May Pharmacy Newsletter

Citalopram Warning in the Older Populations

The use of citalopram in most patient populations is a practice that may be beneficial to those able to tolerate the medication for a wide array of indications from depression to anxiety, however there may be some adverse effects not as well known that may steer treatment in a different direction, particularly in older patients. Currently, the FDA has issued a warning regarding doses above 20mg for patients above the age of 60 that may cause the risk to outweigh the benefits of treatment.[1,2]

Serotonin reuptake inhibitors (SSRIs), including citalopram, carry a certain risk of QTc prolongation. QTc prolongation refers to an abnormal prolongation of the QT interval on an electrocardiogram, which is a marker for potential heart rhythm disturbances. Among SSRIs, citalopram has been identified as the agent with the highest risk in this regard. While QTc prolongation may go unnoticed or be asymptomatic in younger patients, it becomes more concerning in older populations. This is due to the natural decline in metabolic function that occurs with aging, which can affect the clearance of drugs from the body. Additionally, older patients may already be taking other medications that carry similar cardiovascular risks that compound the effect and may advance into more fatal arrythmias like Torsades de Pointes (TdP).[1,2]

Another adverse effect observed specifically in older patient populations is hyponatremia. Symptomatic hyponatremia can lead to various symptoms such as nausea, lethargy, mental status changes, and may necessitate visits to the emergency room or hospital. Citalopram has been associated with an increased risk of hyponatremia in older patients.[1,2,3,4].

Considering the risks associated with citalopram use in older patients, it is recommended that individuals above the age of 60 should not exceed a daily dose of 20 mg for any indication. This limitation aims to minimize the potential for QTc prolongation, hyponatremia, and other adverse effects. Additionally, switching to agents less likely to exhibit these side effects such as fluvoxamine, sertraline, or paroxetine will avoid unnecessary risk to patients. [5]

As always, it is essential for healthcare providers to assess the unique needs and medical history of each patient before prescribing any medication. Close monitoring, regular follow-ups, and open communication between patients, caregivers, and healthcare professionals are crucial to ensuring the safe and effective use of citalopram or any other medication.

Treatment Approach to Cannabinoid Hyperemesis Syndrome

A new American Gastroenterological Association (AGA) clinical practice update highlights cannabinoid hyperemesis syndrome (CHS).

Cannabinoid hyperemesis syndrome (CHS), linked to prolonged cannabis use, is increasingly observed in the United States. However, accurately diagnosing it remains difficult, and there is a scarcity of clinical data.

Recent findings show that CHS typically affects male individuals who have been using cannabis daily or almost daily for many years. Interestingly, while cannabis often triggers CHS, some patients claim it

alleviates their symptoms. CHS is categorized as a subtype of cyclical vomiting syndrome (CVS). Diagnostic criteria include:

- Recurrent vomiting episodes similar to CVS, happening at least three times a year.
- Prolonged cannabis use for over a year before symptoms appear, with frequent use (at least four times per week on average).
- Symptom relief after abstaining from cannabis for at least six months or for a period equivalent to three typical vomiting cycles.

CHS is part of CVS, which consists of four phases: inter-episodic, prodromal, emetic, and recovery. During the inter-episodic phase, patients may experience minimal symptoms, with prophylactic medications like tricyclics and certain supplements being considered. The prodromal phase involves abdominal pain, nausea, and autonomic symptoms, with medications like triptans being used. The emetic phase includes severe vomiting and neurological symptoms, with supportive care being crucial. Recovery allows for resumption of normal activities.

While this framework aids in managing CHS, emphasis should be on quitting cannabis. Abrupt cessation is not advised due to withdrawal risks and low success rates. Collaborative care involving mental health professionals may be necessary for patients with poor response to standard treatments or comorbid anxiety and depression.

References:

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5. Maljuric NM, Noordam R, Aarts N, Niemeijer MN, van den Berg ME, Hofman A, Kors JA, Stricker BH, Visser LE. Use of selective serotonin re-uptake inhibitors and the heart rate corrected QT interval in a real-life setting: the population-based Rotterdam Study. Br J Clin Pharmacol. 2015 Oct;80(4):698-705. doi: 10.1111/bcp.12681. Epub 2015 Jul 29. PMID: 25966843; PMCID: PMC4594706.
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REFERRED DRUG LIST UPDATES CAN BE FOUND HERE:

ACC-RBHA, DD, ALTCS and DCS CHP	Behavioral Health (Non-Title 19/21)

** Drugs that are not on the formulary will require a PA (prior authorization) request to be submitted**

Reminder for quicker determinations of a Prior Authorization use the ePA link for Our Providers: Please click here to initiate an electronic prior authorization (ePA) request.

This newsletter is brought to you by the Mercy Care Pharmacy Team. For questions, please email Fanny A Musto (MustoF@mercycareaz.org), Denise Volkov (VolkovD@mercycareaz.org) or Trennette Gilbert (gilbert@mercycareaz.org)