MOOD STABILIZERS GUIDE

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Initial Dose</th>
<th>Max. Daily Dose</th>
<th>Maintenance Dose</th>
<th>Monitoring Level*</th>
</tr>
</thead>
<tbody>
<tr>
<td>carbamazepine</td>
<td>Tegretol</td>
<td>100 bid</td>
<td>800-1200</td>
<td>1500 6-bid</td>
<td>17-50 μmhos.</td>
</tr>
<tr>
<td>lamotrigine</td>
<td>Lamictal</td>
<td>12.5-25 mg</td>
<td>50-250</td>
<td>100 5-bid</td>
<td>25, 100, 150 μmhos.</td>
</tr>
<tr>
<td>lithium carbonate</td>
<td>Lithium carbonate</td>
<td>300 bid</td>
<td>use drug use drug</td>
<td>150,300,600 cap</td>
<td>0.6-1.2 mEq/L.</td>
</tr>
<tr>
<td>lithium citrate</td>
<td>Lithium citrate</td>
<td>300 bid</td>
<td>* *</td>
<td>hs-bid</td>
<td>300/5R tab -</td>
</tr>
<tr>
<td>oxcarbazepine</td>
<td>Trileptal</td>
<td>150 bid</td>
<td>600-1800</td>
<td>2400 bid</td>
<td>300-600 600mg Li</td>
</tr>
<tr>
<td>topiramate</td>
<td>Topamax</td>
<td>100-200 bid</td>
<td>2000-4000</td>
<td>3000-6000 cap</td>
<td>300-700 μmhos.</td>
</tr>
<tr>
<td>divalproex</td>
<td>Depakene</td>
<td>100 bid</td>
<td>500-1000</td>
<td>1000-2000 cap</td>
<td>125-250,500 μmhos.</td>
</tr>
</tbody>
</table>

Key: *dose strongly determined by concomitant drugs used (see Lamictal product monograph for details). NOTE: doses may not reflect manufacturer’s recommendations and are based on clinical literature and experience; most drugs in this category do not have a formal mood stabilizer indication; use lower initial doses for elderly patients.  Lithium has a therapeutic range strongly correlated with response and toxicity. Levels for the other agents are poorly correlated with response, but may be useful for investigating toxicity and adherence. The antidepressants are tested per clinical guidelines and experience. Constant blood levels are not always recommended due to clinical guidelines and experience.  *Lithium has a therapeutic range strongly correlated with response and toxicity. Levels for the other agents are poorly correlated with response, but may be useful for investigating toxicity and adherence. The antidepressants are tested per clinical guidelines and experience.
RX - IM recommended for rapid resolution: benztropine 1-2 mg, diphenhydramine 50-75 mg, lorazepam 2 mg q30min stop MAOI, seek medical support; RX - supportive care, BP control

generally unresponsive to anticholinergic agents; RX—propranolol 10-20 mg tid or lorazepam

extreme inner restlessness, inability to sit still, excessive motor activity

stop lithium, take Li level and electrolytes, high levels may require hospitalization and dialysis

meperidine delirium, visual hallucinations, urinary retention, dry mouth, blurred vision, tachycardia, no sweating

Department of Psychiatry, Halifax, NS CANADA

This card is meant to support rather than guide management decisions. Information is not comprehensive and errors may exist. Drug doses and other management recommendations may not reflect manufacturers’ recommendations but are based on clinical literature and experience. In elderly and pediatric patients, doses lower than shown on this card may be indicated.

ALCOHOL / BENZODIAZEPINE (BDZ) WITHDRAWAL

ALCOHOL:

Timing of withdrawal states:

24-48 hours: coarse tremor, agitation, diaphoresis, confusion, headache, nausea, vomiting, diaphoresis, diarrhea, hyperactive behavior within 48 hours: seizures ("youn fit") hallucinosis (can be up to 2 weeks) within 5 days: delirium tremens (DTs) hours to days: Wernicke's encephalopathy

Clinical Management

Rx, then lorazepam 100 mg x 3 days then 50 mg po/daily and folic acid 5 mg daily. Give thiamine before glucose.

Give regular doses of BDZ-related to symptoms. Average doses: lorazepam 1-2 mg and diazepam 5-10 mg up to symptom relief. Check alcohol level before initiating BDZs.

BDZs

Key: N—nausea, V—vomiting, D—diaphoresis

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ALCOHOL / BENZODIAZEPINE / QUICK REFERENCE

Name

Findings

Treatment

Acute Dystonia

severe muscle spasms including eyes, tongue, neck, arms, legs, ocular/ocular crisis; torticollis, opisthotonus, impaired breathing

Rx—recommended for rapid resolution: benztpine 1-2 mg, diphenhydramine 50-75 mg, lorazepam 2 mg q30min

Akathisia

extreme inner restlessness, inability to sit still, excessive motor activity generall unresponsive to anticholinergic agents. Rx—prop Tyramine 10-20 mg bid or lorazepam

Anticholinergic Toxicity
delirium, visual hallucinations, urinary retention, dry mouth, blurred vision, tachycardia, no sweating

stop suspected drug(s); Rx—medications to moderate in (e.g., urinary retention) use (e.g., anticholinergic medications). In severe cases seek medical support, may need ICU and physiologic monitoring

Hypertensive Crisis

due to drug or food interactions with MAOIs)
much recover with restarting SSRI; may be milder symptoms with slow taper; switch to fluoxetine then taper autonomic instability, increased CPK

SSRI/SNRI Discontinuation Syndrome

mask like face, cogwheel rigidity, shuffling gait, resting tremor, motor slowing, drooling

SSRI/SNRI Discontinuation Syndrome

sense of dysautonomia, N/V/D, “electric shock” like sensations

most recover with restarting SSRI; may be milder symptoms with slow taper; switch to fluoxetine then taper

QTC Prolongation

Prolonged QTc (+45ms on EKG) arrhythmia, sudden death. At risk: selected drugs, female, advanced age, bradycardia, hypokalemia

stop causative agent(s) (e.g. anticholinergic, TCA, other QT prolonging drugs), correct electrolyte imbalances, treat arrhythmia if needed

Serotonin Syndrome
delirium, agitation, hyperventilation, diaphoresis, myoclonus, hyperreflexia, tremor, hyperthermia, diarrhea, incoordination

stop suspected drugs(s); supportive care; Rx—lorazepam (myocardial, BP control, propranolol) or cyproheptadine (serotonin antagonists)

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This table can be used to identify potential p450-based drug-drug interactions. However, it is not comprehensive and it does not address non-p450 drug-drug interactions (e.g., other types of pharmacokinetic interactions and pharmacodynamic interactions). Therefore it cannot be used to rule out drug interactions. Clinically important interactions may occur if: 1) the patient is taking drug(s) (substrate(s)) extensively metabolized by the liver with significant dose-related side effects or toxicities, and 2) the drug to be added is an inhibitor or inducer of an enzyme that metabolizes these drugs. Note: the wide variation of enzyme activity among individuals. Substrates in elderly patients use lowest initial doses or lower.