RESEARCH ARTICLES: SEXUAL DYSFUNCTION AND ANTIDEPRESSANTS

Rothschild, Anthony. Sexual side effects on antidepressants. Journal of Clinical Psychiatry, Vol. 61, Supplement 11, 2000. pp 28-36.

Discussion Issues:

1. Effective antidepressant treatment does not need to compromise sexual function.
   Myths: That depressed patients do not care about sexual dysfunction.
   That pts. experiencing sexual dysfunction will continue taking the medication as long as the treatment is helping the depression.
   That pts. will spontaneously report sexual problems to their provider.
   That all antidepressants cause sexual dysfunction at the same rate.
2. Causes vary and differentiation of treatment-induced from illness-induced is difficult.
3. Medical illness causes include diabetes mellitus, hypothyroidism, alcoholism.
4. Other medications such as psychotropics, antihypertensives, antiulcer and recreational drugs can contribute.
5. This article includes a 10 question sexual history to be used for assessment (page 29).
6. Characteristic sexual side effects include: inability to ejaculate, delayed ejaculation, delayed or absent orgasm.
7. In another study (Montejo-Gonzalez, Antidepressant induced sexual dysfunction. New Research Program and Abstracts of the 152nd Annual Meeting of the American Psychiatric Association; May 20, 1999):

- 628 patients treated with antidepressants were interviewed.
- Antidepressant induced sexual dysfunction was common.
- Nefazodone (7%)and Mirtazapine (29%) had lower rates.
- Fluoxetine (58%), Sertraline (61%), Fluvoxamine (64%), Paroxetine (68%), Venlafaxine (69%)
- Sexual dysfunction was positively correlated with dose.
- Patients improved when dose was decreased or medication discontinued.
- Men showed higher incidence.
- Women's sexual dysfunction was more intense than men's.

8. Augmentation Therapy: article includes several medications, along with the statement that none have been approved by the FDA for the treatment of sexual dysfunction induced by antidepressants.

- Amantadine: action most likely through its dopaminergic agonist effects; 75-100 mg b.i.d or t.i.d, or 100-400 mg at least 2 days before coitus.
- Bupropion: 75-150 mg for 1-2 hours before coitus relieved symptoms in 38% of patients (nonrandomized study of 47 patients). Increasing to 75 mg t.i.d. daily resulted in improvement in an additional 28% of patients.
  *Clinicians should be aware of potential drug interactions with combining SSRIs with bupropion, particularly fluoxetine.
- Buspirone: 5-10 mg t.i.d. effective in 11/16 patients (69%).

- Cyproheptadine: Sedation and fatigue are common. One study reported improvement in 8/19 patients (42%) receiving 4-16 mg daily.
  *Some reports described a worsening of depressive symptoms with this antiserotonergic medication.
- Sildenafil
- Yohimgine: Improvement of symptoms either partially or completely in 17/21 (81%) patients (dose not mentioned).
  *Use caution for patients with anxiety or panic attacks as can cause reactions such as anxiety and agitation.
- Postsynaptic serotonin antagonists: Nefazodone, Mirtazapine, Granisetron prior to coitus found to be helpful.
- Ginkgo biloba: a non-blind study with doses from 60 mg daily to 120 mg b.i.d. had a response rate of 46% with fluoxetine to 100% with nefazodone.

9. Drug Holidays: Reported a study done by authors in 1994 where patients stopped taking their antidepressant medication 2 days prior to sexual activity. Thirty patients were studied (10 on fluoxetine, 10 on paroxetine, 10 on sertraline). Improvement shown for those on sertraline and paroxetine; no improvement for fluoxetine. No worsening of depressive symptoms in any of the 3 groups.

10. Switching antidepressants: article reviews questions that need to be asked before this is done:

- Will the new drug maintain efficacy for the depressive disorder?
- Will different side effects occur with the new medication that were not present with the former medication?

11. As the depression improves, patients become more aware of their sexual problems.

12. A few antidepressants have been shown to induce sexual dysfunction side effects at a significantly lower rate than the SSRIs (page 34).

- Nefazodone and sertraline: significant improvement with nefazodone. (Feiger. Nefazodone versus sertraline in outpatients with major depression. Journal of Clinical Psychiatry, 1996; 57 (supplement 2), 53-62).
- Bupropion SR and sertraline: reported lower reported frequency of orgasm dysfunction with bupropion SR compared with sertraline. (Kavoussi. Double-blind comparison of bupropion SR and sertraline in depressed outpatients. Journal of Clinical Psychiatry, 1997; 58: 532-537). Limitation of study is that self-reports were used rather than direct patient interviews.
- Mirtazapine: A study compared with a placebo suggests lower rates of sexual dysfunction when compared with SSRIs (Fawcett. Review of the results from clinical studies on the efficacy, safety and tolerability of mirtazapine for the treatment of patients with major depression. Journal of Affective Disorders, 1998; 51: 267-2850.