SELECTIVE SEROTONIN REUPTAKE INHIBITOR

Escitalopram

Lexapro

The active S-enantiomer of citalopram: among the best tolerated and most effective first-line SSRIs, with simple once-daily dosing.

USUAL ADULT RANGE	HALF-LIFE	METABOLISM	ONSET
10-20 mg/day PO	27-32 h	CYP2C19, 3A4; weak 2D6 inhib	1-2 wks; 6-8 wks full

⚠ FDA BOXED WARNING

Suicidal thoughts and behaviors: antidepressants increased the risk of suicidality in pediatric and young adult patients in short-term studies. Closely monitor all treated patients for clinical worsening and emergence of suicidal thoughts and behaviors. Not approved under 7 years of age.

INDICATIONS

- FDA-approved for major depressive disorder in adults and in pediatric patients 12 years and older at **10-20 mg once daily**.
- FDA-approved for generalized anxiety disorder in adults and in pediatric patients 7 years and older, using the same dose range.
- Off-label but strongly supported for panic disorder, social anxiety disorder, and obsessive-compulsive disorder in adults.
- Off-label for premenstrual dysphoric disorder and for vasomotor symptoms of menopause when hormone therapy is unsuitable.
- Consistently ranked among the most efficacious and best-tolerated antidepressants in the Cipriani network meta-analysis of 21 agents.
- Frequently used off-label in medically complex and post-stroke patients because of its low interaction burden and predictable kinetics.

DOSING & TITRATION

- Start **10 mg** PO once daily, morning or evening; increase to the maximum of **20 mg/day** after at least one week if response is partial.
- Fixed-dose depression trials did not show added benefit at 20 mg over 10 mg, so escalate for clear partial response rather than reflexively.
- Pediatric depression starts at 10 mg/day with escalation to 20 mg no sooner than three weeks; pediatric generalized anxiety follows the adult schedule.
- The recommended dose is **10 mg/day** in older adults and in hepatic impairment; no adjustment is needed in mild to moderate renal impairment.
- Available as 5, 10, and 20 mg tablets and a 1 mg/mL oral solution, which allows the very small decrements useful in slow tapers.
- Taper gradually over two to four weeks when stopping to avoid dizziness, paresthesia, irritability, and sleep disturbance.

MECHANISM OF ACTION

- Pure S-enantiomer of citalopram and the most selective serotonin transporter inhibitor available, with negligible activity at other transporters.
- Binds both the primary orthosteric transporter site and an allosteric site, which slows dissociation and may explain its potency advantage.
- Removing the inactive R-enantiomer eliminates a competitive brake, so 10 mg escitalopram is roughly equivalent to 20 to 40 mg citalopram.
- Sustained transporter blockade desensitizes 5-HT1A autoreceptors over weeks, which is the step that tracks clinical antidepressant response.
- Minimal muscarinic, histaminic, and adrenergic affinity accounts for its low rates of sedation, dry mouth, and orthostatic hypotension.

PHARMACOKINETICS

- Bioavailability is about 80 percent and unaffected by food; peak concentrations occur roughly five hours after an oral dose.
- Half-life is **27 to 32 hours**, supporting once-daily dosing at any time of day, with steady state reached in about one week.
- Metabolized by CYP2C19 and CYP3A4 with a minor CYP2D6 role; the demethyl metabolite contributes little to clinical activity.
- CYP2C19 poor metabolizers show roughly twofold higher exposure, and guidelines suggest a 50 percent starting dose reduction in that group.
- Only a weak CYP2D6 inhibitor, making it one of the safest antidepressants to add to complex medical regimens.

ADVERSE EFFECTS

- Nausea, insomnia, somnolence, fatigue, and increased sweating are the common early complaints, usually resolving within two weeks.
- Sexual dysfunction affects roughly **30-40 percent** of treated patients and is the most frequent reason for long-term discontinuation.
- QTc prolongation is dose-dependent but smaller than with citalopram, and escitalopram carries no comparable label dose ceiling.
- Hyponatremia from SIADH occurs mainly in older adults on diuretics and can present as confusion, unsteadiness, or new-onset seizure.
- Serotonin syndrome, increased bleeding with NSAIDs or anticoagulants, and treatment-emergent mania are the serious prescribing concerns.
- Weight change is modest, averaging roughly 1 kg over a year, less than paroxetine and comparable to sertraline in cohort studies.

MONITORING

- Assess suicidality, activation, and agitation weekly for the first four weeks and after each dose change, most intensively under age 25.
- Check serum sodium at baseline and within two to four weeks in older adults, diuretic users, or anyone with new confusion or falls.
- Obtain an ECG only when combining with other QT-prolonging drugs or in patients with known cardiac conduction disease.
- Track response with PHQ-9 or GAD-7 at baseline and every two to four weeks, and reassess diagnosis if there is no change by week six.
- Screen for bipolar disorder before starting and recheck sleep need and goal-directed activity if improvement seems abrupt or excessive.

INTERACTIONS & CAUTIONS

- Contraindicated with MAOIs and within **14 days** of stopping one, and with linezolid or intravenous methylene blue.
- Contraindicated with pimozide because escitalopram raises pimozide exposure and both agents prolong the QT interval.
- CYP2C19 inhibitors such as omeprazole, fluvoxamine, and fluconazole raise escitalopram levels; consider capping at **10 mg/day** in that setting.
- Additive serotonin syndrome risk with triptans, tramadol, fentanyl, lithium, linezolid, and St. John's wort.
- Increases bleeding risk with aspirin, NSAIDs, and anticoagulants through depletion of platelet serotonin stores.

SPECIAL POPULATIONS

- No consistent teratogenic signal in pregnancy; third-trimester use carries small risks of neonatal adaptation syndrome and pulmonary hypertension.
- Compatible with breastfeeding at a relative infant dose of about 5 percent, with sertraline still generally preferred for a new start.
- Approved from age 12 for depression and age 7 for generalized anxiety, the broadest pediatric anxiety labeling among the SSRIs.
- In patients over 65 the recommended dose is **10 mg/day** given reduced clearance and increased hyponatremia and falls risk.
- Hepatic impairment also limits dosing to 10 mg/day; renal impairment needs no change unless creatinine clearance is under 20 mL/min.

PRESCRIBING PEARLS

- 10 mg escitalopram is roughly equivalent to 20 to 40 mg citalopram, without the hard QT ceiling.
- Fixed-dose trials show little added benefit at 20 mg, so push the dose only for real partial response.
- Best pediatric anxiety labeling of the SSRIs, approved for generalized anxiety from age 7.

References

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NOTE

References follow APA 7th edition style. Dosing, boxed warnings, and interaction data change; confirm every clinical decision against the current FDA prescribing information (DailyMed) and your institution's formulary. This sheet is an educational quick reference and does not replace the full label or clinical judgment.