SELECTIVE SEROTONIN REUPTAKE INHIBITOR

Fluvoxamine

Luvox, Luvox CR (brands discontinued; generics available)

OCD-focused SSRI, the only one approved solely for OCD in the US, and the SSRI with the most dangerous CYP1A2 interaction profile.

USUAL ADULT RANGE	HALF-LIFE	METABOLISM	ONSET
100-300 mg/day PO	15-16 h (IR); 16 h (ER)	CYP2D6; potent 1A2/2C19 inhib	1-2 wks; 6-10 wks in OCD

⚠ FDA BOXED WARNING

Suicidality and antidepressant drugs: antidepressants increased the risk of suicidal thinking and behavior in children, adolescents, and young adults in short-term studies, with no increase beyond age 24 and reduced risk at 65 and older. Monitor all patients closely for clinical worsening and emergent suicidality.

INDICATIONS

- FDA-approved for obsessive-compulsive disorder in adults and in pediatric patients aged 8 to 17, the only US indication for the tablets.
- The extended-release capsule is additionally FDA-approved for social anxiety disorder in adults at **100-300 mg once daily**.
- Not approved for major depressive disorder in the United States, although it is licensed and widely used for depression elsewhere.
- Off-label for panic disorder, post-traumatic stress disorder, and binge-eating disorder when other serotonergic agents have failed.
- Off-label at low doses for insomnia or for augmenting clozapine exposure, a strategy that demands close clozapine level monitoring.
- Its potent sigma-1 agonism has driven off-label interest in catatonia and delirium, but the supporting evidence remains preliminary.

DOSING & TITRATION

- Start the tablet at **50 mg** PO at bedtime and increase by 50 mg every four to seven days as tolerated toward the target dose.
- Adult maximum is **300 mg/day**; total daily doses above 100 mg are divided twice daily with the larger portion given at bedtime.
- Pediatric OCD starts at **25 mg** at bedtime with 25 mg increments; the maximum is 200 mg/day in ages 8 to 11 and 300 mg/day in adolescents.
- The extended-release capsule starts at 100 mg at bedtime, increases by 50 mg weekly, and is given once daily up to **300 mg/day**.
- In hepatic impairment reduce the starting dose and titrate more slowly, since clearance falls by about 30 percent in cirrhosis.
- Taper over several weeks when stopping, since the short half-life makes discontinuation symptoms common after abrupt cessation.

MECHANISM OF ACTION

- Potent serotonin transporter inhibitor with no meaningful affinity for norepinephrine or dopamine transporters at therapeutic concentrations.
- Has the highest sigma-1 receptor agonist potency of any SSRI, which may modulate glutamate signaling and endoplasmic reticulum stress responses.
- Sustained transporter blockade desensitizes 5-HT1A autoreceptors and downregulates postsynaptic 5-HT2 receptors over the weeks of OCD response.
- Free of muscarinic, histaminic, and alpha-1 blockade, so its tolerability problems are gastrointestinal and sedative rather than anticholinergic.
- Potent inhibition of CYP1A2 and CYP2C19 is a molecular property unrelated to serotonin reuptake and defines its clinical interaction risk.

PHARMACOKINETICS

- Well absorbed with about 53 percent bioavailability due to first-pass metabolism; food does not meaningfully change the extent of absorption.
- Half-life is roughly **15 to 16 hours**, short enough that doses above 100 mg/day of the tablet are conventionally split twice daily.
- Metabolized primarily by CYP2D6 through oxidative demethylation, with no clinically active metabolites contributing to effect.
- Kinetics are nonlinear, so a doubling of dose can more than double plasma concentration, especially across the 100 to 300 mg range.
- Cigarette smoking induces CYP1A2 and lowers fluvoxamine levels by roughly 25 percent, so levels rise when a patient quits smoking.

ADVERSE EFFECTS

- Nausea affects up to 40 percent of patients and is the most common reason for early discontinuation, though it usually abates within two weeks.
- Somnolence and sedation are more prominent than with other SSRIs, which is why the dose is anchored at bedtime from the outset.
- Sexual dysfunction, insomnia, headache, asthenia, and dry mouth are common and roughly comparable to rates seen with other SSRIs.
- Hyponatremia from SIADH, increased bleeding risk with NSAIDs or anticoagulants, and treatment-emergent mania are the serious concerns.
- Serotonin syndrome risk is amplified because CYP inhibition raises levels of many co-prescribed serotonergic and sedating drugs.
- Anorexia and weight loss occur early, though weight typically normalizes with longer-term treatment at a stable dose.

MONITORING

- Review every co-prescribed medication for CYP1A2 and CYP2C19 dependence before starting, and again at each dose increase.
- Check clozapine and olanzapine levels within one week of starting or changing fluvoxamine, since exposure can rise several-fold.
- Assess suicidality, activation, and agitation weekly for the first four weeks and after each dose change, especially under age 25.
- Track OCD response with the Y-BOCS every four weeks, allowing 10 to 12 weeks at an adequate dose before declaring nonresponse.
- Check serum sodium at baseline and within two to four weeks in older adults or patients on diuretics.

INTERACTIONS & CAUTIONS

- Contraindicated with MAOIs, linezolid, tizanidine, thioridazine, pimozide, alosetron, and ramelteon because of markedly raised exposure.
- Potent CYP1A2 inhibition raises clozapine, olanzapine, theophylline, caffeine, duloxetine, and melatonin levels, sometimes dangerously.
- Potent CYP2C19 inhibition raises diazepam, omeprazole, phenytoin, and citalopram exposure, and moderate 3A4 and 2C9 inhibition raises warfarin INR.
- Additive serotonin syndrome risk with triptans, tramadol, fentanyl, lithium, and St. John's wort, compounded by its CYP effects.
- Smoking status changes exposure by about 25 percent through CYP1A2 induction, so reassess dose when a patient starts or stops smoking.

SPECIAL POPULATIONS

- Limited pregnancy data show no clear teratogenic signal, but the small dataset means better-studied SSRIs are usually preferred.
- Relative infant dose in breast milk is low, under 2 percent, so fluvoxamine is generally considered acceptable during lactation.
- Approved from age 8 for OCD; female pediatric patients often need lower doses than males, and adolescents tolerate adult ceilings.
- In older adults clearance is about 50 percent lower, so start at 25 mg and titrate slowly with attention to sedation and falls.
- Reduce the starting dose in hepatic impairment; no adjustment is required for renal impairment since elimination is hepatic.

PRESCRIBING PEARLS

- The 1A2 problem: fluvoxamine can triple clozapine levels and cause seizures or severe sedation.
- Only SSRI approved in the US solely for OCD, with the ER capsule adding social anxiety disorder.
- Doses above 100 mg/day of the tablet are split twice daily, larger dose at bedtime.

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.