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Our revamped website is up and running! The site has a listing of all forty-four issues of the GeriJournal, links to the eCPS, geriatrics and nursing journals and much more. Please take a look and let us know what you think.

A Little Lithium

Back in the good old days (when I was a young pharmacist) lithium was quite popular. Unfortunately, due to its narrow therapeutic index, adverse reactions, interactions and newer alternatives, its use has diminished significantly.

Thatôs a shame, because lithium is still the most effective treatment for mania and manic-depressive (bipolar) disease. Other drugs, such as Tegretol® and valproic acid have also become very popular as ñmood stabilizersò.

If lithium is being used in our elderly residents, the objective is to keep the serum level below 0.8 mmol/L. A dosage of only 150mg to 300mg is usually all that is required to achieve those levels. Watch out for interactions with diuretics, ACE inhibitors and NSAIDs (ibuprofen, naproxen, etc.). These drugs can increase serum lithium levels.

There is more to the lithium story. Bipolar patients who have taken lithium for years develop dementia less often than the rest of the population. It is now being studied for its ability to protect brain cells.

Which Antidepressant?

There is a dizzying array of antidepressants out there. Iôll give some of the key reasons why we might choose one drug or group of drugs over another in certain situations.

For depression, and many anxiety syndromes, we typically choose an SSRI first. SSRIs have the best side effect profiles and they are effective medications. Some SSRIs, such as Paxil®, have considerable anticholinergic activity. This makes them undesirable in the elderly, as they can cause confusion. Drug interactions with SSRIs are also problematic. Celexa® and Cipralex® are the least likely to interact, so they are usually the best choices for individuals on multiple medications. All SSRIs can lower sodium levels and cause bleeding, so careful monitoring is important.

If there has been no response in six weeks, or SSRIs are not tolerated, another agent should be tried. Second line drugs include venlafaxine, mirtazepine and bupropion (Wellbutrin®). Venlafaxine response is excellent, but it causes more nausea and vomiting than the other drugs. It also can raise blood pressure, so it should not be used when BP is elevated. Mirtazepine is quite sedating and can cause weight gain. These properties are beneficial in some residents, but problematic in others. Bupropion causes insomnia in some. It can also lower seizure threshold, so it should not be used in epileptics.

If these drugs prove ineffective, tricyclic antidepressants (TCA) may be tried. These older drugs (amitriptyline, desipramine, etc.) may cause numerous side effects in seniors, such as confusion, sedation, blurred vision, constipation and dry mouth. As a result, they are used to treat neuropathic pain, for which they are effective, more often than they are used in depression. Venlafaxine is also quite useful in pain treatment, as is Cymbalta®, a newer antidepressant.

Trazodone is also an antidepressant, but it is used mainly for HS sedation and to treat agitation. It often causes dizziness, so it should be used with caution in residents who are at risk of falls.

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