

Clinical Pearls:

Mental and Behavioral Health

- SSRI's can cause not only Serotonin Syndrome, but also QTc prolongation, SIADH and increase bleeding risk. Benefit vs risk analysis is advised when using them in the context of increased such risks.
- Bupropion should be avoided for patients with seizure disorder, eating disorder/poor oral intake.
 - Alcoholism or Benzo use disorder should be ruled out before selecting Bupropion as it can increase seizure/withdrawal risk for those at risk of withdrawal.
 - Bupropion should be immediately discontinued when the patient is showing signs or symptoms of CNS depressant withdrawal.
- PHQ2 or PHQ9 does not rule out Bipolar Spectrum Disorder. Many patients diagnosed with depression do have Bipolar Spectrum Disorder.
 - One should be very careful when prescribing an antidepressant for those who present with/complain of depressive symptoms only.
- It is recommended to screen all adults with depression. PHQ-2 is a validated screening tool and PHQ-9 can be used to further assess severity, with a score of 5 and above consistent with depression.
 - The treatment goal for MDD is to achieve a PHQ-9 of less than 5.
- For patients with alcohol use disorder, naltrexone is considered first-line treatment but is contraindicated for severe liver disease.
 - Acamprosate is an alternative agent which can be used in patients with severe liver disease, however this should be avoided in CKD (eGFR \leq 30 mL/min/1.73 m²).
 - Disulfiram is considered second line treatment.
- Prescribe intranasal naloxone in patients who are at high risk for opioid overdose. This includes patients taking $>$ 50 mg morphine equivalents (MME)/day, concurrent benzodiazepine use, respiratory disorders, illicit drug use, and opioid use disorder.