**IMIPRAMINE:**

Class: Tricyclic Antidepressant.
Indications: Treatment of depression; treatment of nocturnal enuresis in children, Analgesic for certain chronic and neuropathic pain (including diabetic neuropathy); panic disorder; attention-deficit/hyperactivity disorder (ADHD); post-traumatic stress disorder (PTSD)
Available dosage form in the hospital: TAB (10MG, 25MG).
Trade Names:
Dosage:

**-Depression:**

-*Outpatients*: Initial: 75 mg/day; may increase gradually to 150 mg/day. May be given in divided doses or as a single bedtime dose; maximum: 200 mg/day

-*Inpatients*: Initial: 100-150 mg/day; may increase gradually to 200 mg/day; if no response after 2 weeks, may further increase to 250-300 mg/day. May be given in divided doses or as a single bedtime dose; maximum: 300 mg/day.

****Note:** Maximum antidepressant effect may not be seen for 2 or more weeks after initiation of therapy.

**-Post-traumatic stress disorder (PTSD) (unlabeled use):** Oral: 75-200 mg/day

****MAO inhibitor recommendations:**

-*Switching to or from an MAO inhibitor intended to treat psychiatric disorders:*

- Allow 14 days to elapse between discontinuing an MAO inhibitor intended to treat psychiatric disorders and initiation of imipramine.
- Allow 14 days to elapse between discontinuing imipramine and initiation of an MAO inhibitor intended to treat psychiatric disorders.

-*Use with other MAO inhibitors (linezolid or I.V. methylene blue):*

- Do not initiate imipramine in patients receiving linezolid or I.V. methylene blue; consider other interventions for psychiatric condition.
- If urgent treatment with linezolid or I.V. methylene blue is required in a patient already receiving imipramine and potential benefits outweigh potential risks, discontinue imipramine promptly and administer linezolid or I.V. methylene blue. Monitor for serotonin syndrome for 2 weeks or until 24 hours after the last dose of linezolid or I.V. methylene blue, whichever comes first. May resume imipramine 24 hours after the last dose of linezolid or I.V. methylene blue.

**Geriatric**

**Depression:** Initial: 25-50 mg at bedtime; may increase every 3 days for inpatients and weekly for outpatients if tolerated to a recommended maximum of 100 mg/day.
**MAO inhibitor recommendations:** Refer to adult dosing.

**Renal Impairment:**
No dosage adjustment provided in manufacturer's labeling; use with caution.

**Hepatic Impairment:**
No dosage adjustment provided in manufacturer's labeling; use with caution

Common side effect:

Cardiovascular: Arrhythmia, CHF, ECG changes, heart block, hypertension, MI, orthostatic hypotension, palpitation, stroke, tachycardia

Central nervous system: Agitation, anxiety, confusion, delusions, disorientation, dizziness, drowsiness, fatigue, hallucination, headache, hypomania, insomnia, nightmares, psychosis, restlessness, seizure

Dermatologic: Alopecia, itching, petechiae, photosensitivity, purpura, rash, urticaria

Endocrine & metabolic: Breast enlargement, galactorrhea, gynecomastia, increase or decrease in blood sugar, increase or decrease in libido, SIADH

Gastrointestinal: Abdominal cramps, anorexia, black tongue, constipation, diarrhea, epigastric disorders, ileus, nausea, stomatitis, taste disturbance, vomiting, weight gain/loss, xerostomia

Genitourinary: Impotence, testicular swelling, urinary retention

Hematologic: Agranulocytosis, eosinophilia, thrombocytopenia

Hepatic: Cholestatic jaundice, transaminases increased

Neuromuscular & skeletal: Ataxia, extrapyramidal symptoms, incoordination, numbness, paresthesia, peripheral neuropathy, tingling, tremor, weakness

Ocular: Blurred vision, disturbances of accommodation, mydriasis

Otic: Tinnitus

Miscellaneous: Diaphoresis, falling, hypersensitivity (eg, drug fever, edema)

Pregnancy Risk Factor: Animal reproduction studies are inconclusive. Congenital abnormalities have been reported in humans; however, a casual relationship has not been established. Due to pregnancy-induced physiologic changes, women who are pregnant may require dose adjustments late in pregnancy to achieve euthymia.

The ACOG recommends that therapy for depression during pregnancy be individualized; treatment should incorporate the clinical expertise of the mental health clinician, obstetrician, primary healthcare provider, and pediatrician (ACOG, 2008). According to the American Psychiatric Association (APA), the risks of medication treatment should be weighed against other treatment options and untreated depression. For women who discontinue antidepressant medications during pregnancy and who may be at high risk for postpartum depression, the medications can be restarted following delivery (APA, 2010). Treatment algorithms have been developed by the ACOG and the APA for the management of depression in women prior to conception and during pregnancy (Yonkers, 2009).