



Henry A. Nasrallah, MD
Editor-in-Chief

In some cases, a
single psychotropic
can effectively treat
multiple disorders

Parsimonious pharmacotherapy

A substantial proportion of psychiatric patients suffer from a somatic illness concomitantly with a mood, thought, or behavioral disorder. Some complicated patients may be afflicted by a combination of 4 or 5 different psychiatric or general medical disorders, requiring the use of multiple medications, which almost always increases the risk of adverse effects, pharmacokinetic interactions, and adherence gaps, and also escalates costs.

In addition, multiple medications may set off other iatrogenic consequences, such as exacerbation of psychiatric symptoms caused by a nonpsychotropic medication (such as an antihypertensive worsening depressive symptoms) or aggravation of a general medical condition by a psychotropic (such as prolongation of the QT interval or hyperglycemia secondary to an atypical antipsychotic).

Thus, it is quite pleasing when the use of a single medication can simultaneously relieve ≥ 2 unrelated medical disorders, preempting the need for multiple medications. This is the essence of parsimonious pharmacotherapy, a “2 birds with 1 stone” approach that evades polypharmacy and its side effect burden and added cost.

Consider the following examples of how a single psychotropic—by virtue of both its efficacy and what may be considered a side effect—can relieve 2 psychiatric disorders, or a psychiatric and a physical disorder, or even 2 physical disorders:

Depression with premature ejaculation. Delayed orgasm associated with selective serotonin reuptake inhibitors (SSRIs) administered for depression can simultaneously mitigate premature ejaculation as an added benefit.

Bipolar disorder with migraine. Valproate is a commonly used mood stabilizer that also is effective and indicated for migraines. Lithium, another widely used mood stabilizer, can relieve cluster headaches.

A mood or psychotic disorder with insomnia. Antidepressant medications with sedating properties can treat unipolar or bipolar depression and simultaneously allay the insomnia that often coexists with a mood disorder. Similarly, sedating antipsychotic medications administered at bedtime can relieve psychosis and its coexisting insomnia.

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A mood or psychotic disorder with anxiety. Anxiety frequently accompanies unipolar or bipolar depression or schizophrenia. An SSRI can help both depression and anxiety, and some antipsychotics also can relieve both psychosis and anxiety.

Bipolar disorder or schizophrenia with obesity. Some metabolically neutral atypical agents (aripiprazole, lurasidone, ziprasidone) can control schizophrenia symptoms and/or bipolar mania while helping obese patients shed weight acquired during previous treatment with an obesogenic antipsychotic.

Depression and/or anxiety with thrombotic disease. SSRIs treat both depression and anxiety, and their anticoagulant side effect reduces the risk of thrombus formation in patients at risk for thrombotic disease.

Bipolar disorder with leukopenia. Lithium is a standard mood stabilizer that controls bipolar disorder, and its leukocytosis side effect helps increase white blood cell production and alleviate leukopenia.

Depression or anxiety with pain. This is a well-known parsimonious pharmacotherapy. Pain symptoms are a common feature or comorbidity of depression, and practically all antidepressants have analgesic effects.

Bipolar disorder with alcohol or cocaine addiction. The anticonvulsant/mood stabilizer valproate has been shown to significantly reduce both manic symptoms and comorbid heavy drinking in placebo-controlled studies. Another anticonvulsant/antimanic agent, carbamazepine, has been reported to reduce cocaine craving.

Migraine and obesity in a psychiatric patient. Topiramate is approved for migraines but its appetite-suppressing side effect can help decrease weight in patients with a high body mass index.

Posttraumatic stress disorder (PTSD) patients with depression, anxiety, obsessive-compulsive disorder, impulsivity, and insomnia. Here is a good example of how a sedating antidepressant agent—especially an SSRI—can help multiple symptom domains of PTSD.

Most psychiatric practitioners are aware of how to exploit side effects to help a coexisting medical disorder, or how to employ a multi-action drug to relieve a cluster of coexisting symptoms. Thus, psychiatric patients' medical history can and should influence drug selection for the possible employment of parsimonious pharmacotherapy, which is gratifying for clinicians and a welcome antidote to polypharmacy in some patients with multiple medical disorders.



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