

Physician SSRI Discontinuation Work Sheet

SSRI discontinuation syndrome consists of a constellation of symptoms associated with the discontinuation of an antidepressant. This syndrome is experienced by patients who have been on selective, non-selective (tricyclics), and atypical (eg venlafaxine) serotonin reuptake inhibitors.

The therapeutic challenge is to separate relapse of depression from the discontinuation syndrome or a totally unrelated new condition. Onset of depressive relapse typically reoccurs in weeks or months. Symptoms associated with SSRI Discontinuation syndrome usually occur earlier and tend to be somatic in nature, although psychological symptoms can also occur. Rapid symptom resolution after restoring the antidepressant medication usually confirms the diagnosis of SSRI Discontinuation syndrome.

1. Note the typical time of onset for the patient's SSRI withdrawal symptoms.

Typical time of onset of withdrawal symptoms after last dose or dose reduction			
1 to 2 Days	2 to 3 Days	3 to 6 Days	2 to 3 Weeks
Effexor XR (Venlafaxine XR)	Cymbalta (Duloxetine) Luvox (Fluvoxamine) Paxil/Paxil CR (Paroxetine) Wellbutrin SR/XL (Bupropion)	Zoloft (Sertraline) Ciprallex (Escitalopram) Celexa (Citalopram) Remeron (Mirtazapine)	Prozac (Fluoxetine)

2. Chart the patient's new symptoms vs. their usual depressive symptoms.

Patient's new symptoms Summary of symptoms from Patient Questionnaire	Patient's usual depressive symptoms From patient's chart

3. Answer the following two questions.

Are the patient's new symptoms different from previous depressive episodes?
Does the time of onset of new symptoms fall within the expected time frame?

<i>Yes</i>	<i>No</i>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

4. Then:

If the answers in #3 above are both yes, the patient probably has discontinuation syndrome.

Management options for discontinuation syndrome

If symptoms are mild: – Reassure patient, symptoms should disappear within 1 to 2 weeks.

If symptoms are distressing:

1. Restart antidepressant at previous dose.
2. Most patients experience resolution of symptoms within 72 hours.
3. When patient is feeling better, consider initiating a slow taper.

Tapering Services

Contact Pharmacy.ca at 1-800-727-5048 to discuss a slow, personalized taper for your patient. Typically tapers are 10 steps (or longer) but can be customized to your patient's needs. We will Develop the tapering protocol and fax it to you for review and approval. Once we have your approval we will deal directly with the patient for the rest (counselling, delivery, insurance billing, etc).

Patient Questionnaire

Patient Name:		Date:
Which antidepressant are you or were you taking?	Strength and number of times per day?	
How long have you been on an antidepressant?		
When did you take your last dose of the antidepressant, or reduce the dose?		
Date:	Time:	

In the table below please check the box beside the **new feelings** and/or **new symptoms** you have experienced **since** you either stopped taking or reduced the dose of your antidepressant.

New Symptoms Only (Only check box if present)	Please circle	New Symptoms Severity				
		1= mild				5 = severe
<input type="checkbox"/> Flu-like symptoms		1	2	3	4	5
<input type="checkbox"/> Abdominal cramping		1	2	3	4	5
<input type="checkbox"/> Trouble Sleeping		1	2	3	4	5
<input type="checkbox"/> Unsteady walking		1	2	3	4	5
<input type="checkbox"/> Blurred vision		1	2	3	4	5
<input type="checkbox"/> Irritability		1	2	3	4	5
<input type="checkbox"/> Headache		1	2	3	4	5
<input type="checkbox"/> Stomach Ache		1	2	3	4	5
<input type="checkbox"/> Nightmares		1	2	3	4	5
<input type="checkbox"/> Agitation		1	2	3	4	5
<input type="checkbox"/> Dizziness		1	2	3	4	5
<input type="checkbox"/> Electric shock sensations		1	2	3	4	5
<input type="checkbox"/> Muscle jerks		1	2	3	4	5
<input type="checkbox"/> Crying Spells		1	2	3	4	5
<input type="checkbox"/> Restlessness		1	2	3	4	5
<input type="checkbox"/> Lethargy		1	2	3	4	5
<input type="checkbox"/> Change in Appetite		1	2	3	4	5
<input type="checkbox"/> Light headed		1	2	3	4	5
<input type="checkbox"/> Numbness		1	2	3	4	5
<input type="checkbox"/> Tremor		1	2	3	4	5
<input type="checkbox"/> Nausea		1	2	3	4	5
<input type="checkbox"/> Anxiety		1	2	3	4	5
<input type="checkbox"/> Diarrhea		1	2	3	4	5
<input type="checkbox"/> Vertigo		1	2	3	4	5
<input type="checkbox"/> Tingling Sensations		1	2	3	4	5
<input type="checkbox"/> Low Mood		1	2	3	4	5
<input type="checkbox"/> Vomiting		1	2	3	4	5
<input type="checkbox"/> Burning Sensations		1	2	3	4	5

Other Symptoms

(Please describe)

		1	2	3	4	5
		1	2	3	4	5
		1	2	3	4	5