Medication	Consider in…	Avoid in…	Dosing	Side effects	Comments
Cymbalta	**PAIN** especially if co-morbid depression, anxiety d/o. **1st choice.**	Liver disease, bipolar disorder/mania; linezolid, tamoxifen; serotonin syndrome also possible w/Fentanyl, Ultram	Start 30 mg/d w/food, ↑ to 60 mg/d after 1 wk	common: nausea, sexual dysfunction; sometimes : sweating, ↑ BP; rare: mania, suicidal ideation (SI)	One large + trial in chemo-induced neuropathy; capsules only (do not open)
Effexor XR	**PAIN** especially if co-morbid depression, anxiety d/o. **2nd choice.**	↓ by 50% liver dz, ↓ by 25% renal impairment; avoid w/linezolid, serotonin syndrome also possible w/Fentanyl, Ultram	Start 37.5 mg/d in a.m. w/food, ↑to 75 mg/d after 4-7 d, then ↑by 75 mg/wk as needed and tolerated to 300 mg/d	Same as Cymbalta; ↑BP dose-related and more common, as are activation and insomnia	Less expensive than Cymbalta; higher doses (225-300 mg) for depression, 75 mg OK for anxiety; capsules only (do not open)
Nortriptyline	**PAIN** especially if co-morbid depression, anxiety d/o. **3rd choice.**	Suicidal pts (lethal in OD), cardiac disease; avoid or use cautiously with 2D6 inhibitors*; avoid w/linezolid, caution w/Fentanyl, Ultram	Start 25 mg qhs, ↑ by 25 mg q 3-4 d as needed/tolerated (elderly: 10 mg qhs, ↑ by 10 mg/week); therapeutic doses 50-100 mg/d	Common: drowsiness, dry mouth; less common: urinary retention, orthostatic hypotension; can cause constipation	Blood levels available; oral solution available. *Strong 2D6 inhibitors: Wellbutrin; SS/SNRIs except Celexa, Lexapro, Effexor; cinacalcet.
Desipramine	**PAIN** especially if co-morbid depression, anxiety d/o. **3rd choice.**	Cautions, AE's, DDIs same as for nortriptyline. Dosing: start 50 mg qhs, ↑ by 25 mg q 3-4 d as needed/tolerated (elderly: start 25 mg qhs, ↑ by 25 mg/wk); therapeutic doses 150-200 mg/d; blood levels and oral solution available			
Gabapentin	**PAIN** especially if co-morbid bipolar d/o or anxiety.	Caution in renal insufficiency (see package insert for dosing)	300 mg qhs x1, then 300 mg BID; then ↑ by 300 mg/d as tolerated (max 3,600 mg/d, no single dose > 1,200 mg); rec'd dose for neuropathic pain 1,800 -3,600 mg/d; ↓ in renal insufficiency	Common: dizziness, somnolence; less common: weight gain, peripheral edema; rare but serious: angioedema, SI	Oral solution available (250 mg/5 mL)
Pregabalin	**PAIN** especially if co-morbid bipolar d/o or anxiety.	Cautions, AE's, DDI's same as for gabapentin; Dosing: 75 mg qhs x1, then 75 mg BID x 1 week, then increase by 50-100 mg/d as tolerated to 300-600 mg/d; ↓ in renal insufficiency; oral solution available (20 mg/mL). Efficacy comparable to gabapentin; more expensive.			
Methylphenidate	**FATIGUE**; can also improve mood, cognitive function (e.g., brain XRT). **1st choice if no contraindications.**	Severe anxiety, psychosis, hx mania, heart disease (depending on goals of care), seizures (OK if on anticonvulsant), MAOI's (+ linezolid?)	Start 2.5 to 5 mg qam and q mid-day,↑ by 2.5 to 5 mg/d q 3-4 d, usual max in PC 30 mg/d (80 in psych)	Anxiety, insomnia, headache, ↓ appetite (<<common in palliative setting). Abuse potential (schedule II). Rare: priapism, peripheral vasculopathy	Available in transdermal patch and oral solution.
Modafinil	**FATIGUE** (2nd choice)	3A4 inducer: ↓'s midazolam, OCPs, cyclosporine, some chemotherapies (e.g., docetaxel)	Start 100 mg/d, ↑ by 100 mg q week (per insert; q 4 d OK in practice); 200 mg labelled max dose, OK to increase to 400 mg/d	Nausea, headache; warning re: Stevens-Johnson; abuse potential (schedule IV)	Expensive.
Armodafinil	**FATIGUE** (2nd choice)	Cautions, AE's, DDI's same as for modafinil. Dosing: start 50 mg/d, ↑ by 50 mg q week to max of 250 mg/d. Very expensive.			
Mirtazapine	**ANOREXIA** with co-morbid depression, insomnia	MAOIs (as above); serotonin syndrome less of a concern; decrease dose in liver, kidney disease	Start 15 mg/d, ↑ to 30 mg/d after 1 wk, max 45 mg/d;	Morning sedation (improves with higher dose, and/or after about 2 weeks); rarely, ↑ lipids, BP; SI	Minimal evidence, but reasonable choice if co-morbid depression; available as ODT; appetite, sleep improve before mood

Medication	Consider in…	Avoid in…	Dosing	Side effects	Comments
Olanzapine	**ANOREXIA, N/V** with co-morbid mania, agitation; or refractory N/V	Pre-existing Parkinsonism	Anorexia: start 2.5 mg qhs, ↑ to 5 mg after 1 wk; N/V: start 5 mg/d, ↑ to 10 mg/d as needed/tolerated	Sedation, Parkinsonism, constipation, akathisia, ↑ lipids and glucose, neuroleptic malignant syndrome	Best evidence for CINV; limited evidence for anorexia. ODT + IM available; do not use IV

"CHOOSING WISELY"

PAIN: Choose based on co-morbidity

Depression – Cymbalta (unless liver issues, tamoxifen) > Effexor > SSRIs > TCAs

Bipolar disorder or anxiety – Gabapentin > Pregabalin (cost)

Dementia – antidepressant or gabapentin to spare opioids

FATIGUE: Choose methylphenidate unless concerns about mania, psychosis, seizures, cardiovascular disease, abuse potential; modafinil an alternative

ANOREXIA/CACHEXIA: Choose based on co-morbidity

Depression – mirtazapine; quicker onset than for mood

Mania, psychosis, agitation, N/V – olanzapine 2.5-5 mg

NAUSEA/VOMITING: Consider antipsychotic if co-morbid mania, psychosis, delirium; 1st choice haloperidol 2 mg IV/SC; olanzapine 10 mg ODT 2nd choice due to sedation, but quite effective for CINV and can help appetite too

"DISCONTINUING WISELY"

Keep discontinuation syndrome (including marijuana) in the differential for anxiety

Benzos: taper 25%/week x2 then 10% / week; consider switch to longer-acting agent (still need taper, just easier for patient); e.g., 1 mg Xanax or 2 mg Ativan = 0.5 mg Klonopin; add gabapentin, psychotherapy

SS/SNRIs: Paxil, Effexor >> Zoloft > Celexa > Cymbalta > Prozac

Paxil 40 mg: 20 mg x 2 weeks, then 10 mg x 2 weeks then 5 mg x 2

Effexor 225 mg: Don't open capsules! 150 mg x 1 week, 75 mg x 1 week, 37.5 mg x 2 weeks, then switch to IR form: 12.5 bid x 1 week then 12.5 qd x 1 week then d/c; or, change to Prozac 20 mg for 2-3 weeks then d/c

Remember that all SSRIs come in oral solutions for those really difficult cases

DELIRIUM

What? Haldol usually 1st choice except in Parkinson's or pt/family refusal; ECG monitoring probably not necessary unless other risk factors for QT prolongation or very high doses. Available PO, oral solution, IV/SC.

How much and when? Similar to treatment of pain….

• Pick starting dose based on clinical situation: lower doses if frail, elderly; higher doses if severe agitation.

• If 1st dose doesn't control symptoms by Tmax, repeat dose (after ensuring no significant AE's)

• Once symptoms are controlled, total dose in past 24h can be given scheduled, with prn doses available for breakthrough symptoms. Seroquel is divided BID, others can be given once daily (recommend 1 hour before usual hour of sundowning if that's a problem).

	Start Dose	Tmax	Max dose	Half-life
IV Haldol	0.5-2 mg	30 min	50 mg/d	16 h
PO Haldol	1-5 mg	4 h	20 mg/d	18 h
Zyprexa PO/ODT	2.5/5 mg	6 h	20 mg/d	36 h
Risperdal ODT/Soln	0.25-1 mg	3 h	6 mg/d	24 h
Seroquel PO	25-100 mg	1.5 h	800 mg/d	6 h

Example: Frail 80 y/o with Parkinson's, thankfully takes PO: quetiapine 25 mg now and q2h prn (specify symptoms when possible, e.g., loud vocalization, wandering) until max 200 mg; needs 4 total doses in 24 h -> next day 50 mg BID and 25 mg q2h prn, max 4 prns/24h.

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