Pieri (adapted from Tees, Esk and Wear Valley document)
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Date: July 2015. Amended January 2016.	Review Date: January 2018



Patient profile	Suggested options		
In need of sedation	Mirtazapine (lower doses more sedating)		
In need of activation	SSRI		
Cardiac disease	Sertraline. Mirtazapine is a suitable alternative in CHD if SSRIs cannot be used but it		
	should be used with caution		
Diabetes	SSRIs (fluoxetine or sertraline - may alter glycaemic control)		
Epilepsy	SSRIs (sertraline but avoid in unstable epilepsy and carefully monitor in stable epilepsy)		
Hepatic impairment	Fluoxetine (A lower dose, e.g. alternate day dosing, is recommended in patients		
	with significant hepatic dysfunction)		
	Citalopram (maximum dose 20mg/day)		
Renal impairment	Sertraline (caution is advised)		
	Citalopram (maximum dose 20mg/day)		
Parkinson's disease	SSRIs		
Stroke	SSRIs (sertraline)		

There should be very close monitoring of patients being switched from dosulepin to another antidepressant, as there are no published guidelines to determine exactly how the switch should take place. The switch will need to be tailored to each individual and carried out cautiously. The regimen should depend upon the reason for the switch, how severe the depression is and which drug is being switched to. Gradual cross tapering is usually recommended but in some cases a washout period between drugs is required.

The following regime is recommended for changing from tricyclics to sertraline

		Week 1	Week 2	Week 3	Week 4
Dosulepin	150mg od	100mg od	50mg od	25mg od	Nil
Sertraline	Nil	Nil	25mg od	50mg od	50mg od

For conversion to other antidepressants:

- Dosulepin to mirtazapine: cross taper cautiously
- Dosulepin to fluoxetine: cross taper cautiously; halve dose and add fluoxetine, then slow withdrawal.

Further information on the cardiac effects of antidepressants can be found at <a href="http://www.ukmi.nhs.uk/activities/medicinesQAs/default.asp">http://www.ukmi.nhs.uk/activities/medicinesQAs/default.asp</a> UK Medicines Information (UKMi) Q&A 55.6: What is the antidepressant of choice in coronary heart disease?

#### References

Medicines and Healthcare products Regulatory Agency. Drug Safety Update:vol1 (issue 5). December 2007 NICE CG 90. Depression in adults. October 2009

Bazire S. Psychotropic Drug Directory 2012

Taylor D et al. Prescribing Guidelines in Psychiatry 11<sup>th</sup> Edition

Lothian Joint Formularies – Adult: Antidepressants - swapping and stopping, appendix 4.

Summaries of product characteristics for sertraline, citalopram, mirtazapine and fluoxetine accessed at: <a href="https://www.medicines.org.uk/emc/">https://www.medicines.org.uk/emc/</a>

UK Medicines Information (UKMi) Q&A 55.6: What is the antidepressant of choice in coronary heart disease? http://www.ukmi.nhs.uk/activities/medicinesQAs/default.asp

UK Medicines Information (UKMi) Q&A 24.5: What is the most appropriate antidepressant to use in persons with epilepsy? <a href="http://www.ukmi.nhs.uk/activities/medicinesQAs/default.asp">http://www.ukmi.nhs.uk/activities/medicinesQAs/default.asp</a>

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